30 years ago may be recreated to some extent in community homes run by untrained staff, in seaside areas where perhaps insufficient resources have been devoted to a comprehensive re-provision programme.

The opportunity may exist for mental health professionals to train the lay staff, to enable them to further improve the quality of care given in their homes.

It would be interesting to read of the experience of clinicians in other districts.

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"Black" issues in Mental Health Practice (Dr Azuonye) "Cannabis psychosis" (Dr Eva)

DEAR SIRS

I agree with Professor Sims' comment on Dr Azuonye's letter (*Psychiatric Bulletin*, May 1992, **16**, 310–311). I have treated large numbers of white patients with exactly the same problem, also in the Royal London Hospital, for the past 30 years. It is not a "black" issue, it is a drug abuse issue. I would like to know how Dr Azuonye makes the diagnosis of schizophrenia and drug abuse. One cannot repeat too often that no diagnosis is possible in anyone taking drugs until after they have stopped taking them. When they do the symptoms usually disappear rapidly and the diagnosis becomes obvious. Schizophrenia is often strongly diagnosed in these circumstances and neuroleptic drugs are given with all the accompanying disability to the patient and cost to the service and to the community. Indeed this error perpetuates the problem since it purports to offer a "treatment" other than the *only* one that will help, namely stopping the poison that is affecting the brain. As I recently wrote: "If cannabis continues to be used then major tranquillizers are not effective and if it ceases they are not necessary".

Dr Eva's letter in the same issue touches on this subject too. Last year I visited Australia and New Zealand and found the misdiagnosis of schizophrenia when patients were taking cannabis and other drugs as common there as here. As far as nosological status of 'cannabis psychosis' is concerned there are commonly organic, schizophreniform and manic pictures. The important thing is not what you call it but what you do, i.e. stop cannabis.

A national research study on patients attending depot injection clinics to ascertain the extent of drinking or cannabis abuse might pay enormous dividends by removing the schizophrenic label from many patients. This question is of particular importance with the issue of the legalisation of cannabis being raised again.

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Reference

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Primary care psychiatry

DEAR SIRS

Dr Strathdee *et al* described a six stage plan in establishing psychiatric attachments to general practice (*Psychiatric Bulletin*, May 1992, **16**, 284–286) and expressed interest in other approaches used in strategic planning in this field. While Strathdee *et al*'s stages focused on formal organisational arrangements of objectives, location and response, in West Lancashire, we phased our project (GPs, CPNs and psychiatrists) into two phases of service delivery. Phase one comprises out-patient, joint consultation model and regular meetings (modified Balint) to discuss management of selected patients. This is to be followed by phase two of team case conferences and the tripartite community assessment at the patient's location, home/hostel or elsewhere. Both approaches, the Maudsley and ours, aspire to a good working alliance with the clients being the beneficiaries.

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Relatives who refuse to give consent

DEAR SIRS

Regarding Dr Jane O'Dwyer's letter concerning relatives who refuse to give consent (*Psychiatric Bulletin*, April 1992, **16**, 232) I feel I must object. I believe it wrong to dismiss the rights of the next of kin under the act as merely a complicating factor whatever the circumstances. Further, if the treating psychiatrist has done all he/she possibly can why then should

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