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Heroin Abusers in Psychiatric Beds

A Glasgow Study

A retrospective study was carried out of all heroin abusers admitted to an acute psychiatric unit to examine their use of the facility of in-patient care. The compliance with treatment was low. Most patients discharged themselves or were discharged prematurely for using drugs while in the ward; only 21% were discharged as planned. The value of hospital admission in the management of opiate abusers may have to be reconsidered in view of the increasing prevalence of heroin abuse and the limited number of psychiatric beds.

The admission of opiate abusers to hospital for in-patient detoxification was once considered to be a mainstay in their management (Home Office, 1968), but is not now thought to be so important (Thorley & Plant, 1982). It may be a useful first step in a longer programme of rehabilitation involving either community projects or therapeutic communities (Department of Health and Social Security, 1984). In the London drug dependence clinics detoxification is usually carried out on a long-term out-patient basis (Ghodse, 1983). In Glasgow the recent rapid rise in heroin abuse (Ditton & Speirits, 1982) and the reluctance of psychiatrists to prescribe opiates on an out-patient basis has resulted in admission to acute psychiatric units continuing to be used as the main psychiatric response to the problem in many hospitals.

In theory, the benefits to be gained by admitting a heroin taker to hospital are

(a) assessment of physical health and of social and personality factors influencing the drug abuse
(b) management of the physical and psychological withdrawal symptoms in a supportive and controlled environment
(c) provision of 'time out' from the drug scene
(d) opportunity to plan changes in lifestyle
(e) introduction to a community-based project for continued rehabilitation.

The psychiatric service of Glasgow Eastern District, based at Duke Street Hospital, regularly admits heroin abusers to acute psychiatric beds. Initial screening is done on an out-patient basis by a senior psychiatrist to confirm the diagnosis, identify the level of abuse, and assess motivation. In-patient care is offered if appropriate, and patients are usually admitted within three weeks. The duration of in-patient care is flexible, being dependent on the patient's progress as assessed by staff.

Following admission, assessment of physical health is carried out and appropriate treatment given. If there is objective evidence of opiate withdrawal symptoms (such as pupillary dilatation, tachycardia or sweating), medication in the form of oral methadone, chlordiazepoxide or clonidine is prescribed. Random urine screening is undertaken frequently during the patient's stay to detect any surreptitious use of opiates in the ward. Patients are informed beforehand that their use of drugs in the ward will generally result in their discharge. During the day patients attend sessions of group psychotherapy and occupational therapy.

This study was carried out to examine the use of this facility of in-patient care by a group of opiate abusers and their progress.

Method

All heroin abusers who were admitted to the ward between 1 June 1983 and 31 May 1985 were included in the study. Their case records were examined to obtain basic epidemiological data, drug history and details of their progress in the ward.

Results

Over the two year period 56 heroin takers were admitted (41 men and 15 women). In most cases (84%) referral was made by general practitioners, but referrals were also made by other medical specialties (14%) and by social workers (2%). The mean age of the patients was 22.7 years (s.d. = 4.24 years, range = 14–36). Although most were single (79%), none lived alone.

Drug use

The mean reported duration of opiate abuse was 3.4 years (s.d. = 2.16 years) and all patients had been regularly injecting opiates intravenously before admission except for four who had been taking the drugs by insufflation. It was difficult to obtain precise information on the daily amount of opiates taken, as this was usually expressed as the amount of money spent on heroin per day. The mean reported amount spent was £37/day (s.d. = £25.5/day, range = £5–120/day); at the time of the study the patients reported the price of 'street' heroin to be £80–100/g, although its purity and potency varied widely.

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Progress in the ward

Only 20% of the patients did not require medication to relieve withdrawal symptoms. Most patients (61%) received oral methadone given in reducing doses from 30 mg/day over eight days. A further 14% received chlordiazepoxide (initially 80 mg/day), and 5% were given clonidine (initially 0.2 mg/day), both these drugs being given orally.

Most patients (61%) either discharged themselves or left the ward without permission and did not return. A further 18% were discharged by medical staff after urine tests confirmed that they had been using opiates surreptitiously in the ward. Only 21% remained in the ward until their planned date of discharge. A total of 31 patients (55%) achieved a drug-free existence while in the ward in that they were neither receiving prescribed drugs nor using drugs surreptitiously, but many of these patients discharged themselves shortly after reaching this stage.

Those who remained in the ward until their planned date of discharge had (as expected) a longer mean duration of stay (32.7 days; s.d. = 17.2 days) than those who took their own discharge (10.2 days; s.d. = 10.5 days). Seven patients (12%) took their own discharge after only one day. Those who were discharged prematurely for using opiates while in the ward had a mean length of stay of 28.3 days (s.d. = 23.4 days).

Premature discharge was not associated with the non-prescription of medication; indeed, those who completed their stay were slightly less likely to have received medication (25% received no medication), and 90% of those who were discharged due to using drugs surreptitiously had initially been prescribed methadone.

