Treatment Research News

Alcohol, Drugs and Addiction

August 2001 *Newsletter of the Treatment Research Interest Group* **Vol 5 No 2**

EDITORIAL

Unbelievably we are past the middle of 2001. Winter has it's icy grip on Christchurch with some amazingly hard frosts followed by wonderfully clear, but bitterly cold days. Thankfully we had a bit of a break with a warm wind over the weekend which afforded a magnificent view of the Norwest arch over the Alps as one watched the Canterbury Division I Seniors final at Rugby Park (what a nail biter!).

The weather in the weekend in Auckland was fine and warm according to the NCTDers who were up to attend the Gambling: Understanding and minimising harm conference. Gambling and resulting issues seem quite pertinent at the moment, not only with this international conference run by the Compulsive Gambling Society of New Zealand, but also with happenings in the community. Even as we watch problem gambling increase in New Zealand, new forms of gambling and games are being introduced at an alarming rate. Findings from overseas research on gambling are included in Simon Adamson's travel report in this issue.

Also of prominence in the community at the moment is debate over cannabis - how harmful it is and should it be legalised? This month in the TRN there is the theme of research in and some discussion of cannabis. Since arriving at the NCTD I have had quite an education in alcohol, drugs and addiction. Some of the most startling information I have gathered is around cannabis and it's effects. I am continually surprised by research demonstrating the varied results of acute and long term cannabis use. Given the many misconceptions around cannabis, the current celebrity of the legal debate, and, most importantly, the fact that our clients in A & D treatment very often use or abuse cannabis it seemed appropriate to give cannabis some coverage.

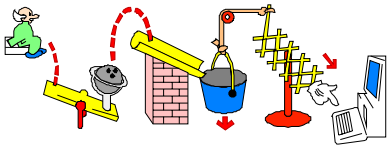
In this issue Doug Sellman and Fraser Todd have provided a summary of the report they put into the Health Select Committee who are currently reviewing the legal status of cannabis. The summary provides a good basis for considering the harms cannabis does and does not pose to individuals and society. "What's new on the street?" this issue also takes a look at cannabis. While it may not be new on the street (it is actually "not new" by about 4 millennium) there are prevalent misconceptions about this commonly used drug which it seemed fitting to clear up. In addition, Simon reports on some international research in cannabis in his report. To round off the cannabis theme there is an article looking at research on cannabis use and adolescents – pertinent for anyone working with youth.

We have most of the "usuals" too. Doug Sellman provides us with the latest news from the NCTD and what is happening with research being conducted by the centre across the country. Fraser Todd has diligently offered up another "I've been reading" giving us a good review of the latest literature in alcohol and drug addiction treatment. Raine Berry provides the Chairperson's report from TRIG and we start a new item, Faces, aimed at putting some faces to names with TRIG's secretary Lindsay Stringer. Finally we get a glimpse in the feature article at what is going on in alcohol and drug treatment research overseas from Simon Adamson's report of his recent visit to the States.

I hope this issue of the TRN provides food for thought as well as debate. Given the many issues surrounding cannabis use and legalisation I look forward to hearing from the readers regarding opinions and concerns with cannabis research.

Meg Harvey
Editor

3 August 2001



NAMES & FACES

With the Alcohol & Drug treatment community in New Zealand being spread from the tip of one island to the bottom of the other we often know the names of people involved in treatment and treatment research, but don't know the faces. This issue we are starting this new feature to provide some linkages between faces and names. First up is name most people will be familiar with – Lindsay Stringer. Lindsay is the TRIG secretary and is based at the NCTD in Christchurch.

Lindsay Stringer (TRIG Secretary)

* * * * *

Treatment Research News is the official newsletter of the **Treatment Research Interest Group (TRIG).**

TRIG was established in 1997 to reflect the interests of workers in the alcohol and drug field in NZ.

The **executive committee** are: Raine Berry (Chairperson), Lindsay Stringer (Secretary), Doug Sellman, Peter Adams, Meg Harvey, Alistair Dunn, Robert Steenhuisen and Michael Baker.

