Fifty-eight questionnaires were returned (58/100): 17.2% nurses had never experience physical violence; 44.8% had rarely experienced physical violence; 32.7% had sometimes and 5.1% had often experienced physical violence. No-one said they had never and only 1.7% rarely experienced verbal violence; 55.1% had sometimes and 43.1% often experienced verbal violence. Of injuries, 1.7% had received many; 31% some and 67.2% none. Of these, only 6.9% required treatments and none needed time off work.

The verbal violence most frequently encountered was obscenities, 45.4%; non-specific threats, 35%; threats to the person, 24.8% and sexual harassment, 9.4%. The majority of verbal abuse came from relatives then medical and then psychiatric patients. The opportunity to discuss incidents was had by 56% but only 9% had a support group; 39.2% had received training in physical violence and 30% in verbal violence. In most cases this was a day course or a lecture.

Our results concur with other studies that physical violence is rare in hospitals but verbal assault is extremely common and seems to be a relatively neglected area in training.

Staffing levels and stress in the department may effect violence. An association has been shown between violence and agency staff levels in psychiatric hospitals (Fineberg *et al*, 1988). We support Drs Kidd & Stark in calling for more formal teaching in aggression management. Provision of support for victims of physical and verbal violence appears lacking. A standardised method of recording verbal violence needs to be developed (Palmistierna & Wistedt, 1987). These issues need urgent consideration to improve safety at work and enhance training and hopefully morale of all health workers.

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Ancestral spirits

DEAR SIRS

I enjoyed Jack Piachaud's article 'A Week in Zimbabwe' (*Psychiatric Bulletin*, March 1992, **16**, 164–166), written in his refreshingly direct style. In it he refers to ancestral spirits which guide the practice of medicine, often through a living "medium".

Is it not so that we too are guided, in the developed world, by the spirits of our ancestors? Two of them appeared on the back cover of the yellow journal, in the form of bronze busts of Stengel and Maudsley. In psychoanalysis particularly, one gets the feeling that the closer an eminent analyst has been to the inner circle of Freud's disciples, the more he functions as a "medium" for Freud's ancestral spirit.

The language may be different, but as Dr Piachaud brought out, the human experience is much the same.

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'The madness of George III'

DEAR SIRS

In his review of Alan Bennett's 'The Madness of George III' (*Psychiatric Bulletin*, April 1992, **16**, 249–250) Hugh Freeman rightly points to the conceptual muddle in the play's conclusion which is exemplified by "Ida Macalpine" who declares that the king was "not mad but suffering from porphyria". However, he wrongly traces this to non-medical historians. I am afraid that the real villains of the piece were the distinguished medical historians Macalpine and Hunter who also incorrectly overemphasised the diagnosis of porphyria which has never been proven. It might amuse your readers to read my review of their book from the *British Journal of Psychiatry* (Levy, 1970) which, *inter alia*, puts the case against the diagnosis of porphyria.

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Screening of the over-75s

DEAR SIRS

Further to Dr MacKenzie's article (*Psychiatric Bulletin*, March 1992, **16**, 146–147), I write to describe related work in Manchester. The continuing development of the Department of Old Age Psychiatry in South Manchester includes the introduction of a liaison service to interested general practitioners. As part of this process I am engaged in a project to assess the feasibility of helping GPs to screen their patients, aged 75 and over, for dementia and depression in a reliable and valid way.

At the planning stage of this work 55 local GPs were sent a questionnaire about screening for

psychiatric disorder. Forty replied, a response rate of 74%. The purpose was to determine their present practice and attitudes and what they required of a screening instrument. This complements MacKenzie's questionnaire with less detailed but more wide ranging information.

In summary, the results were:

(a) 77.5% screened as the opportunity arises
(b) 50% use ancillary staff, though this group still did screening themselves
(c) 60% said they screened for dementia and 47.5% for depression. Only 12.5% used a validated instrument for the assessment of dementia while no-one used an established depression scale
(d) 72.5% said they had 5 minutes or less to assess mental condition; this rises to 87.5% if a cut off of 7 minutes is used
(e) only 5% thought such screening would 'be of no use' with 32.5% thinking it 'very useful'
(f) brevity and patient acceptability were the most important qualities for screening instruments.

It has been shown (Iliffe *et al*, 1991) that ancillary staff can identify psychiatric morbidity but it is clear that GPs do much of the screening themselves. It is likely that positive findings from ancillary staff are passed on to the GP for action. These factors emphasise the importance of increasing GP awareness and knowledge of psychiatric disorder. Regular use of validated screening instruments may improve their ability to identify psychiatric morbidity and raise their awareness of psychiatric disorders in the elderly.

We have therefore set ourselves the task of finding or devising simple measures of cognition and mood which the GP can use within the constraints of his brief consultations.

I agree with Dr MacKenzie that screening the elderly cannot be rationally encouraged without prospective outcome studies. To my knowledge none has specifically addressed mental illness but those that have looked at a wider range of interventions have used crude outcome measures such as mortality and hospital bed occupancy and produced equivocal results. The tools for evaluative research of this kind, e.g. clinical outcome indicators and measures of cost are increasingly available.

The expanding academe of old age psychiatry is well placed to use such methods to provide a rational basis for service development.

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Emergency assessment clinics

DEAR SIRS

The report by Huckle & Nolan (*Psychiatric Bulletin*, February 1992, **16**, 82–83) does not address a number of problems which surround the operation of emergency assessment clinics (EAC). Some were reviewed by myself (Clark, 1982a) and others referred to by Neilson (*Psychiatric Bulletin*, 1992 **16**, 112).

These clinics are usually major gateways to psychiatric in-patient care yet their operations are not always supported in a meaningful way by senior psychiatric staff. Between 1975 and 1978, 80% of admissions to psychiatric in-patient care in one Tayside district were arranged through an EAC. I found in this clinic that junior doctors were reluctant to seek help from their seniors, especially at night. The range of options for alternative management available to junior doctors out of hours can be very limited and the option of reviewing the circumstances which led to the referral usually impossible. This is especially important if situational distress, marital conflict or even a lack of awareness of home based drug treatment possibilities by the general practitioner are involved. I interviewed GPs who had referred patients to an EAC in Tayside in 1979 and suggested that what many were looking for was someone to take over the handling of the crisis rather than advice about how they might manage it themselves. Where doctors did want such advice they were not impressed by an opinion from a senior house officer. Junior doctors are also unlikely to be able to provide much information about home treatment strategies.

Feedback from this gateway to care to referring agents is variable. If it is carried out by senior house officers it is unlikely to influence GPs' referral practices. Diagnoses made by junior doctors may be influenced by a need to legitimate their decisions to admit, especially when a high proportion of patients are admitted. Of 3,391 patients seen at the Dundee EAC in a three year period, only 84 were not given a formal psychiatric diagnosis and only 1.7% sent away.

In a different study (Clark, 1982b) attenders at an EAC were of lower social class with more serious diagnoses than those attending an out-patient clinic. More patients attending the out-patient clinic were considered to have no psychiatric diagnoses. Out-patient attenders were seen by consultants and/or senior registrars; EAC attenders were seen by senior house officers or registrars.

EACs appear to offer the expertise of the most junior psychiatric medical staff to the most acutely disturbed lower socio-economic status patients in a