Cannabis use in patients with schizophrenia: motivation for use and relation to clinical variables
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Citation for published version (APA):

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CHAPTER 1.4

Cessation of cannabis use by patients with recent-onset schizophrenia and related disorders

N. Dekker, L. de Haan, S. van den Berg, M. de Gier, H. Becker, D.H. Linszen
Abstract

Background. Cannabis abuse has been found to be a component risk factor for the onset and poor outcome during the early course of schizophrenia and related disorders. Cannabis use has become a target for prevention and treatment of schizophrenia patients. Therefore, knowledge of factors that influence continuation and cessation of cannabis use is crucial. However, little is known about factors associated with cessation of cannabis use in young schizophrenia patients.

Sampling and methods. We examined medical records of 206 consecutively admitted young patients with schizophrenia or related disorders, to explore factors associated with cessation of cannabis use.

Results. Of all patients that had used cannabis (167) in the past, more than half (87) ceased the use of cannabis before they were admitted to our clinic. Most patients ceased the use of cannabis after they became psychotic and after their first contact with psychiatric services. According to the urinalysis, only 5 patients seemed to have lied about their time of cessation. No differences in patient characteristics were found between patients that ceased their use of cannabis and patients that continued their use.

Conclusions. The results suggest that start of treatment for psychosis is related to the cessation of cannabis use, at least in part of the patients.
Introduction

Several studies indicate that the prevalence of substance use disorders among individuals with psychotic disorders is higher than in the general population, with lifetime estimates of more than 40% (Fowler et al. 1991, Dixon 1999, Green 2005). Patients with first-episode schizophrenia are also likely to have a high rate of co-morbid substance use disorders, with cannabis being a prominent drug of abuse (Green 2005, Buhler et al. 2002, Van Mastrigt et al. 2004). In a first episode sample of 357 patients, 78% misused substances and 35% had a diagnosis of cannabis abuse or dependence (Van Mastrigt et al. 2004). In another sample of 232 patients at first admission, 14.2% had a lifetime history of drug abuse, with 88% reporting the use of cannabis (Buhler et al. 2002). In schizophrenia patients, cannabis use has been associated with an early age of onset of the disease (Van Mastrigt et al. 2004, Veen et al. 2004, Barnes et al. 2006), and more and earlier psychotic relapses (Linszen et al. 1994). For the prevention and treatment of cannabis use among schizophrenia patients, not only knowledge of factors which influence the initiation and continuation of cannabis use is crucial, but also of the factors associated with cessation of cannabis use are important.

As opposed to the numerous studies that have been conducted investigating self-reported reasons for cannabis use in patients with psychotic disorders (Fowler et al. 1991, Test et al. 1989, Dixon et al. 1991, Warner et al. 1994, Baigent et al. 1995, Addington and Duchak 1997, Spencer et al. 2002) little is known about self-reported reasons for cessation of cannabis use among these patients. Also, there are limited data on the course of cannabis use in young schizophrenia patients, the proportion of patients that cease the use of cannabis and the time of cessation.

A few studies have examined the course of cannabis use in first episode psychosis patients. Wade et al. (2006) examined the course of substance misuse in 103 individuals treated for first-episode psychosis. Between baseline and 15-month follow up, there was a significant reduction in the rate of cannabis misuse from 63.1% to 41.7%. Patients who continued substance misuse were more likely to be younger, male and single, less likely to have completed secondary school and more likely to be heavy cannabis users prior to entry to treatment compared to patients who ceased substance use. Reasons for cessation were not examined. Another prospective study of first-episode psychosis (Addington and Addington 2001) found a lower rate of cannabis misuse during the first year of treatment compared to the pre-treatment period. Of the initial 30 patients (32% of total) that met the criteria for current cannabis abuse, 7 still abused cannabis after 1 year, which was a significant drop. Baseline predictors and reasons for cessation were not examined.

In chronic psychosis, two prospective longitudinal studies of the course of substance misuse have been reported (Cuffel and Chase 1994, Bartels et al. 1995). Cuffel and Chase (1994) reported 1-year rates of substance abuse and dependence remission and relapse in a sample of schizophrenic patients taken from the Epidemiologic Catchment Area study. They found that individuals who developed abuse or dependence over the year were younger, male, and showed increases in depression and risk for hospitalisation. Individuals who remitted from abuse or dependence were older, female and showed decreases in depression over the year. Another prospective naturalistic study (Bartels et al. 1995) of 148 outpatients with chronic psychosis found that those patients with initial drug abuse had a higher rate of remission (54 %) than those with initial drug dependence (31 %) at the 7 year follow up.

