his cervical spine suggested an extensive posterior ligament tear with instability at the level of C6-7. His injury was initially treated with a firm polythene neck collar. Subsequent flexion and extension radiographs showed instability with subluxation of C6 on C7. This was stabilised by bone grafting and fixation with Halifax hooks.

Spinal injuries that result from diving accidents are underreported and not confined to water sports. As noted by Mr Grundy and colleagues, alcohol and bravado compound this problem. Pop events may provide the right ingredients for such accidents to occur.

C L M H GIBBONS
A D McLAIN
A H R W SIMPSON

Accident Service,
John Radcliffe Hospital,
Oxford OX3 9DU

1 Grundy E, Penny P, Graham L. Diving into the unknown. *BMJ* 1991;**302**:670-1. (23 March.)

Mental handicap and guardianship

SIR,—Under the Mental Health (Scotland) Act 1984, the term "mental impairment" refers only to compulsory admission to hospital—therefore there is no requirement for a diagnosis of mental handicap to be accompanied by "abnormally aggressive or seriously irresponsible behaviour" before an application for guardianship can be made. Certainly the conditions in the particular case described in "Any Questions"[1] would indeed seem to warrant an application for guardianship under the Mental Health (Scotland) Act 1984. The difficulty is that guardianship is in no way an emergency procedure.

SHEILA McDONALD

Mental Health Unit,
Gogarburn Hospital,
Edinburgh EH12 9BJ

1 Tiplady P. Any questions. *BMJ* 1991;**302**:517. (2 March.)

GPs and long term mentally ill patients

SIR,—Dr Tony Kendrick and colleagues report the results of questioning 369 general practitioners in South West Thames region about their workload from long term mentally ill patients in their practices, and their opinions on who should be the key worker for these patients.[1] They note that nearly half the general practitioners replying were in group practices of three to five partners and that the patients were widely but unevenly distributed, with at most 10 in one practice and often far fewer. It was hard for general practitioners to keep in touch with them, and most general practitioners wanted the community psychiatric nurse to assume responsibility for them for regular care, and referral when necessary to specialist agencies (including general practitioners themselves for physical care).

In 1987 we made a somewhat similar survey as a pilot project on behalf of the research committee of the Royal College of Psychiatrists in a different part of England far from London—the Northern region, which includes Cumbria, Cleveland, and Newcastle.[2] In addition to asking general practitioners for their opinions we inquired about the specific work they did for patients with chronic schizophrenia who were receiving monthly injections of a depot neuroleptic drug. Of the 686 general practitioners who replied, only 125 had such patients on their lists: there were 445 patients, a quarter of whom were actually being seen regularly by community psychiatric nurses, the rest by practice nurses, health visitors, or general practitioners themselves. The distribution of cases was extremely uneven: 41 practices had only one each, but another 40 practices had from four to eight cases each. The number in a practice seemed unrelated to the number of partners. Our statistics contain some flaws, but the general picture in the north seems similar to that near London.

Long term mentally ill patients include several distinct management groups, among them manic-depressive patients with frequent illnesses possibly controlled by lithium, schizophrenic patients receiving oral drugs only or no drugs, and elderly patients with paraphrenia or depression quite apart from dementia (one quarter of the 2000 patients receiving depot neuroleptic drugs in our survey were aged 60 or more, an age group imperfectly considered by Dr Kendrick and colleagues). The uneven scatter of these varied cases, always in small numbers in a practice, makes it difficult for general practitioners to recognise their special features and handle them well, and both in South West Thames and the north general practitioners favour the community psychiatric nurse assuming responsibility for them.

In my opinion the aftercare of long term mentally ill patients in the community would be much improved if community psychiatric nurses were formally recognised everywhere as the key workers. This would mean for them some increase in status as medical auxiliaries, with some more specific training, and the right to refer cases to a general practitioner, psychiatrist, or social worker and (after teaching and experience) to vary the prescription of a limited range of neuroleptic and antiparkinsonian drugs and lithium carbonate. This should be within the NHS and not under local authorities to ensure even standards, adequate staff and funds, and an ease in following cases across local authority boundaries as a proportion of the patients can be mobile. Those patients who are lost because they will not go to see their doctor may be willing to accept the visit of a nurse. Perhaps the royal colleges of nursing, general practitioners, and psychiatrists could jointly develop an acceptable national scheme to improve community care through a formal role for community psychiatric nurses.

