

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.

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### **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.

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### **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 a 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.

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