In the general population, several studies have identified factors associated with cessation of cannabis use. Earlier studies (Kandel and Raveis 1998, Hammer and Vaglum 1990) have found that
cessation of cannabis use was significantly related to the establishment of an adult social role as a partner or as a parent, and negatively correlated to long-term unemployment. These findings support the role incompatibility theory (Thornton and Nordi 1975), which implicates that the role of a cannabis user is incompatible with the acquisition of typical and normative adult roles. Goodstadt et al (1984) found in a large high school sample that those students who started to use cannabis at a very young age were less likely to quit than those who tried it later. A more recent one year prospective study (Van den Bree et al 2005) among 13718 adolescents found that three risk factors influenced all stages of development of cannabis use (including failure to discontinue use): own and peer involvement with substances, delinquency and school-related problems. Sussman and Dent (2004) found in a five year prospective study among 339 teenage marijuana users that light users, those who obtained a conventional adult role, those who had relatively few friends that used marijuana and those who were female were relatively likely to quit. Chen and Kandel (1995), who investigated factors associated with cessation of cannabis use from adolescence to adulthood in a sample of 706 marijuana users, found that the two most important predictors of stopping marijuana use were frequency of marijuana use and age. Infrequent users and individuals in their late twenties were most likely to stop using. Early onset into cannabis use and using illicit drugs other than marijuana delayed cessation.

The aim of this study was to examine factors associated with the cessation of cannabis use in a clinical sample of consecutively admitted adolescent and young adult patients with recent onset schizophrenia and related disorders. We tried to answer the following four questions:

- What is the proportion of patients that cease cannabis use prior to treatment in our clinic for young schizophrenia patients?
- What are the differences between patients that ceased cannabis use and patients that continued their use?
- When did patients stop using cannabis in relation to their psychiatric history?
- Are patients honest about their reported cannabis cessation?

**Methods**

**Subjects and procedure**

We examined 206 medical records of consecutively admitted patients with schizophrenia or related disease (schizoaffective disorder, schizophreniform disorder, psychosis due to cannabis use and psychosis NOS) who were consecutively admitted to the inpatient and day-care unit of the Adolescent Clinic of the Psychiatric Department of the Academic Medical Center in Amsterdam from 2002 to 2005. This clinic is specialized in the treatment of young schizophrenia patients aged between 16 and 28 years. Patients are referred to the program by outpatient and inpatient care facilities in the region.

**Data collection and measures**

For this study data were retrieved from medical records. Shortly before and after admission in the clinic all patients are asked routinely about their psychiatric history, prior and current symptoms and past and current substance use. Clinical discharge diagnoses according to Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV: APA 2000), were made with the use of all available diagnostic information (systematic interviews with patients and parents and previous medical records) by two clinical psychiatrists and two residents, after which the diagnoses were
reviewed by a research psychiatrist (Spitzer and Williams 1995). Besides self-report measures, a laboratory test (urinalysis) is conducted routinely for detection of drug use (cannabis, cocaine and amphetamines) in the first week of admission. We collected data of the psychiatric treatment history, data about the onset of the first positive psychotic symptoms (hallucinations, delusions, and disorganisation). We also used quantitative data of past drug use and recent drug use that patients reported shortly after admittance. We determined whether the patient had used cannabis, in what average amount and at what age patients started using cannabis. Patients that had used cannabis less than 5 times in their lives were counted as never users. All patients that had ceased the use of cannabis before admittance to our clinic were counted as those patients that had ceased their use. Of all those patients, we looked at what age they had done this and whether reasons or certain occurrences during cessation of cannabis use had been reported in the medical records. We also determined whether patients had ever used hard drugs (ecstasy, cocaine, lsd, amphetamines/speed, opiates). For a more complete description of characteristics of drug use in this population, we made a comparison between males and females. Furthermore, results of the urinalysis for cannabis use were used.

**Data analysis**

For analysis of the data we used SPSS 12.0.1. To assess group differences on categorical drug use variables among males and females, and among patients that ceased cannabis use and patients that continued their use, we conducted chi-square tests for independence. To compare means on continuous variables we used independent-sample t-tests. To relate the time of cessation of cannabis use to the psychiatric history, we divided the time of cessation in four periods: prior to onset of psychotic symptoms, after onset of psychotic symptoms but before first outpatient care, during or after first outpatient care, during or after prior admittance for psychosis. According to the time (month-year) of cessation that was reported by the patient and the timeframe of his psychiatric history, patients were assigned to one of these groups. We performed a chi-square goodness of fit test to determine whether these different groups were equally represented among those patient that had ceased their cannabis use.

