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.

https://doi.org/10.1192/pb.19.5.324 Published online by Cambridge University Press

Both these patients reported using neuroleptics intravenously for their sedative properties. Despite this potentially hazardous activity no complications occurred other than mild local phlebitis at the site of injection.

RICHARD DUFFETT and MARTIN LAKER, *Royal London Hospital Rotation*

No such thing as a free lunch – or a leather-bound desk diary!

Sir: Dr Azuonye (*Psychiatric Bulletin*, 1994, **18**, 779) provides an interesting glimpse into how consultant psychiatrists view medical representatives. I am surprised he finds that the majority of 'gift-accepting' consultants feel they are not influenced in their choice of drug by these gifts.

We should not forget that medical representatives are employed to sell their products. They are not part of the health service and any gifts or sponsorship they provide are for the purpose of increasing their 'market-share'.

Whether by material gifts or education, drug companies must believe that their representatives influence doctors' prescribing. Let us not kid ourselves otherwise.

PAUL RAMCHANDANI, *Newsam Centre, Seacroft Hospital, York Road, Leeds*

Community treatment orders

Sir: We were interested to read Dr Turner's comments on a recent debate at the Royal College of Psychiatrists concerning community treatment orders (CTO) (*Psychiatric Bulletin*, 1994, **18**, 657–659).

A CTO could prove to be the least restrictive form of treatment for many patients. Its use could be limited to patients who relapse soon after discharge and become potentially dangerous to others because of their non-compliance. It would improve treatment compliance, reduce time spent in hospital and reduce levels of dangerousness (Sensky *et al*, 1991).

The liberty of the individual should be protected by the Mental Health Act (MHA) 1983. Patients considered at risk on discharge from a section 3, and previously dangerous to others because of non-compliance, could be assessed by an expanded Mental Health Review Tribunal (MHRT), a body which already exists to ensure the proper implementation of the MHA. If appropriate, on discharge from section and hospital, restrictions could be imposed regarding compliance with treatment. This would act in a similar way to the existing section 41 restrictions, sometimes added to a section 37 treatment order. We propose the restrictions would be administered by the MHRT.

Secondly, the tribunal could insist on a comprehensive treatment plan for each patient which would include the use of non-pharmacological therapies in addition to medication. Thirdly, the risk of developing adverse effects such as tardive dyskinesia is considerably increased by so-called 'drug holidays' (Glazer *et al*, 1989) so this cannot be used in argument against a CTO.

The issue of racism within psychiatry must be discussed but is not a valid argument against at CTO. To do so prevents progress but not racism. Once again the tribunal would be expected to prevent potential abuses.

It is disturbing to hear the suggestion that compulsory treatment in the community would be "community care on the cheap". Given that more research is required to enable the costing of community care it would be facetious to argue that proposing a CTO is driven by economics and not a wish to see more responsive mental health legislation.

As doctors we are more interested in appropriate medical treatment for our patients and less in the politics of detention. While previously these two provisions were complementary, the move to the community means this is no longer so and we must now insist that we are only prepared to take responsibility for the treatment of dangerous non-compliant out-patients if we have the backing of statutes to enforce it. Furthermore, if the state denies us this then it should not attempt to apportion blame with the use of supervision registers, which are in any case contrary to the tenets of patient confidentiality.

GLAZER, W. M., BOWERS, M. B. Jr., CHARNEY, D. S. & HENINGER, G. R. (1989) The effect of neuroleptic discontinuation on psychopathology, involuntary movements and biochemical measures in patients with persistent tardive dyskinesia. *Biological Psychiatry*, **26**, 224–233.

SENSKY, T., HUGHES, T. & HIRSCH, S. (1991) Compulsory psychiatric treatment in the community. *British Journal of Psychiatry*, **158**, 792–799.

MARTIN LOCK, *Three Bridges Regional Secure Unit, Ealing Hospital, Southall* UB1 3EU; and