Please direct **enquiries to Lindsay Stringer**,
PO Box 2924, Christchurch,
Phone (03) 364 0480, email:
lindsay.stringer@chmeds.ac.nz

Data Collection Grinds On

The data collection in a typical clinical study can be described in three phases. The first third is a breeze; almost a thrill as the honeymoon of a new project unfolds. The principal investigator feels clever and sleeps with a smile on her face. This period quite quickly begins to slide into a middle phase of hard work as the realities of the data collection problems for the particular study start to bite and mount. The principal investigator discovers the numerous limitations of the study and begins to feel like a very average academic and increasingly very weary at the end of the day. She increasingly spends more and more spare time worrying about the study, including weekends. The final third of the data collection is a nightmare as time begins to run out, the budget is spent and to stop data collection now seriously risks the already borderline statistical power of the study. Sleepless nights and early morning worries begin to dominate the researcher's life as she begins to contemplate a new career…..It is easy to understand why many clinical studies never achieve the hoped for data collection, let alone traversing the tribulations of statistical analysis, write up and then the fire of peer review publication!

The NCTD has two current substantial studies in which data collection grinds on. The first is Daryle Deering's validity study of the Degree of Drug Use Index (DDIVS) in which the full initial sample of 70 non-Maori and 35 Maori patients chosen at random from the Christchurch Methadone Programme is almost complete. The second, Simon Adamson's Naturalistic Treatment Outcome Project (NTOP) in which a real life description of the people accessing alcohol and drug treatment in New Zealand and what happens to them 9 months later, is also way beyond the initial honeymoon period of data collection. We are fortunate both within the NCTD as well as for our field, to have in Daryle and Simon, two very able and persistent researchers who will continue to front these important studies way beyond the point that many would give up.

Further studies continuing and previously commented on in detail here in the TRN are: (1) A 4 year follow-up of the Brief Treatment Programme, a randomized controlled trial of motivational enhancement therapy, previously commented on in detail and now published in the Journal of Studies on Alcohol; and (2) The Rolling Telephone Study.

There are also a number of important pieces of PhD work being undertaken at the NCTD, which will be the subject of later reports, when TRN space permits.

Newly funded work

Two new research projects have recently been funded. Firstly is a pilot Maori clinical trial funded by the Alcohol Advisory Council of New Zealand. Paul Robertson is the principal NCTD investigator. The overall aim of the work is to develop an outpatient kaupapa Maori treatment protocol which in the first instance will be feasibility tested in 20-30 Maori in one or two sites in New Zealand, followed by a more definitive study of the treatment. Secondly is the first step in a programme of pathological gambling research, funded by the Gambling Purchasing Agency of New Zealand. Dr Dominic Lim is the principal NCTD investigator. This first step is involving baseline data collection of a representative sample of people with pathological gambling undergoing outpatient treatment in preparation for a followup of treatment outcome. Part of the work will be the identification of other behavioural addictions in this clinical sample along with a detailed description of alcohol and drug as well as other mental health problems. Later it is hoped that funding will be available for pharmacotherapy study, which brings me to a concerned final comment.

A Concerned Final Comment

There is a new era of treatment development in the addiction treatment field internationally, which involves the use of seemingly effective pharmacotherapies, including the range of anticraving medications – naltrexone, nalmefene, acamprosate, ondansetron etc. Not only is there no substantial active research in New Zealand involving the application of such medications but access to these medications in clinical practice is severely limited. True, naltrexone is now registered for use as an anticraving agent in alcohol dependence, but it is not funded, so patients are required to pay around $10-12 a day for treatment, which for many is way beyond their daily living budget. The lack of any real access to these medications by patients severely limits the collective clinical experience in this whole new area of treatment. The alcohol and drug treatment field in this country therefore takes on a Third World look with its clinicians and researchers increasing appearing in an international context as "bare foot" workers. New Zealand seems to be short of research money with many excellent projects in the most recent Health Research Council (HRC) Grant Application Round not ending up being funded. Amongst these was a pharmacotherapy study of ours focused on alcohol dependent adolescents. Listening to the sort of projects of colleagues currently being funded in Australia by similar

governmental bodies to our HRC produces a strong impression that our pharmacotherapy study would've been funded in Australia. This is very frustrating, but at the end of the day the real loss is not so much ours, but that of our patients with alcohol dependence and their families.

