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Marijuana risk needs to be recognized

U.S. election-night victories for marijuana advocates in Washington State and Colorado bring the possibility of wider legalization, both in Canada and the U.S., closer. For family members who have seen the use of marijuana trigger mental illness in their loved ones, that's not an appealing prospect, although they may know the arguments for legalization and even agree with some of them.

At the very least, legalization should bring with it an intensive educational campaign, especially for youth, explaining the dangers of marijuana to those with a genetic predisposition to schizophrenia or other serious mental illness. It should also include a general warning because while in most instances there is some inherited genetic linkage, there are also "spontaneous" cases of schizophrenia – that is, cases where there is no prior clue of vulnerability.

Everyone, in that sense, is at risk and, with that, at risk of marijuana being toxic for them.

There's no longer any doubt that marijuana does produce this triggering effect in those who are susceptible. The scientific literature confirming this has now become impossible to ignore. UBC genetics researcher Jehannine Austin, who delivered the most recent NSSS lecture at Lions Gate Hospital, calls marijuana "the most significant avoidable risk factor" for developing a mental illness. In other words, if there is schizophrenia or bipolar disorder somewhere in your family, and you want to take every precaution you can to avoid falling ill yourself, the most important single thing you can do is stay away from pot.

Family members with a mentally ill relative, meanwhile, often know first-hand the damage cannabis can do, witnessing its impact close up. They've also observed how continuing use of marijuana, even after someone is diagnosed and is taking medication, can disrupt or impair recovery.

The North Shore Schizophrenia Society has made a special effort of its own to let young people know of the risk they're taking. In 2008, it produced a leaflet for use in secondary schools outlining the role marijuana ("weed," in the leaflet) can play in triggering schizophrenia.

The NSSS "Partnership Presentations" in North Shore secondary schools and at Capilano University, also touch on the subject.

"You don't know what you could be getting into…."

Sarah Fox, diagnosed with schizo-affective disorder, most often represents those with an illness in the NSSS presentations and isn't afraid to tell it like it is. When she was diagnosed at age 17 she'd already been smoking marijuana for two years. Her depression had turned into mania. She suffered panic attacks and became delusional. She didn't accept her hallucinations as a sign of illness and lived rough, self-medicating with harder street drugs. Eventually, after a merry-go-round of hospital stays, she gained insight. Her antipsychotic medication, she realized, only made her feel better when she wasn't abusing drugs.

Now in her early 30s, she's on the lowest dose of medication for her illness and leads a full and active life. Because of this, she's blunt with students: "Don't smoke pot. You don't know what you could be getting into. I've been there. I don't want to go back. I don't ever want to lose what I've gained."

Nevertheless, the younger generation has grown increasingly tolerant of pot use. A December 2012 study by the National Institute of Health in the U.S., found that 41.7% of Grade 8 students, and only 20.6% of Grade 12 students, believe occasional pot use is harmful, the lowest levels since 1979. These statistics appear even though a major study, in 2010, of 3,800 Australian teenagers found those who used marijuana were twice as likely to develop psychosis compared to teens who never smoked it.

By decriminalizing pot use, giving it the appearance of an innocent recreational activity, anyone, particularly those who are the most vulnerable, can become confused about its safety.

The referenda in Washington and Colorado will turn the selling of marijuana into a legitimate business, to be regulated and held responsible for its operations in the same way as any other business. While possession and use will be officially limited to adults 21 years and older, such a provision will be hard to enforce, but the age limit isn't a major consideration anyway. What's really at play is the cachet that legalization gives to marijuana use.

With this in mind, it's fair to ask who will take the lead in educating the public on the potential risk factors associated with cannabis. This, of course, includes the mounting scientific evidence indicating that marijuana is a precipitating factor in the development of psychotic disorders – especially true if there's an existing family history of mental illness.

Vague promises not altogether reassuring

As officials in those states work to devise a system of accountability for licensing growers, processors, and retailers, how much time and emphasis will be placed on raising awareness about marijuana's dirty little secret – the increased likelihood that a person using marijuana will fall ill with schizophrenia or other psychotic disorder?

