Many of those who suffer from mental illness self-medicate with illegal drugs – both to deal with their illness and to offset the effects of medication. So why not prescribe the self-medications, suggests **Tim Sayers**

Drug of choice

a radical prescription for dual diagnosis

CONSIDER this: a young man approaches psychiatric services suffering with hearing voices. They are causing some distress. He admits to using cannabis on a regular basis, but well within what he would consider the cultural norm for him and his friends. He might well be diagnosed as schizophrenic (due to the voices), having drug problems (which might have triggered the illness), and at the same time will have become a criminal because of the cannabis use. One day he is a normal member of society, the next, he has three labels, each with their own negative connotations and stigma attached. What effect might this have on the person's mood?

NOISES OFF

Meanwhile, the psychiatrist might well be thinking that a prescription for anti-psychotic medication might ease the distress of the voices and hence reduce the need for drug use. Your average side-effects for any anti-psychotic medication in the British National Formulary, the recognized guide for prescribing medications in this country, would include drowsiness, agitation, apathy, nightmares, insomnia and sometimes depression, alongside more disturbing, and sometimes irreversible, syndromes of severe involuntary movements in up to 70% of patients on longer term treatment.

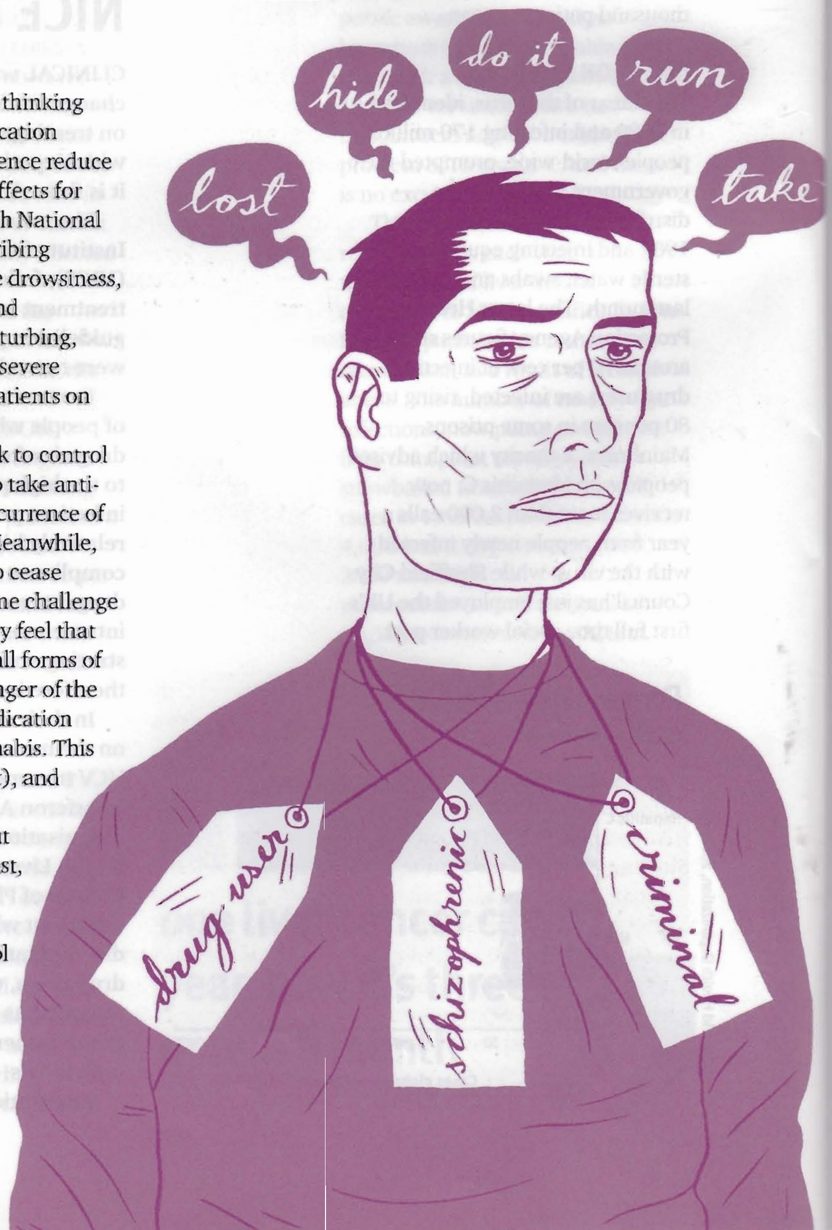
Will the anti-psychotic medication work to control the voices? Up to two thirds of people who take anti-psychotic medication will experience reoccurrence of psychotic phenomena within two years. Meanwhile, the psychiatrist instructs the young man to cease smoking cannabis. This could be an extreme challenge to some people, like Rastafarians, who may feel that cannabis is the appropriate treatment for all forms of illness. An issue here might also be the danger of the psychiatrist prescribing anti-psychotic medication whilst the person continues to smoke cannabis. This can cause confusion, ataxia (unsteady gait), and reduced respiration.