Doug Sellman
23 July 2001

This newsletter is sponsored by
Glaxo Smith Kline, marketers of Methadone Syrup 5mg/ml and Kapanol™

TRAVEL REPORT: ARIZONA 17 - 21 JUNE 2001

The Sixty-Third Annual Scientific Meeting of the College on Problems of Drug Dependence (CPDD)

This conference in the desert was attended by about 1000 delegates. General impressions include recognising that the A&D research field in the US is huge. There is a lot of money, which often goes on large trials with enviable sample sizes. Quite a bit of money also obviously goes on quite poor research with very few subjects, conducted by researchers who seem unfamiliar with the world of statistics.

Something that really surprised me was the near invisibility of ethnic minorities. Considering many studies reported on clinical samples with upward of 50% ethnic minorities (mainly African American and Hispanic) there was a complete absence of any discussion of differing treatment needs or any other issues from a cultural or ethnic perspective.

Presentations of particular interest to me included:

National Drug Abuse Clinical Trials Network (www.nida.nih.gov)

A symposium on the National Drug Abuse Clinical Trials Network provided real food for thought. Essentially it was presented as an attempt to improve the lag between current knowledge of effective treatment and what is actually delivered. The notion of "Technology Transfer" was described as a "loser concept" as new treatments don't simply replace the old, rather there is a blending of the new with the old and the gradual shift that occurs with training and recruitment of new staff. Drawing on this and also the practices of NASA and the heart disease field NIDA has developed a clinical trials network. Basically the idea is that clinical trials present a unique opportunity to blend research and practice. One of the key factors in this has been including senior clinicians as named investigators, recognising that they have important expertise and including them from the start of the project, i.e. from conceptualisation on. In fact it was suggested that clinical settings might prove to be a good place to generate research ideas and set priorities based on their clinical relevance. It struck me that this general approach would be an excellent way of "enlightening" both parties – to the methods and value of research on the one hand and to the realities and priorities of clinical work on the other. This is an excellent model, which is most applicable I guess for clinical trials, very few of which occur in New Zealand (although I'm probably describing nothing here that is terribly new to those of you involved in the current development of the Maori clinical project). Another benefit of this approach was that they seem to have set up a network of sites where there is an existing infrastructure for any future multi-site studies.

Buprenorphine

I attended a symposium covering the history of the development of buprenorphine and the process of bringing it to the market in the US. One presenter started by describing the American View thus: "Addicts are sick, they need help. They also sin, so don't treat them too well". There was a lengthy description of the legislative process that has occurred to now make buprenorphine available from all GPs offices, which highlighted the difficulties of getting addiction treatment taken seriously in the world of politics. The session was ended by Jerome Jaffe as discussant, who rather burst the bubble of unalloyed enthusiasm of the presenters. He warned that to prescribe buprenorphine physicians would only need 8 hours training, contrasting this with the burdensome regulations surrounding prescribing of methadone and LAAM. While on the surface this seems good it could easily lead to some poor practice that would produce a governmental knee-jerk of heavy regulation or withdrawal from the market. Jaffe was particularly concerned that despite best intentions physicians were unlikely to provide any counselling.

Gambling

St Louis Epidemiological Catchment Area study – found a low association between Pathological Gambling and alcohol and PG and Nicotine. In the drug using sample the criteria of "chasing loses" was present in 94% with PG versus 36% of sub-threshold PGs (n=700ish).

With regard to the neurobiology of PG there have been no previous neuro-imaging studies to date, so Marc Potenza from Yale described a study which investigated activity in the neolimbic and subcortical regions when showing a PG sample three different video clips – sad, happy and gambling-related. It was also conducted with cocaine dependent sample using a cocaine-related clip. The gambling sample consisted of 21 (11 male) patients with no substance use disorder other than nicotine. Males had significantly greater peak emotional response and urge to gamble. There was increased ventral anterior cingulate cortex (AC) activity in controls but not

PGs during viewing of gambling scenarios, but not sad and happy scenarios. In contrast the cocaine group had an increase in AC activity compared to controls for the cocaine scenario. There was a relative decrease in activity in frontal areas for PG compared to controls, which was similar to what was found in the cocaine sample. Potenza concluded that while there were some similarities between PG and cocaine groups there were also differences, but felt it was too early in their research to go much beyond this.