Discussion

At this hospital one heroin abuser is admitted on average every two weeks; these patients are typical (in terms of age and sex) of heroin abusers attending other drug dependence clinics in Glasgow (Fraser & Leighton, 1984). More than half reach a drug-free state, however short-lived, while in the ward, but many of these patients discharge themselves shortly afterwards. Most patients do not remain in the ward until their planned date of discharge but discharge themselves after an average of ten days. A further number are discharged by medical staff for using opiate drugs surreptitiously while in the ward.

The prescription of medication to ameliorate withdrawal symptoms seems in anything to have a negative effect on satisfactory progress, although it is possible that the patients who required such medication were more severely dependent or less motivated and therefore less likely to remain in the ward. If is difficult, however, to quantify withdrawal symptoms, and the value of admission may lie in the 'time out' element rather than in pharmacological detoxification. In addition, the relatively long period of time after admission (28 days) before many patients started using opiates in the ward suggests that the longer-term craving for the drug, perhaps enhanced by boredom, is just as likely to produce relapse into using drugs again as the acute withdrawal symptoms. For this reason, much emphasis is placed on using the period of in-patient care to introduce the patient to a longer-term programme of rehabilitation in the community to prevent future relapse. Since most patients discharge themselves before this can be properly effected, much doubt is thus cast on the overall usefulness of admission.

The main shortcoming of the study is the lack of objective long-term follow-up information on the patients. We have had little success in arranging for these patients to attend the hospital for follow-up, which is perhaps a result of the policy here of not prescribing substitute drugs on an out-patient basis.

The significance of the frequent outcome of irregular self-discharge is also uncertain. It is possible that those who discharged themselves irregularly from the ward were just as likely to lead a drug-free existence thereafter as those who remained until their planned date of discharge. However, the often sudden, impulsive and desperate nature of the wish to leave hospital in these cases suggests that it probably indicates imminent relapse. Even if admission to hospital does not result in total abstinence thereafter from opiate use, though, it may have a significantly beneficial effect, perhaps by reducing the degree of dependence or by decelerating a process of physical and social deterioration.

The practice of admitting heroin abusers to psychiatric beds may not be a completely useless exercise, and currently accounts for a small proportion of psychiatric bed occupancy, but the poor compliance observed in this study suggests that this form of management now needs to be examined more critically in the current climate of limited psychiatric resources and an ever-increasing population of heroin abusers seeking psychiatric help.

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Capgras Syndrome: A Case Report from Zimbabwe

A case of Capgras syndrome in a black Zimbabwean patient is described. The syndrome occurs in the setting of a schizophrenic illness, but psychodynamic factors are readily identified despite the patient's different cultural background.

Early clinical descriptions by French authors (Magnan, 1893; Janet, 1903; Capgras & Reboul-Lachaux, 1923) referred to 'l'illusion des sosies' (the illusion of doubles), and it was not until 1929 that the term 'Capgras syndrome' was suggested (Levi-Valensi, 1929) in recognition of that author's contribution. For some years the syndrome was believed to be rare (Enoch & Trethowan, 1979), but recent reports indicate that it is much more common than was formerly suspected (Quinn, 1981). Berson (1983) reviewed the English literature, and found 133 cases. A report has also been received from Jamaica (Sims & White, 1973), and in Africa Collomb (1965) described the characteristic misidentification in one of his patients but did not identify the syndrome. We were unable to trace any other report of its occurrence in a black African patient.

Case report

A 27 year-old single, unemployed black male patient was admitted to Harare Hospital in June 1982 with a three-day history of violent and aggressive behaviour towards his father, and also of consuming large quantities of alcohol and stripping in public. On admission he told the staff angrily that his father was not his father but only a "caretaker", who was forcing him to visit various *ngangas* (traditional healers) with the intention of proving that the father was in fact the real father. He further alleged that the surburb of Mufakose, where the "caretaker" resided, was not real either but a carbon copy of the genuine town.

The patient's belief that the real father had been substituted by a "caretaker" began five years before admission, when the patient suddenly resigned from his job because "the boss was looking at him in a queer way". The following day, his father took him to discuss this with a priest. While the discussion was in progress the patient waited outside. He then observed that an impostor and not his father emerged from the church. He was certain that it was an impostor because of the differences which he noted: the real father was a kind, caring, religious and good person, whereas the "caretaker" was a fat, ugly, mean and strict person, who wanted to make the patient a slave in the house. The "caretaker" somehow knew the patient's thoughts and prevented him from taking a job. The patient further believed that the "caretaker" was bewitching him.

The father reported that from that time the patient had never again addressed him as "father" but invariably referred to him as "that man". The patient became argumentative, disrespectful and often broke household objects. Once he threw away the family radio because it was broadcasting news about him. He suspected that neighbours were plotting against him and that his family had poisoned his food. He often spoke to imaginary people.

Except for the delusional content, there was no evidence of thought disorder at the time of admission. Auditory hallucinations were present: the patient could hear the voices of his ancestral spirits comforting and commending

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