

around Comanesti in the Bacau district of Romania for the past year. The Group has found that there are no psychiatric services in Comanesti, and the physician at Comanesti Hospital has requested assistance from the Group in setting up a psychiatric clinic and in instruction in modern methods of treatment; it is a great need requiring urgent action.

A suitably qualified psychiatrist interested in providing help in this way would have the full backing of the Appeal Group. It is suggested that he or she should make a preliminary visit to the town to meet the doctors and other key people to discuss the plans in detail. Arrangements could then be made for a return visit to organise the setting up of the service, subject to the approval of the plans by the Director of Health in Bacau. Interested psychiatrists should get in touch with Dr Isabel D. Johnson, Medical Adviser, Biggin Hill and Tatsfield Romanian Relief Appeal, 22 Sandhills Road, Reigate, Surrey RH2 7JR.

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Conceptions of 'cannabis psychosis'

DEAR SIRS

As a District Medical Officer in Tobago, West Indies, I looked at the attitudes of local health workers to the concept of 'cannabis psychosis' using a questionnaire based on that in Littlewood's study among 132 psychiatrists in the Birmingham region (Littlewood, 1988). My numbers are much smaller and obviously lack the statistical power of Dr Littlewood's study, but may be of interest as they reflect attributes among the local doctors and community psychiatric nurses responsible for this whole community.

Questionnaires were given to 11 doctors and two community psychiatric nurses. Five of the doctors said they knew little about the subject as they had specialised in other fields. Of the remaining eight respondents, all found cannabis psychosis a "useful diagnosis"; seven had seen patients whom they considered to have this condition; one felt that these patients were more likely to be detained compulsorily than other patients, three disagreed and four did not know; one agreed that cannabis psychosis is "a self-

limiting condition", two disagreed and five did not know; five felt that major tranquillisers were "the best single treatment", two others chose reassurance and one chose ECT; five believed that cannabis psychosis was "more common" among people of African origin, while one felt it was commoner among people of racially mixed origin. This increased frequency was felt to be because this group smoked more cannabis in six cases, and one person replied that they were more vulnerable to its effects. Five people felt that cannabis use was "a significant mental health risk" and two disagreed. Two people felt that it caused a distinct illness and the remainder felt that it precipitated other mental illnesses. The group of respondents had been involved in 31 psychiatric admissions on the island in the previous year, of which 19 were compulsory. Three of these admissions were caused by or involved the use of ganja.

Cannabis psychosis was a label often used a few years ago in the UK (Camey *et al*, 1984), particularly regarding disturbed, young, black male patients, although its use as a label has become controversial and its existence as a diagnostic entity questioned. It is interesting, therefore, that unlike the British psychiatrists studied, all my respondents accepted it as an entity. As in Dr Littlewood's study, most respondents felt that major tranquillisers were the best treatment and most respondents felt that cannabis psychosis was commoner among people of African origin, not because of susceptibility but because they smoked more cannabis. Most felt that cannabis use was a significant mental health risk in contrast to the British psychiatrists' responses; indeed, they suggested that a tenth of urgent psychiatric admissions involved the use of cannabis.

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