Cannabis

I caught part of the symposium entitled Marijuana Withdrawal, although it covered a broader range of issues. Cannabis withdrawal has been demonstrated in animals, including the induction of withdrawal using a cannabinoid antagonist (not named though). It has also been widely reported in clinical surveys and trials, despite not being acknowledged in the DSM-IV. Reliable symptoms reported include aggression, anger, craving, diminished appetite, sleep difficulty and having strange dreams. Most symptoms occur over 5-15 days, initially appearing 0-3 days after cessation. The exception was strange dreams which were high throughout 43 days of follow-up, leading the author to consider it an offset effect rather than part of a withdrawal syndrome. Sleep difficulty was highly variable and therefore still unclear. Weight returns to normal by week five.

Posters

There were over 500 posters presented at this conference – one for every two delegates! Quality varied quite a lot, with some excellent and others a bit dodgy, it's amazing what gets funded in the US.

Continued on Page 7

Treatment Research Interest Group (TRIG)

Alcohol, Drugs and Addiction

NEW MEMBERSHIP FORM

PLEASE ENROL ME AS A NEW MEMBER OF TRIG (TREATMENT RESEARCH INTEREST GROUP). I HAVE READ AND SIGNED THE DECLARATION BELOW.

Surname _____ First Names _____

Postal Address _____

_____

_____

Daytime Phone Number _____ Fax Number _____

E-Mail Address _____

The objectives of TRIG are:-

- *To foster interest in scientific research on treatment of people with alcohol and drug related problems in New Zealand.*
- *To disseminate and promote research findings related to effective treatment of people with alcohol and drug related problems within New Zealand.*
- *To support the development of improved treatment services for people with alcohol and drug related problems in New Zealand.*

Declaration

I support the objectives of TRIG and wish to be a member of TRIG for the 2001/2002 year. I understand this will entitle me to three editions of the Treatment Research News (TRN) and a reduction in the registration fee at the Annual Treatment Conference 2001.

Signed _____ Date _____

☐ I would like to make a donation to TRIG of $ _____

Thank you for completing this form and sending it back to:
Lindsay Stringer, PO Box 2924, Christchurch (Phone 03 364-0480, Fax 03 364-1225)

ADOLESCENTS AND CANNABIS

Cannabis use is increasing in New Zealand, particularly amongst younger age groups. Compared to other countries, New Zealand has higher rates of initial cannabis use and problems with cannabis in adolescence. A New Zealand 1998 survey demonstrated that cannabis use peaks at 18-19 years (Field & Casswell, 1999). The Christchurch Health and Development Study found 40% of their cohort had tried cannabis by the age of 18 (Fergusson & Horwood, 2000). These and data from the Dunedin longitudinal study (Poulton et al, 1997) indicate that experimentation with cannabis is now a behaviour of the majority of adolescents. Research from Dacey & Moewaka Barnes (2000) indicates that cannabis use among young Mäori appears to be high with 60% of those aged 15-29 years having used cannabis and 23% of this age group currently using cannabis.

While recreational use of cannabis may not be a major concern there is evidence that by 18-years-old there is a 4% risk of an adolescent developing a DSM-IV disorder for cannabis with this rising to 9% by 21-years-old. The risk of adolescent Mäori developing a DSM-IV disorder for cannabis are double that of non-Mäori with a 9% risk by age 18 years and a 15% risk by age 21 years (Fergusson & Horwood, 2000).

In clinical settings there is a trend of younger age groups using and having difficulties with cannabis. Auckland research found that of the Regional Alcohol & Drug Services clients, youth (defined as under 20-years-old) accounted for 60% of those presenting with alcohol and/or cannabis problems (Paton-Simpson & MacKinnon, 2000). The NCTD National Telephone Survey of Alcohol & Drug Services in 1998 similarly found that under the age of 25 years 51% of clients were presenting with alcohol and/or cannabis problems and that Mäori were more likely to be categorised as cannabis users (41%) compared to the remainder of the sample (22%) (Adamson et al, 2000).