We now have a recipe for depression. But what has the young person found, in the past, to be the most effective way of managing low mood, stress and agitation? Quite possibly smoking cannabis, drinking alcohol and taking amphetamines. This would appear to be a very good rationale for why these seem to be the drugs of choice for people suffering with severe and enduring mental health problems: they work, their effects are instantaneous and, from the perception of the user, come with few acute, disturbing side-effects.

Tim Sayers is a psychiatric nurse working for an assertive outreach team in Leicester.

CRAVING

What we see is a concept of dependence that flies in the face of the traditional medical model. A secondary illness to the psychiatric disorder is, in fact, the patient's self-medicated cure for the first illness, quite possibly without the patient's knowledge. It also becomes the person's self-medicating cure for the effects of the anti-psychotic drugs. Where craving is concerned, don't we all crave a cure for our illnesses? If one has a headache



doesn't one crave a paracetamol? To talk of abstinence in this situation would appear ridiculous.

What we must look at is how to improve the clinical outcomes of self-medicating. The big issue here is addressing levels of tolerance, which can lead to controlled drug and alcohol use spiralling out of control. The best way to address different tolerance levels in my view is by prescribing. Those who feel that a more open social approach to psychiatry is the way forward, with medication being useful, but not the answer, might consider this radical approach to be the way forward.

CREATIVE PRESCRIBING

We need to acknowledge the rationale behind the use of drugs and alcohol and use creative prescribing of either the drugs and alcohol themselves, or realistic alternatives. This might appear to be a pretty crazy proposition, but there is strong evidence to support the prescribing of heroin, methadone or amphetamines.

Cannabis was widely prescribed as a medicine in several cultures right up to the twentieth century, but research into its medicinal use has been curtailed by its illicit status and corresponding barriers to research. By prescribing to the person you engage the person by possibly the only means by which you can engage them: by empathising with them. It shows that you have listened to them and that you are trying to understand what they are going through.

OPEN MINDED

For every doctor with a traditional medical understanding, there will be a corresponding percentage of nurses, occupational therapists and social workers who subscribe to a moral model, although they might deny it vehemently. I think

"This might appear to be a pretty crazy proposition, but there is strong evidence to support the prescribing of heroin, methadone or amphetamines."

that the major challenge to introducing change to a more open minded model of care will be resistance from professionals across the board. When I first conceived the idea of this model of increased understanding of people with dual diagnosis, and for a concept of prescribing to them, it seemed to be such a radical idea that it bordered on the absurd. However, through extensive reading on the subject, this view has increasingly appeared more credible.

It has confirmed to me that the traditional medical model of dependency is outdated and the treatments ineffective. There is an increasing body of knowledge that supports the propositions within this article of a medical/socio-cultural model. I would also suggest that the knowledge available would warrant further research in this area, but I would suggest we proceed with caution: there is not enough evidence to warrant a drastic change in practice. But having this increased knowledge and understanding can only help in the extremely difficult field of working with this client group. ■

DUAL DIAGNOSIS: A VIEW FROM THE GROUND

Kim Moore is team manager at The Maple Unit, a dedicated dual diagnosis service based in Haringey, north London. It is one of only a handful of its kind in the UK and has been running for five years.

"We get referrals from acute in-patient units, community mental health teams and local alcohol and drug services. In 2002, we assessed 270 from in-patient units and 138 from other services. Most are diagnosed with schizophrenia or a form of pychosis, are poly-substance users, alongside alcohol and prescribed drugs. Many of our clients are aged under-35, Afro-Caribbean and have been either sectioned or voluntarily admitted.

"We start by giving them an assessment, which can take anything up to three months. We assess their mental health, substance misuse and any contact they have had with police – whether they have a history of knife carrying, violence or are on bail. Nearly three quarters have a history of being arrested, although only a small number are violence-related arrests.

"Some say they want help with benefits, housing, to stop using drugs, or to go on methadone scripts. Most haven't engaged with other services and have been bounced around between them. On average we treat people for 14 months.

"The most popular combination of drugs used by dual diagnosis clients are crack cocaine, cannabis (usually skunk) and alcohol (usually super brews). A snapshot study found just under a third are of no fixed abode, most of these are roofless and a majority are unemployed. Men outnumber women by three to one.

"Around a third self-medicate using illegal drugs. Drugs like heroin and alcohol are used to 'dampen down' voices in their heads and emotional pain through physical and sexual abuse as children. Self-medication could work in some cases but would be no good for people whose mental health problems are precipitated by drug use. We tell them there are other options to using drugs like methadone, detox and herbal teas and talking therapies."

Illustration: Paul Blow