Our paper was not meant to be judgemental but was an attempt to make professionals aware of a group of people, however small, who have real problems relating to their culture, beliefs and language.

A. JAWAD SHEIKH and SAEED FAROOQ, *Mental Health Services, Bruce Burns Centre, Solihull Hospital, West Midlands B91 2JL*

Risk of violence to junior doctors

Sir: Even if the commendable recommendations on the physical layout of assessment areas made in Lillywhite's article (*Psychiatric Bulletin*, January 1994, **19**, 24–27) were met, I believe that junior doctors would still be at high risk of being the target of violent patients. The initiative of the College to familiarise junior doctors with 'breakaway' techniques will certainly improve the chances of doctors to reduce injury to themselves and patients, although if these skills are to be effective, they should be practised and revised at shorter and more frequent intervals than currently.

A useful addition to helping reduce the risk is to consider ways to prevent aggression before it begins. I propound training to improve skills in two areas: detection of cues of impending physical aggression of patients during interviews and learning methods to defuse verbal aggression of patients, so often present and at times the prelude to physical violence. I suggest the use of expert tuition using video and role-play techniques.

DAVID MARCHEVSKY, *Bentham Unit, Ealing Hospital, Southall, Middlesex UB1 3EU*

Supervision registers: is there the need for a referendum among psychiatrists?

Sir: I wish to join the growing number of psychiatrists who say that 'strong concern' about the guidance on the introduction of supervision registers is not enough. I am in complete agreement with Dr David Gill (*Psychiatric Bulletin*, 1994, **18**, 773–774) that we must not collude with something which not only "threatens civil liberties and breaches confidentiality" but also increases stigma and implicitly endorses a simplistic direct link between violence and mental illness, which is incorrect.

Like him, I have been amazed at the number of psychiatrists who appear to conform because the government says they should. However, I remain optimistic that many of my colleagues are individually resisting and I would like to suggest a referendum or similar measure. If the majority of Members and Fellows of the College voted to refuse to implement the register, the NHS Executive would have no choice but to withdraw the present guidelines.

At the risk of stating the obvious, it is vital that psychiatrists clearly emphasise that the most, indeed the only, effective mental health services are ones which are well-resourced and user-friendly and which engage the large majority of seriously mentally ill patients in voluntary participation and treatment. An efficient care programme approach can and should incorporate all that is necessary to identify, target, actively assess and review, with assertive outreach and multi-agency and multi-district communication when appropriate, the same particularly vulnerable group outlined in the supervision register guidelines. Therapeutically the register is both superfluous and counter-productive.

The government is now pursuing new legislation in the form of a supervised discharge order. Should this controversial proposal become law, there would, of course, be a logical basis for a supervision register within a clear legal framework.

ALISON ABRAHAM, *Mid Sussex NHS Trust, The Princess Royal Hospital, Haywards Heath, West Sussex RH16 4EX*

NHS superannuation regulations

Sir: May I draw attention to some errors in Dr M. J. Harris's note on the NHS superannuation regulations (*Psychiatric Bulletin*, 1994, **18**, 713).

Under the regulations a mental health officer is a whole-time member of the staff of a hospital used for the treatment of persons suffering from mental disorders who is employed for the whole, or almost the whole, of his time in the treatment or care of such persons or a maximum part-time specialist employed solely in the treatment of the mentally disordered.

It should be noted that, to qualify for mental health officer status, whole-time employees must be employed "for the whole, or almost

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the whole" of their time in the treatment or care of mentally disordered persons. It is not sufficient to devote "the majority of their clinical sessions to clinical psychiatry" as stated in Dr Harris's note.

It is not necessary to apply for mental health officer status. However, it would be wise for anyone who is uncertain whether he comes within the scope of the above definition (for example, perhaps, a NHS psychiatrist who is not attached to the staff of any hospital, or a psychiatrist who has significantly reduced his clinical commitments in order to undertake administrative or other non-clinical work) to confirm his position with the NHS Pensions Agency at Fleetwood.

An increasing number of psychiatrists are employed by NHS trusts on terms which differ from the national Terms and Conditions of Service for Hospital Medical and Dental Staff. It is advisable for anyone in this position to clarify with his employers whether or not the whole of his earnings are pensionable. Contributions can be made to a personal pension scheme in respect of any non-pensionable earnings.

It is service which is doubled after 20 years service as a mental health officer, not contributions. Also, only complete years of service are doubled. Hence 32.5 years service as a mental health officer counts as 44.5 years for the purpose of calculating benefits, not 45 years as stated.

I share Dr Harris's sadness at the abolition of mental health officer status, but it is an anachronism whose continuance is difficult to justify.

IAN G. BRONKS, *27 Friar Gate, Derby DE1 1BY*

Sir: I found Dr Bronks' letter very helpful, particularly in clarifying some of the issues about which I was inaccurate. However, the main purpose of my original note was to draw attention to the change in the superannuation regulations and to indicate to people that they should check that they are noted as having mental health officer status. Dr Bronks is, of course, quite right that you do not have to register. However the NHS Pensions Agency does not always accurately record people's mental health officer status, particularly if they have had breaks in service, worked part-time or had academic posts, and it is therefore worthwhile checking with the Pensions Agency whether they have accurately recorded all the years worked on a whole-time basis being employed for the whole, or almost the whole, of the time in the treatment or care of mentally disordered persons.

I think Dr Bronks is quite right in saying that it is advisable for anyone now being employed by NHS trusts on terms which differ from national terms and conditions of service to clarify their position with their employers and with the Pensions Agency.

M. J. HARRIS, *Sub Dean, Royal College of Psychiatrists*

Intravenous neuroleptic misuse

Sir: We report on two male patients with schizophrenia who intravenously injected crushed tablets of chlorpromazine and haloperidol respectively.

Case a

The first patient, age 28, had a ten year history of paranoid schizophrenia. He had been an in-patient for over two years with persistent auditory hallucinations and paranoid delusions. In his late teens he had abused a variety of drugs including heroin intravenously. Despite receiving regular neuroleptic medication in high dose he would frequently request additional chlorpromazine tablets from nursing staff. For many months he self-administered these crushed chlorpromazine tablets intravenously, discarding the used syringes outside his bedroom ward window. Over this period of time, urinary drug screens were performed frequently but only revealed the presence of phenothiazines. Later after commencing clozapine he admitted using crushed chlorpromazine tablets intravenous to reduce his psychotic symptoms.

Case b

The second patient, age 30, had an eight year history of schizophrenia and was detained under section 37 of the 1983 Mental Health Act with restrictions under section 41. He was known to have abused cannabis regularly for many years but not known to have used intravenous drugs. He was found twice crushing haloperidol tablets and in possession of a syringe and tourniquet. He admitted injecting himself intravenously with this preparation on several former occasions.

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