It is evident from the above research that adolescents in New Zealand have substantial exposure to cannabis and a significant minority develop problems. A particular area of concern for adolescents using cannabis is the effects it may have on their brain development and education. Solowij (1998) concluded that long-term cannabis use does not have a *severe* debilitating impairment on cognitive function. It does, however, lead to subtle selective impairment, primarily effecting the ability to focus, sustain and shift attention. This subtle impairment may have more significance for adolescents who are in an accelerated phase of life in terms of developing cognitive abilities and expanding their knowledge base through education. Further, of concern to adolescents are Solowij's findings that while cognitive effects from cannabis found in adults are probably reversible, they are not perhaps entirely or for everyone.

From what age do we need to be concerned about adolescent using cannabis? International research indicates that cannabis use initiation occurs largely after the age of 15 years (Bailey & Hubbard, 1990; Kann et al, 1996). There is New Zealand evidence that ¼ of 16-year-olds are using cannabis regularly (Fergusson et al, 1996). In a Mäori sample 41% of those who had tried cannabis had done so between the age of 15 and 17 years (Dacey & Moewaka Barnes, 2000). These findings suggest that mid to late adolescence is a common time for cannabis use.

Given the increasing numbers of New Zealand adolescents using and having problems with cannabis and the potential effects on their education and consequent employment or income, what treatment is available for adolescents with cannabis abuse or dependence? Not much. Neither here nor overseas are many treatments targeted specifically at cannabis problems let alone adolescent cannabis problems.

There has been some work using cognitive-behavioural interventions (CBT) with cannabis problems by Copeland and colleagues in Australia at National Drug and Alcohol Research Centre (NDARC). A randomised controlled trial is currently underway comparing a group receiving CBT, a group with a single-session brief intervention and a delayed-treatment control group.

More generally, but not specifically with cannabis, a couple of studies have looked at treatment for adolescents with drug problems. Riggs et al (1997) in Denver, USA used fluoxetine in adolescents with comorbid substance use disorders. They found fluoxetine to significantly improve depression with few side effects and recommended it's use in treating adolescents recovering from substance use disorders who were experiencing major depression. The other study looking specifically at adolescents was by Braukmann et al (1985). This somewhat dated study looked at efficacy of community versus group-homed based treatment programs. While there were some during-treatment differences, at a year-follow-up there were no differences in recovery in community versus group based treatment groups.

Research into the treatment of adolescents with cannabis problems is lacking, but several sites around the country (including Dunedin & Christchurch) are starting to work in this area. We'll keep you posted on progress.

Meg Harvey
NCTD

WHAT'S NEW ON THE STREET? AN OLDIE BUT A GOODIE?

This month, given the theme of other contributions, I thought I would look at a drug we all think we know a lot about, but our knowledge is often based on a series of assumptions - cannabis. This is a pertinent drug for the treatment field – in our study with methadone clients up to 70% use cannabis, many daily. Similarly RADS in Auckland has reported that 35% of their clients present with a cannabis problem (Paton-Simpson, MacKinnon 2000). The 1998 national drug survey found cannabis to be the third most popular drug in New Zealand (Field, Casswell 1999). New Zealanders use a lot of cannabis in comparison to many countries.

The active ingredient in cannabis is 9-delta-tetrahydrocannabinol. Cannabis is commonly available in three preparations: marijuana (leaves and head of the plant); hashish (compressed leaves and resin of the plant); and hash oil (extracted from the resin). The hippocampus, cerebral cortex, cerebellum and basal ganglia are the sites of densest cannabinoid receptors and are involved in cognition and memory, mood and higher intellectual functions, as well as motor functions. The lack of cannabinoid receptors in the brain stem explains the relative nonlethality of THC.

