or resources to help manage patients in the community. It has been suggested that a supervision register might be developed in conjunction with the care programme approach.

Most mental health professionals support the principles of the care programme approach. They would also agree that its implementation has been patchy as its enormous resource implications have not been fully acknowledged. At a recent meeting medical, nursing, and other colleagues expressed their serious concerns about the introduction of the supervision register. Some of the most important concerns are that there is no clear benefit to patients; that the criteria for inclusion in the register are too broad; how patients should be informed of their inclusion on the register and how this may affect them; that there has been very little consultation; that there is no extra resource; that not all suicides, and certainly not all violent behaviour, are associated with psychiatric disorder; and how patients can come off the register.

It is important to follow up patients with serious psychiatric illness who are at risk of suicide or of harming others. Good follow up can be organised through the care programme approach if it is given sufficient resources.

People with serious psychiatric illness need good community provision, housing, employment, and easy access to well funded psychiatric services. We believe that we are being asked by the government to collude in an exercise designed to shift accountability and disguise poor psychiatric provision. The supervision register is of no proved benefit to patients. Indeed it may be harmful, both directly by the official labelling of some people as potentially at risk and indirectly by obscuring the real underlying problems for some of our more seriously ill patients.

S O'CONNOR Consultant psychiatrist	PAUL BIRKETT Consultant psychiatrist
J PARKER Consultant psychiatrist	P DEDMAN Consultant psychiatrist
D MUMFORD Consultant psychiatrist	R BROWN Consultant psychotherapist
D A COOK Consultant psychiatrist	J SHORT Senior registrar
D KINGHAM Consultant psychiatrist	S ARNOTT senior registrar
P J A WILLEMS Consultant psychiatrist	A MOORE Senior registrar

United Bristol Healthcare Trust,
Bristol BS19 3SG

- 1 Coid J. Failure in community care: psychiatry's dilemma. *BMJ* 1994;308:805-6. (26 March.)
- 2 Kammerling M, O'Connor S. Unemployment rate as predictor of rate of psychiatric admission. *BMJ* 1993;307:1536-9.

Targeting community mental health services

EDITOR,—We agree with the conclusions drawn by Alison S Conway and colleagues¹ and would like to comment on several aspects of their results.

A community based mental health service may be in a position to facilitate admissions, even though it has "avoiding admissions" as one of its goals, but we think that rather than quantifying admissions, finer measures of the effectiveness of such a service (as well as appropriateness of bed use) are whether admissions are planned or emergency, voluntary or involuntary, and the duration of each admission episode.² The authors do not provide any data on this and it would be interesting to know if the corrected means for durations of admissions decreased after the service became part of the community services.

An accurate assessment of disabilities in psychiatric patients is fraught with problems³ and should be based on in depth and qualitative measurements.⁴ In that context, we need not necessarily be disheartened at results from

measures such as employment, when about 2.7 million people (most of whom are psychiatrically well) are unemployed, and accommodation, which depends heavily on external factors such as housing associations. The relatively disappointing results on these measures may partly be explained by low rates of contact with social workers, but to test this it would be necessary to compare outcomes of two matched groups—one with a high level of input from social services—under care management arrangements, for example—and the other receiving standard input from social services. Furthermore, optimal implementation of care programming does not necessarily require social workers to be key workers in order to be effective members of community mental health services.

Although community care is inherent in de-institutionalisation, it is probably unjustified to extrapolate the results of experiences with such resettlement programmes to community based services for non-institutional, younger, and more acutely mentally ill people. Thus, the absence of change in mean social functioning after three years of aftercare provision by community oriented services could, in reality, reflect the prevention of a further deterioration and "slipping through the net" which may well have resulted with traditional, hospital based services.

Results similar to the authors' have been reported elsewhere outside the United Kingdom⁵ and provide further proof that good psychiatric care involves close multidisciplinary teamwork in both community and hospital. Instead of being mutually exclusive, they can—and should—be mutually complementary.