A University of Washington professor emeritus, Roger Roffman, helped draft pieces of the marijuana reform law in Washington state. He's gone on record as saying that any of pot's "potential dangers" will be recognized in money set aside for public health from the taxes generated from marijuana sales. He cites

"education, treatment, and research" as options. This sounds good, but is quite vague, unlike pointing out squarely the critical need to alert people to the specific risk involving mental illness. The danger, moreover, isn't "potential," it's real.

It's hardly ever mentioned, however, if at all, by those calling for legalization. A group of former Vancouver mayors and, later, of former provincial attorneys general, for example, have come out publicly in favour of legalization, arguing that prohibition hasn't worked and citing violent gang-related crime, public fear, and financial cost to society. That's fair enough in itself. Without outlining the specific risks presented by marijuana, however, and providing specific strategies for reducing those harms, such declarations are worrisome.

Vague talk about managing any health problems resulting from marijuana isn't reassuring. The risks inherent in marijuana use, in fact, need to be addressed right now, whether legalization follows or not, and legalization can't properly be considered unless those risks are first addressed.

If such risk, and corresponding education and warning measures, were understood clearly as part of legalization to begin with, there would be more of a chance of effective follow-through when and if legalization occurred.

BC health guide not so healthy

A faulty B.C. Health Guide which first appeared many years ago is still being distributed – copies are showing up again at some local pharmacies – despite some real problems when it comes to mental illness.

The guide, 448 pages of it, covers a lot of ground, from abdominal pain to yeast infections and everything, alphabetically, in between – well, everything except schizophrenia and bipolar disorder.

In a 24-page section on "mental health, addictions, and mind-body wellness," the two illnesses aren't even mentioned, although depression, anxiety, and panic attacks are given some space.

A description of signs of onset and of full-blown symptoms of schizophrenia and bipolar disorder, a note on the importance of early intervention, and some guidance on getting a person to hospital although they might not acknowledge they're ill, would have been useful.

So would something on the uselessness in these cases of psychological nostrums like positive thinking and opening yourself up to humour – nostrums which the guide does offer.

Some passages, moreover, are just wrong-headed when it comes to serious mental illness. In a section on violence, for example, the guide states authoritatively, without qualification or exceptions, that "violent behaviour is learned behaviour."

This is no help in understanding why people who are psychotic, or in the prodromal (onset) stage, may commit violence and what to do when they threaten violence.

The guide was produced for the B.C. government by Healthwise, a company in Boise, Idaho. Whatever their sins, B.C. Ministry of Health review and approval was required.

That this gap in the guide wasn't noticed, or that nobody at the Ministry cared even if they did spot it, is discouraging.

Let's hope that there aren't many copies left.

An advocate's lot is not a happy one

Gilbert and Sullivan fans will be familiar with that great comic song in The Pirates of Penzance, "A policeman's lot is not a happy one."

Now well into our fifth year of publication, we can't help thinking of it, because it reminds us that "An advocate's lot is not a happy one." And alas, in our case, there's no comedy to it.

We're always writing about system failures, and they don't seem to stop.

We don't have any choice but to report them and the tragic consequences that often occur, and it's not fun. Yes, an advocate's lot is not a happy one.

Still, for each failure there's the other side of the coin – the things that can be done, learning from these case histories, that would really improve mental health services.

Here's a shortlist of some of those possibilities:

- Urgent outreach on the North Shore and Sea to Sky
- Pro-active, mobile casework whose leading objective is to prevent relapse
- Use of involuntary admission when someone is obviously becoming psychotic, without waiting for dangerous behaviour
- Including family members as integral members of the treatment team
- For that reason, and common sense, sharing clinical information with involved family members the way information is shared with other members of the treatment team (that is, without insistence on having the patient's permission)
- Giving family members' observations and concerns proper weight; understanding their instincts are usually right and taking prompt, pro-active action accordingly
- Training and professional development programs delivered by experienced family members, including such base training for UBC psychiatry residents
- Active use of extended leave as part of a seamless treatment, outreach, and recovery process
- Expansion of Assertive Community Treatment
- Reallocation of resources from programs for the worried well to the treatment and recovery of the seriously ill
- Never saying to a family member, "It's up to him [the ill person] to come in" or "I can't talk to you, I can only talk to her."

All of this is possible with a bit of common sense and clear strategic thinking for the most effective allocation of resources.

And it would make an advocate's lot a much happier one.