The effects of cannabis are felt within 10-30 minutes and last about 2-3 hours. Ingesting, as opposed to smoking, cannabis means the effects appear later and last longer. Very high doses may produce hallucinations or paranoid delusions. The most common effects include:

- relaxation and sleepiness
- heightened sexual arousal
- inability to keep accurate track of time
- hunger
- decreased social interaction
- problems with short-term memory
- impairment of ability to carry out multi-step tasks.
- mild levels of suspiciousness or paranoia

Physiological changes that may occur with minor intoxication include:

- fine shakes or tremors
- decrease in body temperature
- decrease in muscle strength and balance
- decreases in levels of motor co-ordination
- dry mouth
- bloodshot eyes
- nausea, headache and lowered blood pressure

Two popular misconceptions of cannabis are that when purchased cannabis is just cannabis (increasingly, cannabis laced with tranquillisers or opiates is available) and it's relationship to mental health. There is a relationship between cannabis and depression. This has been assumed by many to mean smoking cannabis causes depression. In fact, there is evidence that it may well be that people suffering depression smoke cannabis to relieve symptoms of depression. A similar scenario can be seen with psychosis and some patients using cannabis to ease psychotic symptoms.

Debate and queries about cannabis are welcome.
Meg Harvey
NCTD

References

Paton-Simpson, G., MacKinnon, S. (2000). *Alcohol and drug problems in community clients at Auckland Regional Alcohol & Drug Services*. Auckland, New Zealand: ALAC Occasional Publication No 11.

Field, A.F., Casswell, S. (1999). *Drugs in New Zealand: National Survey, 1998.* University of Auckland: Alcohol & Public Health Research Unit.

TRIG NOTICES

AGM REMINDER

Hi everyone I want to remind our members of the coming TRIG AGM which will be held as usual at the Cutting Edge Conference. It would be lovely to hear from anyone unable to come to the AGM who wants to have some input and especially lovely to hear from anyone interested in getting involved at the executive level. I look forward to seeing other members in Napier.

The AGM will be held on Friday 14 September at 12.30pm

Raine Berry
Chairperson

CONT FROM PAGE 5

I was also interested to see a poster describing a 12 session CBT based therapy used for MMT patients unable to control illicit opioid use. It was a pilot study that randomised 23 patients to either the CBT or session-intensity matched treatment as usual. The CBT focused on exposure to interoceptive cues of craving, cognitive restructuring and somatic coping skills. There was a significant benefit for CBT women but not men.

So, I found the conference to be a worthwhile experience, and also was pleased to be able to reflect that for a national population of 3.8 million and a small research population the quality delivered at Cutting Edge is really quite respectable. I am very appreciative of the time and costs contributed by the Canterbury DHB to attend this conference.

Simon Adamson, NCTD

NCTD Submission to the Health Select Committee re Cannabis

In February, the NCTD made a submission to the Health Select Committee, who are currently engaged in an inquiry as to the most effective public health and health promotion strategies to minimise the use of and the harm associated with cannabis. Below is a summary of this submission.

Cannabis use is neither very harmful nor very harmless. Simple categorical statements can be unhelpful in thinking through the harm of cannabis use. At least eight key questions need to be considered when thinking about cannabis harm:

1. What is the relative risk of harm related to cannabis use compared with alcohol?

Overall, cannabis use appears to be no more harmful than alcohol use and may be less.

2. What is the harm of occasional cannabis use?

Occasional use of cannabis by the vast majority of New Zealanders is unlikely to be associated with any clinically significant harm.

3. What is the harm of regular cannabis use?

Regular use of cannabis is associated with increased risk of at least five different harms:

(i) Developing cannabis dependence (similar risk to alcohol);
(ii) Respiratory disease (similar to smoking tobacco);
(iii) Motor vehicle accidents (less risk than for alcohol);
(iv) Negative impact on adolescent development (cognitive impairment/anti-conventional lifestyle) (possibly more risk than alcohol);
(v) Exacerbation of psychotic episodes and treatment non-compliance in people with schizophrenia and bipolar disorder (probably more risk than alcohol).

4. What is the harm from cannabis prohibition?

At least seven harms have been described [Hall 2001]: loss of liberty for otherwise pro-social citizens; creation of a large-scale black market; disrespect for the law by users; social harms for those convicted of a criminal offence; impairment of health education about cannabis; loss of benefits from cannabis use including promising medical uses; inappropriate use of scarce law enforcement resources.

