Effects of neuroleptic medication

DEAR SIRS

Chapman & Mulvihill's paper on perceptions of the clinical and psychosocial effects of neuroleptic medication by patients with schizophrenia (*Psychiatric Bulletin*, 1990, **14**, 331–332) produced two surprising results. Firstly, the reported response rate was 72% from a postal questionnaire, and secondly, the overwhelming majority of patients responded favourably to questions about medication. These results were unexpected from a group of patients whose internal and external worlds are often chaotic, and at odds with our clinical experience of having repeatedly to persuade patients of the benefits of remaining on medication. We therefore set out to determine if those patients seen most often by hospital doctors are less contented with treatment.

Postal questionnaires asking about perceived benefits and side effects of neuroleptic medication were sent to members of the Oxford branch of the National Schizophrenia Fellowship (NSF), a similar organisation to the original study. For comparison, questionnaires were given to patients receiving depot neuroleptics at hospital run facilities, and at general practice health centres served by the same psychiatric team. Patients receiving depot medication were chosen as they were easily identifiable, and were thought more likely both to have seen a psychiatrist and suffer from schizophrenia.

Of 58 questionnaires sent to NSF members, 14 were completed and returned (24%), ten from subjects receiving depot medication. Ten out of 16 hospital patients (62%) and nine out of 17 health centre patients (59%) agreed to complete the questionnaires. Those who refused to participate were known to be mentally unwell or refusing medication at the time. The groups were similar with respect to past history of illness.

Of those patients receiving depot medication, 24 out of 29 (83%) thought medication was quite or very important in aiding recovery from illness, and a similar proportion thought it important in helping them to remain well. Seventeen out of 29 patients (59%) reported that side effects had interfered with their life "quite a lot" or "very much". Weighing up the benefits and side effects of treatment, 17 out of 29 (58%) were "quite" or "very" satisfied with their medication.

The response rate of 24% from NSF members in this study is closer to that which we expected. This suggests the previous study population was biased and the replies were from an atypical group of patients. The response rate from the other two groups was better but patients were approached personally. Information available about non-responders suggests that these patients were less compliant and more dissatisfied with their medication. With a low response rate, it is difficult to derive firm conclusions from the findings. It is clear, however, that many patients recognise benefits from neuroleptics despite suffering concomitant side effects. They appreciate being asked about side effects and their reports being taken seriously. They also appreciate trials of alternative medication which may lessen their drug induced handicap.

ANDREW BARKER

Research Institute for the Care of the Elderly
St Martin's Hospital
Bath BA2 5RP

JANE SCOURFIELD

Whitchurch Hospital
Cardiff

LOUISE SELL

The Elms Clinic
Horton General Hospital
Banbury

"Cannabis psychosis"

DEAR SIRS

I am the only consultant psychiatrist for the Tairawhiti District on the East Coast of the North Island of New Zealand, which has a population of 48,000, and covers an area almost as large as Wales. The coastal area to the north of Gisborne has long been notorious for the growing of cannabis, offering for the grower the best sunshine in New Zealand and the lowest police presence. Over the last year, there have been an average of two acutely psychotic patients transferred per month from the East Coast to the Gisborne Hospital for treatment. Because of the high incidence of cannabis use in that area among the unemployed (recent estimate equals 90% unemployment), we routinely conduct drug screens on urine specimens. Of the last 15 such admissions from the East Coast, 10 have proved to be positive for urinary cannabinoids. These patients tend to get well quickly with a minimum of treatment.

We have, too, had the experience of such patients being discharged, free of psychotic symptoms, only to return with a florid relapse, and biochemical evidence of further consumption of cannabis. This type of evidence is difficult to refute, and my feeling is that the nosological status of "cannabis psychosis" will not remain unclear for many more years.

It is because there is no specific symptom cluster associated with cannabis use (i.e. the symptoms can mimic other psychotic states), that the entity of cannabis psychosis is eschewed in the literature. The thinking is confused. Because the symptoms occur in other states, how can it be argued that the entity does

not exist? After all, many diagnostic entities are based on aetiology, not symptoms.

