Practice and communication policies which include GPs will improve the relationship with the CMHT, the mentally handicapped people and the GPs.

DORA KOHEN
Charing Cross/Westminster Medical School
St Dunstan's Road, London W6

SHEILA WHITE
Community Services for People with Learning Difficulties
48 Glenthorne Road, London W6

RICHARD MILLINGTON
Community Services for People with Learning Difficulties
48 Glenthorne Road, London W6

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"Cannabis psychosis"

DEAR SIRS

I read with interest the letter by Dr Cembrowicz (*Psychiatric Bulletin*, May 1991, **15**, 303) which reported on the popularity of "cannabis psychosis" as a diagnosis used by health workers in Tobago, West Indies. The study of psychiatrists in Birmingham which Dr Cembrowicz referred to (Littlewood, 1988) reported that although most did not find "cannabis psychosis" a useful diagnosis, a significant minority (40 out of 104 respondents) did. In view of the lack of evidence to support the separate clinical entity of "cannabis psychosis", and the lack of agreement among psychiatrists as to what this label represents, it has been suggested that clinicians discard the term (Thornicroft, 1990) and instead employ the appropriate diagnosis from ICD-9 or DSM–III–R. Cases where there is clouding of consciousness would be coded as "transient organic psychotic conditions" (293.0) in ICD-9 and as "cannabis delirium" (292.81) in DSM–III–R. Those occurring in clear consciousness would be coded as "paranoid and/or hallucinatory states induced by drugs" (292.1) in ICD-9 and as "cannabis delusional disorder" (292.11) in DSM–III–R.

Littlewood commented on the readiness of the psychiatrists he studied to prescribe major tranquillisers for cases of "cannabis psychosis", despite their perception of this as a self-limiting condition. Improvement in our knowledge of how to treat such cases is likely to be hampered if clinicians fail to distinguish between those showing features of an acute organic reaction and those resembling a functional psychosis.

The diagnosis of "cannabis psychosis" may survive in clinical practice, like the "amotivational syndrome" did for many years, not because of its validity but because it fits popular assumptions about the effects of illicit drug use. Or could it just be that it is easier to remember than the appropriate ICD or DSM code?

HUW THOMAS
Hensol Hospital
Near Pontyclun,
Mid-Glamorgan, CF7 8YS

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Ode to the Code

DEAR SIRS

I read Dr Travers's article on the new Code of Practice (*Psychiatric Bulletin*, May 1991, **15**, 274–275) with some interest. My interest was abruptly interrupted in the paragraph dealing with guardianship, by two intrusive pieces of obfuscation. Being a psychiatrist and therefore in the know with respect to the private, and often stigmatising, language which we seem to develop, I was able to understand it on second or third reading. I am fairly sure though that those who are not in the know would be completely puzzled. May I therefore make yet another plea for dropping curious neologisms and new definitions of commonplace words which add nothing to comprehension.

The passage that gave me a problem is "guardianship is to be considered as an alternative to sectioning". The aggressive word "sectioning" here does not of course refer to some frightful fate which befalls the patient, but simply compulsory admission. Furthermore, guardianship has its own sections of the Mental Health Act 1983. In the next sentence we are told that it is sad that those mentally disordered individuals under guardianship are referred to as patients? This puzzle is illuminated by an implied new definition that an individual has to be in hospital before they can qualify for the term patient. What on earth am I supposed to call my out-patients? I treat "patients" on guardianship orders and I expect many other psychiatrists do also.

JOHN GUNN
Institute of Psychiatry
De Crespigny Park
London SE5 8AF

Psychiatry in war

DEAR SIRS

There are a couple of ambiguities in Jacqueline Atkinson's two informative articles (*Psychiatric*