JOHN CRAMMER

Steeple Aston,
Oxfordshire OX5 3SE

1 Kendrick T, Sibbauld B, Burns T, Freeling P. Role of general practitioners in care of long term mentally ill patients. *BMJ* 1991;**302**:508-10. (2 March.)
2 Crammer J, Eccleston D. A survey of the use of depot neuroleptics in a whole region. *Psychiatric Bulletin* 1989;**13**:517-20.

Violence in general practice

SIR,—Dr John Hulbert suggests that threats and verbal abuse do not form part of a continuum with physical assault.[1] He also proposes that assaults on doctors are not common enough to have merited their recent publicity.

McNeil and Binder examined the relation between threats of violence in the two weeks before admission to an acute psychiatric ward and subsequent physical assaults.[2] They found that 32% of patients making threats assaulted someone within three days of their admission. Similar findings were reported by Werner *et al*, who found that a third of verbally aggressive patients in their series subsequently committed assault. They also showed that 80% of assaults were preceded by verbal aggression.[3] Although these studies were of psychiatric populations, there seems no reason to doubt that other client groups exhibit a similar progression. Indeed, a recent Health Services Advisory Committee report recognised the potential for threats and verbal aggression to escalate to violence and emphasised the importance of training staff to recognise warning signs.[4]

Dr Hulbert reports that two deputising doctors in his service have been assaulted "with injury": such figures are often underestimates. There is evidence that assaults on staff are underreported, particularly if guidelines are not provided on which incidents to report. Staff may also be afraid that they will be held responsible for the incident having occurred.[5] The Health Services Advisory Committee has recommended that each workplace should have a system for reporting any violent incident with a patient or patient's relative, whether or not it led to damage or injury.[4]

Adequate training significantly reduces both physical assaults and injuries to staff.[6] If assaults on health care professionals are to be reduced it is necessary to accept both that they occur and that they are preventable. Every effort should be made to improve the reporting of violent incidents (including those not resulting in injury), to facilitate training in the recognition and management of aggression, and to provide support when incidents occur. This support should not take the form of victim blaming. We believe that the acceptance of violence as an inevitable part of medicine is the greatest barrier to its reduction, and we agree with Adler *et al* that it is important to state that physical aggression has no place in the health care system.[7]

CAMERON STARK

Argyll and Clyde Health Board,
Paisley PA1 1DU

BRIAN KIDD

Southern General Hospital,
Glasgow G51

1 Hulbert J. Violence in general practice. *BMJ* 1991;**302**:658. (16 March.)
2 McNeil DE, Binder RL. Relationship between pre-admission threats and later violent behaviour by acute psychiatric patients. *Hosp Community Psychiatry* 1989;**40**:605-8.
3 Werner PD, Yesavage JA, Becker JM, Brunsting DW, Isaacs JS. Hostile words and assaultive behaviour on an acute inpatient psychiatric unit. *J Nerv Ment Dis* 1983;**171**:385-7.
4 Health Services Advisory Committee. *Violence to staff in the health services.* London: Health and Safety Commission, 1987.
5 Lion JR, Snyder W, Merrill GL. Underreporting of assaults on staff in a state hospital. *Hosp Community Psychiatry* 1981;**32**:497-8.
6 Infantino JA, Musingo S. Assaults and injuries among staff with and without training in aggression control techniques. *Hosp Community Psychiatry* 1985;**36**:1312-4.
7 Adler WN, Kreeger C, Ziegler P. Patient violence in a private psychiatric hospital. In: Lion JR, Reid WH, eds. *Assaults within psychiatric facilities.* New York: Grune and Stratton, 1983.

Health check ups in middle age

SIR,—I am puzzled as to how Professor Kozo Tatara and colleagues are able to conclude from their data that the use of health checks has caused the lower morbidity in the elderly population—it seems almost trite to point out that all they have shown is an association. To begin with, the Health Services Act was passed only in 1982, so it is difficult to see how the population who were screened (aged 40 or over) relates to the population who required less inpatient care (aged 70 or over). What is more, the paper does not provide any information about the social class structure of the cities, smoking habit, intake of alcohol, etc. Given what we already know about the use of screening services (that they are used most by those in higher social classes with healthier lifestyles and least by those who really need them), is it not equally likely that the rate of attendance for health screening is simply a marker of compliance with "healthy" behaviour? Until we are given more data I feel that it would be extremely unwise to suppose that elderly people are going to be healthier because they are offered more health screening in middle life.

ROGER A FISKEN

Royal Liverpool Hospital,
Liverpool L7 8XP

1 Tatara K, Sinsho F, Suzuki M, *et al*. Relation between use of health checkups starting in middle age and demand for inpatient care by elderly people in Japan. *BMJ* 1991;**302**:615-8. (16 March.)