Use of Qat in the UK

DEAR SIRS

A recent newspaper article (*The Independent*, 1992) suggested that the plight of some Somalian refugees in this country is compounded by the adverse effects of heavy use of Qat, a mood-altering plant. Last year I encountered an acute psychotic episode associated with the use of Qat.

My patient, a 28-year old Somalian male student, was brought to me by friends concerned by his agitated, restless, sleepless state. He described paranoid ideas and had felt suicidal. There was no previous psychiatric history. He was admitted informally to a local psychiatric unit where his symptoms settled rapidly, was discharged after a few days on no medication, and has remained well since.

It emerged that his symptoms had followed a spell of heavy Qat consumption.

Qat (Gat, Khat, or Mira) is the leaves and young shoots of Catha Edulis, a tree that grows at high altitude in East Africa (Ghodse, 1989; Kennedy, 1987). Originating in the Yemen, it is traditionally used in the Middle East and parts of North and East Africa by chewing or, formerly, by infusing the leaves (Arabian or Ethiopian tea). It has been described as a remedy for depression since the 13th century and is often a pleasurable group activity after a traditional meal, in rooms specially set aside and furnished, and is an important and traditional part of local social life. Official business and commerce are often conducted while Qat is chewed during the afternoon siesta. It is also used by students and local lorry drivers to combat fatigue. Active ingredients include Cathine (D-pseudonorepinephrine) and Cathinone; effects are described as mildly stimulant and euphoric but may lead to restlessness, sleeplessness, anorexia, gastro-intestinal symptoms and (rarely) a psychotic reaction. Psychological but not physical dependence is said to occur (an abstinence syndrome has not been described) and heavy users and their families may experience economic hardship in their home countries (Baasher, 1983). Several countries have attempted to ban or regulate its use; this has been debated since the 16th century (Kennedy, 1987) in the Yemen, where it is an important cash crop. Its use is not illegal in the UK and it is imported, freshly gathered, by air.

In its original setting, Qat has been used for centuries as a mild and usually harmless stimulant and social lubricant of cultural and economic importance, sanctioned by tradition. When transmitted into another culture, will there be different health implications?

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The Independent, 27.3.92, p. 6.

Cannabis psychosis

DEAR SIRS

Dr Huw Thomas (*Psychiatric Bulletin*, September 1992, **16** 572) has perfectly illustrated the problem with the current thinking on cannabis and psychosis I wrote about in my letter (*Psychiatric Bulletin*, May 1992. **16**, 310–311). I have to agree with him that there are several different interactions between the drug and psychotic illness, and that this leads to confusion. The confusion arises because there is no specific symptom cluster associated with cannabis use, and the psychiatric presentations can mimic other psychotic states. Professor Cohen makes this point quite clearly in saying that alcohol and cannabis use, if investigated in patients attending depot clinics, could remove the schizophrenic label from many of them (Cohen, S.I., *Psychiatric Bulletin*, September 1992, **16**, 513).

I argued previously that it is time to use an aetiological, and not symptom-based, system of diagnosis in the case of cannabis psychosis. This would remove much of the confusion and even denial of the existence of the entity. How can it continue to be argued, when psychotic symptoms follows heavy use of the drug in a subject with no other aetiological factors present, that it is not a cannabis psychosis? The diagnosis can always be revised if other, previously unknown, factors come to light. Are other diagnoses not revised at times?

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Correspondence on this topic is now closed – eds.

Psychogeriatric care

DEAR SIRS

Benbow & Jolley's survey (*Psychiatric Bulletin*, September 1992, **16**, 533–535) confirms the shift of provision of long-stay residential care out of old mental hospital wards and into nursing homes in the private and voluntary sector. The authors are unenthusiastic about this shift, are concerned about the loss of consultant 'sovereignty' over beds and the inevitable changing face of consultant work.