5. What are the benefits of cannabis?

Cannabis has a wide range of effects including being anxiolytic, sedative, analgesic, psychedelic as well as a stimulator of appetite. It is a very safe drug in that no deaths directly attributable to acute cannabis use have ever been reported [Ashton 2001]. Promising therapeutic applications exist for the following conditions: nausea and vomiting, multiple sclerosis and other neurological disorders, loss of appetite and weight in cancer and AIDS, pain, raised intra-ocular pressure, insomnia anxiety and depression, epilepsy, and asthma [Robson 2001]. Cannabis prohibition impedes advancement and refinement of these therapeutic possibilities.

6. Would liberalisation of the legal status of cannabis increase the rate of regular use of cannabis?

The answer appears to be no, at least for decriminalisation. Some of the best research data comes from the Australian experience of decriminalisation of cannabis use (prohibition with civil penalties) in three states, South Australia (in 1987), Australian Capital Territory (in 1992) and the Northern Territory (in 1996). The rate of regular use of cannabis in these three states has not increased disproportionately compared with the other states in Australia which have similar prohibition with criminal penalties, as currently exists in New Zealand [Lenton et al 2000]. When commercialisation is introduced as part of the liberalisation of the legal status of cannabis however, the story is different. The best research data on the influence of commercialisation of cannabis use comes from the Dutch experience of allowing coffee shops to sell small quantities of cannabis, under strict conditions. This policy appears to be associated with increased regular use of cannabis [MacCoun & Reuter 2001].

7. Would liberalisation of the legal status of cannabis decrease the harm from cannabis prohibition?

The answer appears to be yes. In research comparing the experience of people apprehended for a cannabis offence, those in Western Australia (criminal penalties) reported greater adverse social consequences compared with those in South Australia (civil penalties). These consequences included problems with employment, accommodation and relationships, along with continuing involvement with the criminal justice system [Lenton et al 2000].

8. What are the likely consequences of liberalisation of the legal status of cannabis?

Fergusson (2001) identifies the central dilemma in considering change to the legal status of cannabis as one of competing goals of protecting vulnerable groups or protecting the rights of occasional recreational users. Our interest is the vulnerable groups. We suggest that liberalisation of the legal status of cannabis would in fact bring about the following improvements for those with cannabis dependence and those at risk of developing it:

(i) improved treatment environments, including school environments
(ii) improved respect for the law by users, particularly those who incline towards rebelliousness;
(iii) decreased social harms for those convicted of a criminal offence;
(iv) improved opportunities for education about cannabis and its harms.

Given the evidence that regular use of cannabis is unlikely to significantly increase with decriminalisation, the rate of development of cannabis dependence is unlikely to significantly increase, even though the occasional use of cannabis by

recreational users may increase. Occasional use of cannabis does not increase the risk of cannabis dependence in the same way that regular use does.

Conclusion

Removing prohibition of possession of small quantities of cannabis for personal use in private, most likely will bring about a reduction in the overall harms associated with cannabis use and its current legal status in New Zealand, through removing the harm associated with criminalisation. However any change in the legal status which involves commercialisation, even at a low heavily regulated level, most likely will bring about increased regular use of cannabis with attendant harms associated with regular use.

Doug Sellman & Fraser Todd, NCTD

I'VE BEEN READING . . . . .

Marc A Schuckit is a name every self-respecting Alcohol and Drug clinician is familiar with, and his reputation for producing high quality research that is clinically relevant is unsurpassed. He is at it again. In the July edition of the American Journal of Psychiatry ***(American Journal of Psychiatry 158:1084-1090, July 2001)*** he reports on the findings of a five-year prospective study of the clinical course of alcohol abuse and dependence. About 1/3rd of 298 patients with DSM-IV alcohol dependence no longer met any criteria at 5 years, and 55% of 288 patients with DSM-IV alcohol abuse no longer met criteria. These figures are not surprising. Of interest though is the finding that only 3.5% of those with alcohol abuse had developed alcohol dependence 5 years later, belying the commonly held belief that a significant proportion of those with abuse will proceed to dependence in the future. He also reports that of a range of factors, those that most reliably predict continuance of dependence 5 years later are male gender, lack of marital stability, a history of cannabis or cocaine use, and the diagnostic criteria of tolerance, using longer or more than intended, inability to cut down and use in hazardous circumstances. These findings are important. In narrowing down the predictors of continued dependence, we are able to better advise our patients regarding whether controlled use is a realistic option or not. Those with one or more of the risk factors mentioned above warrant more encouragement to stop drinking than those without.