Academic Department of Psychiatry,
St Mary's Hospital Medical School,
London W2 1NY

Paddington Mental Health Team,
Westminster Social Services,
London W2 1NY

Napsbury Hospital,
London Colney,
Hertfordshire AL2 1AA

Department of Psychiatry,
St Mary's Hospital,
London W2 1NY

NARESH GANDHI
Clinical research fellow

SUE HOLMES
Team manager

MARTIN LOCK
Senior registrar in psychiatry

NITIN PURANDARE
Registrar

- 1 Conway AS, Melzer D, Hale AS. The outcome of targeting mental health services: evidence from the West Lambeth schizophrenia cohort. *BMJ* 1994;308:627-30. (5 March.)
- 2 Tyrer P, Ferguson B, Wadsworth J. Liaison psychiatry in general practice: the comprehensive collaborative model. *Acta Psychiatr Scand* 1990;81:359-63.
- 3 Heiman EM, Shanfield SB. Psychiatric disability assessment: clarification of problems. *Compr Psychiatry* 1978;19:449-54.
- 4 De Jong A, Giel R, Slooff CJ, Wiersma D. Social disability and outcome in schizophrenic patients. *Br J Psychiatry* 1985;147: 631-6.
- 5 Salokangas RKR. Community care and need for treatment of schizophrenic patients in Finland. *Br J Psychiatry* 1994; 164(suppl 23):115-20.

Preventing injuries from bar glasses

Lobby the government for a safety standard

EDITOR,—Jonathan Shepherd's editorial on preventing injuries from bar glasses highlights the importance of violence as a public health issue.¹

Work in the south east of England to determine priorities in preventing accidents and reducing injuries that are consistent with the *Health of the Nation* strategy has provisionally identified assaults among young men (aged 15 to 34) as an area for further consideration.²

As a result, East Sussex Health Authority is currently conducting a retrospective study into the causes of injury among the 316 declared victims of assault who attended a local accident and emergency department in 1993. How many of these assaults involved injuries from beer glasses has yet to be determined. Initial correspondence with the local licensed victuallers association suggests, however, that publicans will be resistant to the voluntary introduction of tempered glassware regardless of the final extent of the problem. This is partly because they are suspicious that the safety properties of tempered glassware have been exaggerated for commercial reasons.

Therein lies a catch 22. Unless a large control group of public houses voluntarily adopts tempered glassware, it is difficult to build a strong case for the effectiveness of tempered glass in reducing injuries. Without a convincing case for its benefits, it is difficult to persuade publicans to gradually switch over to it. However, the gravity of the physical and psychological trauma of attacks with glasses is such that preventive action should not be further delayed by this quandary.

The government is currently reviewing existing consumer protection legislation. I think that public health doctors should use this opportunity to lobby in support of Shepherd's arguments for a safety standard for beer glasses.

JEREMY COLE
Health promotion adviser

Accident Prevention Health Promotion Unit,
East Sussex Health Authority,
Eastbourne BN21 3XY

- 1 Shepherd J. Preventing injuries from bar glasses. *BMJ* 1994;308: 932-3. (9 April.)
- 2 Cryer C, Davidson L, Styles C. *Injury epidemiology in the south east: identifying priorities for action*. London: South East Thames Regional Health Authority, 1993.

No such thing as safe glass

EDITOR,—Jonathan Shepherd has noted the differences between tempered (toughened) and annealed (untoughened) glasses.¹ In 1975 it was reported that 22% of crimes of violence in a Scottish city involved "bottles or tumblers."² The British crime survey indicated that only 31% of violent offences in public houses or clubs were reported to the police. There were an estimated 420 000 assaults in such places in England and Wales in 1991.³

During 1993 a survey was conducted in Edinburgh. A systematic random sample of 100 public houses was selected. Telephone interviews were conducted with their managers or owners. Ninety five respondents cooperated with this exercise.

Of those who responded, 51 used only annealed glasses, 31 only tempered glasses, and nine both; four were unsure. Tempered glasses were reported to be safer, more durable, and therefore slightly cheaper than annealed glasses. Of managers using only one type of glass, 19 stated that tempered glasses were safer, none preferred annealed glasses, and 10 were uncertain. On the other hand, of managers using one brand of annealed glass, seven stated that tempered glasses were safer and 29 did not know ($\chi^2=9.72$, $df=1$; $P<0.01$). Eleven respondents who thought that tempered glasses were safer mentioned that such glasses shattered into small innocuous fragments, but two managers reported that tempered glasses sometimes exploded in hot water. More injuries to staff had occurred during the previous two years with annealed than with tempered glasses ($\chi^2=9.72$, $df=1$; $P<0.01$). Five injuries caused by glasses were deliberate; only one of them involved a tempered glass. Only two serious accidental injuries were related to glasses, one a tempered glass, the other an annealed glass. Seventy two reports of injuries from glasses or bottles were noted in the past two years. Only