Validity of self-reported cannabis use was established by its correspondence with urinalysis test results. The laboratory of the Academic Medical Center uses the enzyme immunoassay method for detecting tetrahydrocannabinol (THC) metabolites in urine samples, with a cut-off level of 50 ng/ml. Cannabis has a detection window up to 30 days, but the detection time has been documented in literature to be even longer (up to three months) and more variable in populations of heavier cannabis users (Mushoff and Madea 2006). However, given the relatively high cut-off level of 50 ng/ml we chose a detection window of one month. Of those patients that said they stopped using cannabis, but had positive urine for THC, we determined whether the time of cessation was in the detection window of one month.
**Results**

**Baseline Characteristics**

Table 1 shows baseline characteristics of the 206 patients of whom the medical records were reviewed. Most patients were male (86%). The average age at admission was 21.8 years (SD 3.0). Almost two third of the patients was diagnosed with schizophrenia. One third of patients had never been admitted for psychosis before, the rest was admitted once or more times. Every patient had had contact with a psychiatric caregiver before admittance to our clinic.

Table 1. Baseline characteristics of 206 patients with schizophrenia or related disorders

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>206 (100)</th>
<th>177 (86)</th>
<th>29 (14)</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (%)</td>
<td>177 (86)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female (%)</td>
<td>29 (14)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at admission, mean (SD)</td>
<td>21.8 (3.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis according to DSM-IV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia, (%)</td>
<td>132 (64.1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder (%)</td>
<td>34 (16.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophreniform disorder (%)</td>
<td>9 (4.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis-induced psychotic disorder (%)</td>
<td>10 (4.9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotic disorder NOS (%)</td>
<td>21 (10.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None (%)</td>
<td>68 (33.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One (%)</td>
<td>82 (39.8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two (%)</td>
<td>33 (16.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three or more (%)</td>
<td>23 (11.2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior contact with psychiatric caregiver (%)</td>
<td>206 (100)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Drug use**

Drug use characteristics are shown in table 2. Cannabis was the most used substance; 81% had used cannabis. Males were more likely than females to have used cannabis (p < 0.001). The average age of first cannabis use was 15.6 years. The average amount of joints used per week was 16.2. Almost all patients who ever used hard drugs, also had used cannabis.

Table 2 Characteristics of drug use of 206 patients with schizophrenia or related disorders

<table>
<thead>
<tr>
<th>Drug use before current admission</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=206</td>
<td>n=177</td>
<td>n=29</td>
<td></td>
</tr>
<tr>
<td>No drug use (%)</td>
<td>37 (18.0)</td>
<td>23 (13.0)</td>
<td>14 (48.3)</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Cannabis (%)</td>
<td>167 (81.1)</td>
<td>153 (86.4)</td>
<td>14 (48.3)</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>Only cannabis (%)</td>
<td>72 (35.0)</td>
<td>65 (36.7)</td>
<td>7 (24.1)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Cannabis + hard drugs* (%)</td>
<td>95 (46.1)</td>
<td>88 (49.7)</td>
<td>7 (24.1)</td>
<td>p &lt; 0.05</td>
</tr>
<tr>
<td>Age of first cannabis use, mean (SD)</td>
<td>15.6 (2.4)</td>
<td>15.5 (2.2)</td>
<td>15.4 (1.5)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Joints used per week, mean (SD)</td>
<td>16.2 (14.8)</td>
<td>16.1 (14.3)</td>
<td>17.5 (21.6)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Cessation of cannabis prior to current admission (%)</td>
<td>87 (52.1)</td>
<td>78 (44.1)</td>
<td>9 (31.0)</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

n.s. = not significant

* ever used hard drugs: ecstasy, cocaine, lsd, amphetamines/speed, opiates
Chapter 1.4 - Cessation of cannabis use

Proportion of patients that ceased cannabis use prior to treatment in our department

Of all patients that had used cannabis (n = 167), more than half (n = 87) ceased their use before they were admitted to our clinic. The average age of cessation in the group of patients that stopped using cannabis was 20.4 years (see table 2).

Comparison of patients that ceased cannabis use and patients that continued their use

In table 3, patient characteristics are given from patients that ceased cannabis use and patients that continued their use. We found no differences between these groups.

