Section 5 (2)

DEAR SIRS

D. I. Khoosal (*Psychiatric Bulletin*, May 1992, **16,** 312) discussed implementing a Section 5 (2) to transfer a patient from a NHS owned psychiatric nursing home to a hospital. If the home is a "hospital" or has the appropriate registration as a "nursing home", detention is possible under the Mental Health Act. In our district, in response to a similar situation, the MHA commission confirmed that a patient can be transferred under Section 5 (2).

Hence, what Dr Khoosal proposed may be legally "possible" but not necessarily optional for the patient: although not having the same consequences as an Assessment or Treatment Order, Section 5 (2) restricts the patient and is followed by medical and social service examinations with a view to implementing them. Consideration should be given to the interests of the patient, who would have the benefit of three opinions, rather than one, for a Section 2 or 3 to be initiated in the first instance, assuming these may be obtained expediently.

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"Cannabis psychosis"

DEAR SIRS

Dr Eva (*Psychiatric Bulletin*, May 1992, **16,** 310–311) predicts that the nosological status of "cannabis psychosis" will soon become clear. The relationship between cannabis and psychotic conditions is complex. An acute toxic confusional state following ingestion is well documented and probably dose-dependent, except in a few individuals who develop an idiosyncratic psychotic reaction at low doses. First time users may also be more susceptible. An acute psychosis in clear consciousness with schizophreniform or mania-like features can also occur. Clinical data on the role of cannabis in the aetiology of more persistent paranoid or affective disorders are sparse. That established schizophrenics use the drug is well recognised and may represent self-medication. One group of investigators has claimed to show that cannabis use is an independent risk factor for the development of schizophrenia (Andreasson *et al*, 1987).

It is hardly true to say that the entity of cannabis psychosis is eschewed in the literature. There have been many papers on the subject since American researchers began taking interest in response to the drug's widespread use there in the late 1960s. What is still not clear is which of the several interactions between the drug and psychotic illness is referred to by "cannabis psychosis". Because of this confusion the term is best avoided.

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References

ANDREASSON, S., ALLEBECK, P. & ENGSTROM, A. (1987) Cannabis and schizophrenia: a longitudinal study of Swedish conscripts. *Lancet*, **ii,** 1483–1485.

Out-patient non-attenders

DEAR SIRS

I read with interest the letter from Drs Hellewell & Pugh (*Psychiatric Bulletin*, May 1992, **16,** 306) in which they report the findings of a case-controlled study of new out-patient non-attenders. The authors suggest that it is possible to predict non-attendance at the first out-patient appointment on the basis of an analysis of the GP's referral letter. While I accept that there is considerable variation in the quality of these letters, my own data from a larger sample contradicts the view that differences in standards of communication from GPs is reflected in non-attendance. I believe that the way in which Drs Hellewell & Pugh present their findings from this important area of research is potentially misleading.

I studied 100 consecutive GP referrals of catchment area patients to the Maudsley Hospital Out-patient Department, of whom 74 were referred to out-patient clinics and 26 to the emergency clinic. The non-attendance rate among the former was 33.8% (95% confidence interval 23.0 to 44.6%). Non-attendance at the first appointment was not associated with patients' age, marital status, ethnicity of home-ownership, though the unemployed were less likely to keep appointments than those in work (non-attendance rate 41.8% v 17.9%, $P=0.06$).

Among this sample there were no associations between non-attendance and any features of the referral itself. In particular, non-attendance was *not* predicted by the omission of the reason for, or expected outcome of, specialist referral from the GP's letter. Furthermore, there were no differences between attenders and non-attenders in terms of the quality of referral letters as defined by legibility, information content or diagnostic development.

I accept that there may be differences in GP referrals and patient behaviour between Manchester and Camberwell, though these are unlikely to explain the clear differences in our findings. In my view these are more likely to be methodological in origin, and I am especially surprised that the investigators found such strong statistical associations from such a small sample of patients.