

of 90-100 mm Hg was visited two to three times weekly by the community midwife, who examined the patient's abdomen, tested urine, and measured blood pressure at each visit. After the 32nd week of pregnancy she viewed the patient's fetal movement chart. She was empowered to refer a patient back to the doctor at any time or straight to hospital if the diastolic blood pressure was greater than 100 mm Hg or she considered admission to be appropriate for any reason. If admission proved necessary the patient remained in hospital while the diastolic blood pressure was over 100 mm Hg, or if there was evidence of fetal compromise, and was then discharged home for further supervision. This policy was not implemented in women with accompanying proteinuria or suspected placental dysfunction.

The table shows the results and compares them with the figures for the corresponding six months of 1982 when this policy was not in operation. No baby died or suffered morbidity as a result of the new policy. Admissions for hypertensive disease were significantly reduced when expressed as a proportion of all admissions (35/189 (18.5%) in 1982 *v* 19/173 (11%) in 1983 ( $p < 0.05$ )) and as a proportion of admissions initiated by medical staff (35/71 (49%) *v* 19/166 (29%) ( $p < 0.02$ )). Altogether 112 inpatient bed days were saved over six months. Supervising hypertension associated with pregnancy added only 5% to the workload of the community midwives, who welcomed the rewarding and responsible nature of the work. In addition, a close personal relationship was established between patient and community midwife, which was of great benefit after delivery.

#### Results of new policy of treatment for pregnant women with hypertension, 1983

	February- July 1982	February- July 1983
No of deliveries	438	465
No of patients with one or more admissions	126	117
Total No of admissions	189	173
No of admissions for hypertension	35	19
Total No of admissions initiated by medical or midwifery staff	71	66
Total bed occupancy by pregnant women with hypertension (days)	391	179
No of patients supervised at home by midwives		38
No of patients visited by midwives and subsequently requiring admission to hospital		9

#### Comment

These results suggest that uncomplicated hypertension in pregnancy is more suitably managed by careful domestic supervision by community midwives than by admission to hospital.

I thank Mrs C Farrar and the Huddersfield community midwives.

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## Psychosis after cannabis abuse

Psychosis after abuse of cannabis is well recognised,<sup>1,2</sup> but we know of only one report from the United Kingdom.<sup>3</sup> The lack of such reports has been used to support the case for legalisation of cannabis. We therefore tried to estimate the prevalence of serious mental illness after cannabis abuse.

During 1979-81 the Department of Health and Social Security (DHSS) was notified of 714 admissions of patients with drug psychosis. Only two (0.3%) cases were attributed to cannabis abuse, compared with 10 (25%) of 40 patients with drug psychosis discharged from Shenley Hospital during 1980-2. We describe five of the latter patients, who had not abused alcohol or drugs other than cannabis, and four others (one seen 10 years previously, one from a local remand centre, and two seen more recently at Shenley). All admitted heavy recent use of cannabis. Their histories were confirmed by families, friends, police, social workers, and probation officers.

#### Patients

Five patients were black and four white (seven men and two women). All but one were aged under 40 (mean 27, range 20-51). Two were married, one divorced, and six single and without stable heterosexual relationships. The symptoms of the episodes of psychosis varied. Two patients had schizophreniform symptoms, three more undifferentiated delusional psychosis, three manic bouts, and one a confusional state. All were physically fit and free of cerebral disease. Seven had had previous episodes of psychosis: all except one after use of cannabis; the remaining one was after use of LSD.

The two patients with schizophreniform symptoms had family histories of psychosis: one had a grandfather and two uncles with mental illness, and the other had three first degree relatives and two others with schizophrenia. One manic patient had an alcoholic mother. The premorbid personalities of the group were unremarkable apart from a tendency to violence. Several patients had criminal records. Violent behaviour was also characteristic of their psychoses. Religious themes were prominent in their delusions and abnormal perceptions: three patients (two Rastafarians and one Pentacostalist (all black)) showed intense premorbid preoccupation with politico-religious matters characterised by fervent emotional experience or drug taking as a religious practice or both. One (white) man successively held marxist and fascist opinions and extraordinary religious beliefs.

Of the two patients with schizophreniform symptoms, one contracted a stable marriage, enjoyed normal work and social relationships, and remained well and off all medication for 10 years; the other's symptoms remitted completely within three days. Psychotropic medication was required only for controlling acute behaviour disturbance. No patient required outpatient psychotropic medication. One patient was readmitted with depression and depersonalisation after abusing cannabis.

#### Comment

Our patients' psychotic episodes were severe but brief and occurred immediately after heavy use of cannabis. Clinical symptoms included undifferentiated, manic, schizophreniform, and confusional psychoses. Only the patients with schizophreniform symptoms had family histories of mental illness. Patients were admitted compulsorily by the police, were generally uncooperative, discharged themselves, and did not keep appointments. Their psychotic episodes cleared up completely without obvious residual impairment, psychotropic medication playing little part. Recurrence commonly followed further cannabis taking. As we had excluded patients who abused several drugs and alcohol, cannabis rather than other agents was probably the provocative factor. Depression and depersonalisation occurred between psychotic episodes.<sup>5</sup>

Psychosis after cannabis abuse appeared to be more common among patients discharged from Shenley Hospital than in England and Wales overall. Explanations for this may include clinicians' lack of awareness of the possibility of cannabis psychosis, differences between diagnoses on admission and discharge, underreporting of cases within the specific DHSS drug categories, and inaccurate recording. Our study of diagnoses on discharge from a psychiatric hospital with a catchment area containing a large area of social deprivation suggests that cannabis abuse frequently precedes mental illness, in which it may have a causal role.

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