Table 3 Comparison of patient characteristics between patients that ceased cannabis use and patients that continued their use

<table>
<thead>
<tr>
<th></th>
<th>Total of cannabis users</th>
<th>Patients who ceased cannabis use</th>
<th>Patients who continued cannabis use</th>
<th>Level of significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=167</td>
<td>n=87</td>
<td>n=80</td>
<td></td>
</tr>
<tr>
<td>Gender, male/female</td>
<td>153/14</td>
<td>78/9</td>
<td>75/5</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age of first cannabis use, mean (SD)</td>
<td>15.6 (2.4)</td>
<td>15.7 (2.3)</td>
<td>15.5 (2.5)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age of first psychiatric care for psychosis, mean (SD)</td>
<td>20.3 (3.2)</td>
<td>20.5 (2.9)</td>
<td>20.1 (3.5)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age at admission in our clinic, mean (SD)</td>
<td>21.9 (2.9)</td>
<td>21.9 (2.9)</td>
<td>21.9 (2.9)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Drug use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only cannabis (%)</td>
<td>72 (43)</td>
<td>36 (41.4)</td>
<td>36 (45.0)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Cannabis + hard drugs* (%)</td>
<td>95 (57)</td>
<td>51 (58.6)</td>
<td>44 (55.0)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Joints used per week, mean (SD)</td>
<td>16.2 (14.8)</td>
<td>17.2 (16.1)</td>
<td>15.2 (13.2)</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

n.s. = not significant

* ever used hard drugs: ecstasy, cocaine, lsd, amphetamines/speed, opiates

Time of cessation in relation to psychiatric history

In figure 1 the moment of cessation is related to the psychiatric history. Overall, the greatest part of all cannabis users that ceased the use of cannabis, did so after they became psychotic. One third of patients stopped using cannabis during or after a prior admittance for psychosis. There was a significant difference between the numbers of patients in the different groups representing time of cessation (chi square value 18.920, p = 0.001). Self-reported reasons for cessation were found in 45 (51.7%) records of patients that had stopped using cannabis. A prior admission was reported 23 times, worsening of psychotic symptoms was reported 13 times, panic/anxiety 3 times, new year’s resolution twice, complaints after cannabis use (like nausea) 3 times, pressure by others twice and fear of brain damage once.

Reliability of self-reported cannabis use cessation

Of all 87 patients who reported they had ceased the use of cannabis, 73 (83%) had their urine analysed. Of those, 11 (15%) tested positive for cannabis. Five of them were tested outside the detection window, because their self-reported moment of cessation was more than one month before the urine test date. Four of the 11 patients that tested positive for cannabis had said that they had ceased the use of cannabis less than one month before, so they were tested in the detection window period. Of two of the 11 patients the time of cessation was not available, so we cannot determine whether they were tested in the detection window or not.
Discussion

The main finding of this retrospective cohort study of young patients with recent onset schizophrenic disorders was that more than 50% of those who had used cannabis in the past had ceased the use of cannabis before they were admitted to a clinic specialized in the treatment of early schizophrenia. Of all patients that had ceased the use of cannabis, one third did so during or after a prior admittance for psychosis and a quarter did so during or after first outpatient care for psychosis. Moreover, a prior admittance was reported most frequently as the reason for cessation. The exact motivation for cessation during this treatment for psychosis is unknown, but perhaps outpatient care and admittance for psychosis have an effect on this motivation. Further, it may well be that motivation to receive treatment is related to motivation to stop using cannabis. Two other studies (Wade et al 2006, Addington and Addington 2001) have examined the course of substance use of young patients treated for first episode psychosis. They both show a significant drop in cannabis use between baseline and follow up (up to 15 months), supporting the idea that treatment and the motivation for ceasing the use of cannabis are related, at least in part of the patients.

We found no differences in patient characteristics between patients that ceased the use of cannabis, and patients that continued their use. Two prospective naturalistic studies (Cuffel and Chase 1994, Bartels et al 1995) in chronic psychosis have examined factors associated with remission of substance...
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use. Bartels et al (1995) found that those patients with initial drug abuse had a higher rate of remission (54 %) than those with initial drug dependence (31 %) at the 7 year follow up. Cuffel and Chase (1994) found that individuals who remitted abuse or dependence over the year were older, female and showed decreases in depression over the year. A distinction in type of drug was not made in these studies, so the specific course of cannabis use is not known. Additionally, whether these findings generalize to patients with first-episode psychosis is not known. In contrast to our results, studies in the general population (Goodstadt et al 1984, Sussman and Dent 2004, Chen and Kandel 1998) did find that people that ceased their use of cannabis were more likely to be female, older, started use of cannabis at an older age and used less amounts of cannabis. Limited variance in age and gender in the cohort we studied probably precluded finding differences between patients that ceased cannabis use and those that didn’t.