Since 1984 we have pursued vigorously a policy of joint development of specialist nursing homes for

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people with severe dementia to replace long-stay hospital beds. The Domus Project provides three – shortly to be four – homes for 12 people each, managed and staffed by our close collaborators, South London Family Housing Association. Consultant input is no less than when the beds were in the mental hospital – indeed it is somewhat greater and the work is infinitely more rewarding. The policy of the Domus homes of providing care for those who are most seriously disabled with severe behavioural problems is shared by members of the management committee which has a good representation of health service professionals. An early evaluation of the Domus Homes to be published shortly suggests that quality of care is significantly better than in conventional long-stay wards.

Benbow & Jolley are right to stress the importance of specialists being involved and committed to long-stay care provision but the best way to do this is by working jointly with the local authority and the independent sector. There are major benefits for patients in a collaborative approach, but consultants need to 'let go' a little and be prepared to share their resources. It is worrying to read how few have grasped the opportunities now available to improve the quality of long term care for their patients.

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Diminished responsibility

DEAR SIRS

I read with interest the letter from Dr Green (*Psychiatric Bulletin*, August 1992, **16,** 511–512). The Homicide Ordinance of Hong Kong basically follows the Homicide Act of the United Kingdom.

Section 56(2) Mental Health Ordinance of Hong Kong stipulates that defendants of capital offence be examined and reported on the presence or absence of insanity and on fitness to plead. The report is sent to the Attorney General and Registrar of the Supreme Court. Defendants of murder cases are often seen when the trial date is drawing near, that is, months after the index offence. It is fully justified to assess fitness to plead near the court date. However, the forensic psychiatrists are then left with the formidable task of retrospectively addressing the defendant's mental condition at the time of the index offence.

The 'typical case' cited by Dr Green is not uncommonly encountered in Hong Kong. The defendant may give a history suggesting the presence of psychosocial stressors and depressed mood around the time of the index offence. During mental state examination, the defendant often just appears worried about the trial but does not exhibit any mood symptoms. In such cases, the definition of abnormality of mind in the Homicide Ordinance is relevant. The key issue is whether we consider the defendant's mental condition at the time of the index offence as arising from 'inherent causes'. This is the pre-requisite question which is subject to clinical scrutiny and which we have to answer before proceeding to the issue of responsibility. There are cases in which the defence proposes personality attributes as inherent causes and the forensic psychiatrist is certainly in the position to give his opinion within his professional expertise.

Concerning the question of diminished responsibility, I share the experience of Dr Green. After submission of a psychiatric report according to Section 56(2) Mental Health Ordinance, the Crown Counsel may have copied my report to the defence counsel who then writes to me asking for a definitive opinion on whether or not the criterion of substantial impairment of responsibility is satisfied. In fact, Section 56(3) of the same Ordinance explicitly states that a report submitted in accordance with subsection (2) shall not express any opinion as to the degree of responsibility of the defendant at the time when the index offence was committed. Obviously, the law is not putting any constraint on the psychiatrist's response to questions raised by the defence. However, when a psychiatrist is prepared to give a clear-cut answer to the question of diminished responsibility, he should bear in mind what he expresses may no longer be an independent expert opinion but a personal opinion carrying some subtle emotional element.

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DEAR SIRS

Dr Green's letter (*Psychiatric Bulletin*, August 1992, **16,** 511–512) rightly casts a cold eye on the complex issues raised by a plea of diminished responsibility in homicide cases. To enter into such a debate, one is obliged to take on the thankless task of stalking the borderlands between law, psychiatry and philosophy, which like most border territories are matters of wars and disputes, of danger and confusion and most significantly of change and reversal.

The structure of section 2 of the Homicide Act 1957 has been criticised as being obscure and of dealing in unintelligible concepts. However, there is a clear and simple message underlying this piece of legislation, which is that criminal liability depends on mental responsibility and mental responsibility depends on abnormality of mind. Thus the Act includes one psychological assessment and two decisions about responsibility, viz. one attribute of

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