Another tradition in the alcohol and drug field is group treatment, but it has received little recent research attention. Marques and colleagues ***(Addiction 2001, 96:6:a 835-846)***report on the outcome of a randomised trial comparing – group vs individual cognitive behavioural therapy for people with alcohol or drug dependence. Following patients over a 15-month period they found no differences in drug consumption levels, presence of dependence and associated psychosocial problems. A timely reminder of the benefits of group treatments at time when individual therapies seem to be preferred in many settings.

A recent Supplement of ***Alcoholism Clinical and Experimental Research (May 2001)*** reported the proceedings of a symposium called the 2000 ISBRA Meeting in which was summarised a number of interesting streams. Of special note, Boeining and colleagues discuss "Pharmacological Relapse Prevention in Alcohol Dependence". Among the papers presented in that stream were several indicating that naltrexone has little effect on relapse when taken in addition to abstinence based treatments, but is safe to be taken while patients are still drinking in which case it tends to significantly reduce the amount of alcohol consumed. In other words, it seems most effective at helping heavy drinkers continue to drink in a controlled fashion. Acamprosate on the other hand appears effective taken while abstinent to prevent a return to drinking. While neither of these medications are available and funded in New Zealand, they are now increasingly used in other countries and subsidised in Australia. The message here I suppose is that we should either lobby for the availability of these medications here, or spend the treatment funding on one way tickets for our patients across the Tasman – which might not only improve treatment outcomes but also save us money! A sobering thought in itself.

Heroin and opioid use by adolescents has increased significantly in Europe over the past few years raising concerns about appropriate treatments. Hopfer and colleagues ***(Journal of the American Academy of Child and Adolescent Psychiatry, 2000;39:10:1316 - 1323)*** have now reported similar findings from a large data base in the United States where, they show, there was a significant increase in heroin use by adolescents during the 1990's. Despite a move from IV use to snorting heroin in the adult population, high rates of intravenous use persisted in adolescents. In their discussion, the authors point to the lack of any significant research into the treatment of adolescent heroin use other than two studies reported over 20 years ago which suggested that methadone supported detoxification was associated with high rates of relapse, as one might expect. There is little data on the rates of opioid use by adolescents in New Zealand. Despite this and the lack of treatment research, the National Protocols for Methadone Treatment in New Zealand 1996 state that "People receiving methadone treatment should be at least 16 years old; and preferably over 18 years old. Similar recommendations are planned for the current revision of the guidelines. Given these situations, research into the epidemiology and nature of adolescent opioid use in New Zealand, and effective treatments for it are urgently required.

And finally, in an interesting piece of research Corvin and colleagues have found a relationship between severity of smoking and severity of psychotic symptoms in patients with bipolar affective disorder ***(British Journal of Psychiatry, 2001;179:35-38)***. It has been known for some time that people with schizophrenia have high rates of nicotine use and dependence. Speculations as to the reason for this have hypothesised that nicotine use affects the symptoms of schizophrenia, in particular improving some of the psychotic experiences such as auditory hallucinations by improving "gating" of filtering of extraneous sounds. In this study, Corvin and colleagues report that on average, 68.7% of patients with psychotic bipolar disorder used nicotine regularly, the rates being significantly higher in those with more intense psychotic symptoms. They speculate that these results suggest the relationship exists between nicotine use and psychosis rather than any particular diagnosis. Thus addressing nicotine use should be a particular focus for all patients with psychosis rather than just those with schizophrenia.

Fraser Todd
Senior Lecturer
NCTD

Contact Person for Treatment Research News:
Meg Harvey
Phone 364-0480
Email: meg.harvey@chmeds.ac.nz

Treatment Research Interest Group (TRIG)
PO Box 2924
Christchurch

TRIG is sponsored by the National Centre for Treatment Development (NCTD)
Dept of Psychological Medicine
Chch School of Medicine
4 Oxford Terrace