JAMES EVA

Tairawhiti Area Health Board
Private Bag
Gisborne, New Zealand

'Black' issues in mental health practice in the United Kingdom

DEAR SIRS

In the year beginning October 1990, I admitted 10 African-Caribbean patients at the Royal London Hospital (St Clement's), three informally, two under Section 2, one under a Section 4, later converted to a Section 2, and four by way of the penal system (one Section 35, two under Section 37 and one Section 37/41). Seven of these patients were violent before admission, of whom six were violent towards nursing staff. With the exception of one female patient, each had been taking illegal drugs such as cannabis and LSD. The diagnoses made were: affective personality disorder (1), drug-induced psychosis (2) and schizophrenia and drug abuse (7).

Only a handful of these 10 patients were referred as non-emergency cases by their general practitioners, seven were admitted under Sections of the Mental Health Act 1983, four had come in by way of the Prison Service, six had been violent before and during their admission, and nine had been on illicit drugs. Follow-up showed many continuing to take drugs and being readmitted in a floridly psychotic state with others simply not showing up for appointments. This handful of patients fulfils all of the 'racial sterotypes' about which African-Caribbean people bitterly complain and whose treatment provokes considerable controversy. For many African-Caribbeans, what is done for their mentally ill is from a racist perspective which has a negative effect on the utilisation of psychiatric services.

The College (1989) has been very concerned about racism in the training and employment of psychiatrists, and in the delivery of care to mentally disturbed members of ethnic minorities. The Special Committee set up in 1987 proposed 26 Recommendations aimed at reducing the impact of racial thinking on psychiatric training and practice.

I think that now is the time to try to find out whether the complaints of African-Caribbeans are justified, that they make use of the avaiable resources, and that they are properly treated. Psychiatrists of African-Caribbean origin should play a positive and constructive part in this process.

I would recommend that the Executive Committees of the African-Caribbean Medical Society, the Afro-Caribbean Mental Health Association and the National Black Mental Health Association should arrange to meet with the members of the College Special Committee and use the 26 Recommendations as a basis for discussion.

I. O. AZUONYE

The Royal London Hospital (St Clement's)
London E3 4LL

Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1990) Statement by Council on psychiatric practice and training in British multi-ethnic society. *Psychiatric Bulletin*, **14**, 432–437.

DEAR SIRS

Dr Azuonye describes 10 patients under his care, including the nature of their referral, their legal status and their mental state. There is nothing in his description to indicate poor medical practice, nor discrimination against these patients and the only distinguishing feature of a racial nature is that he categorises these patients as African-Caribbean.

We would certainly welcome a well-researched investigation into the nature of the treatment received by racial minorities. The Special (Ethnic Issues) Committee has now reported to the College and therefore been discharged. However, if the organisations Dr Azuonye mentioned would like to make contact with the College concerning African-Caribbean mental health issues, I would be very happy to meet them.

Professor A. C. P. SIMS
President

Terminator 2 – Judgement Day

DEAR SIRS

I agree with Ralph Footring (*Psychiatric Bulletin*, December 1991, **15**, 796–797), that 'Terminator 2' was a thoroughly enjoyable movie but that psychiatric care was displayed in its worst possible light.

An altogether different psychiatric perspective in the film is in the character of the Terminator himself. He is a robot without emotions who has been constructed with the ability to learn from experience. During the film he is curious about the tears of the boy he has been programmed to protect: he cannot comprehend them. Later on the boy urges him not to kill anybody: he does not understand this either. This theme of understanding another's existence and feelings is pursued in the film within the relationship between the Terminator and his ward. The film ends with the robot seemingly having grasped some notion of what human emotions are, and implicitly even having some of his own. The screenplay makes this an important part of the film.

Autistic children and adults have difficulty in acknowledging the existence of others and being emotionally connected to the world. There is considerable public fascination over autistic states of mind. This is reflected in popular media. Mr Spock in