The reasons patients described for cannabis cessation were in concordance with the only other study we are aware of (Addington and Duchak 1997) that assessed reasons for stopping drugs in patients with both schizophrenia and drug abuse or dependence. A total of 21 cannabis using patients were asked to give reasons why they might stop drug use. As in our study, reasons related to symptoms (confusion 67%, becoming paranoid 71%, hallucination 48%) and hospitalization (38%) were reported. Also disapproval of others (of a doctor 71%, of parents/relatives 86%) was important. The two most reported reasons were disapproval of parents/relatives and costs (both 86%).

Cannabis was the most used substance in our study population, which is in agreement with other studies among patients with recent onset schizophrenic disorders (Green 2005, Buhler et al 2002, Van Mastrigt et al 2004, Barnes et al 2006). In the Dutch general population, cannabis is also the most commonly used drug (Abraham et al 2001). Eighty-one percent of our study population had used cannabis, in agreement with other studies finding a high prevalence of cannabis use in patients with schizophrenia (Regier et al 1990, Hambrecht and Häfner 1996, Degenhardt and Hall 2001). This percentage is substantially higher than in the general population: a survey in The Netherlands in 2001 shows that the percentage of people that ever used cannabis in a comparable age group (16-29 years old) is between 30 and 40 (Abraham et al 2001). In our study population men were more likely to have used cannabis than females. In literature, more studies describe that substance use disorders are seen more frequently in men with schizophrenia than in women with schizophrenia (Buhler et al 2002, Hambrecht and Häfner 1996). In the general population, cannabis use is also more prevalent among men than among women (Abraham et al 2001).

Urinary tests for cannabinoids can be positive for days to weeks after ceasing cannabis, complicating the interpretation of positive results (Musshoff and Madea 2006). However, of the 73 patients that had stopped using cannabis and had their urine analysed, 5 (6.9 %) patients did have positive urinalysis outside a detection window of 1 month. They seemed to have lied about their current use of cannabis. Overall, when we look at the concordance between self-report and the urine test result in our population, it seems that most patients are honest about their current use of cannabis. A few studies have described the concordance between self-report of substance use and results of urinalysis in patients with psychosis. In a Norwegian study Helseth et al (2005) found, like we did, that psychotic inpatients were reliable in reporting their substance use. Out of 35 patients that had reported having used one or more substances for intoxication during the month prior to admittance, only one patient tested positively for a drug not reported in the interview. In contrast, Claassen et al (1997) found in a population of psychotic patients seeking treatment in an urban American emergency room, that self-reported use of substances was uncommon among patients with positive results. A country’s drug policy probably has an influence on the reliability of self-report data of
substance use. In The Netherlands cannabis use is not illegal, so self-report data may be less biased than in some other countries.

This study has several limitations. First, all data were retrieved from medical records. We were dependent on what medical staff had asked the patients and what they had reported in the records. However, in all our medical records a structured way of reporting is used by every psychiatrist and resident. Cannabis use is an important topic of the diagnostic interview at admission. However, reasons for cessation of cannabis were only reported in 52% of cases. A prospective study design with structural interviews may yield a more complete insight in this topic. Asking for reasons for cessation, may give an estimation of the risk that patients will restart their habit of using cannabis in the future. Second, concerning past drug use and time of onset of symptoms there may have been recall bias by patients. However, we used correspondence of prior psychiatric caregivers and information retrieved by the parents as well, to check the self-reported data of patients. Third, because of the retrospective design of this study, we were only able to describe data concerning cessation in the group that did actually stop using cannabis in the past. It would be interesting to follow the course of cannabis use in the patients that did not cease their use of cannabis before the diagnostic interview at admission. Additionally, it would be interesting to know whether patients that had stopped using cannabis prior to admittance in our clinic could sustain this abstinence. Fourth, in the comparison between patients that ceased the use of cannabis and those who continued the use of cannabis, we were not able to look at differences in characteristics of symptoms and symptoms severity. For prevention and treatment strategies, it is important to know whether this is related to cessation of cannabis.

Conclusions
In conclusion, this retrospective study of consecutively admitted patients with recent onset schizophrenic disorders found that a substantial part of cannabis users ceased their cannabis use during or after first contact with psychiatric services. Admission to a psychiatric hospital was the most frequently reported reason for cessation of cannabis use. Treatment for psychosis seems to be related to the motivation to cease the use of cannabis, at least in part of the patients. On the whole, patients were honest about their current use of cannabis, which is probably related to our country’s liberal drug policy. A prospective study with a structured interview concerning past and current motivation for cessation of cannabis use may contribute to a better and more complete understanding of predictors for cessation in a population of young schizophrenia patients.
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