Response to Miller (2017): Communicating the role of cannabis in the risk of developing psychosis.

The points Dr Miller raise further important issues we need to consider in thinking about the relationship between cannabis and psychosis.

With regard to later research, I accept that much of the research published after the millennium was not included in my original article as the focus was how work prior to this time had evolved and how well it had stood the test of time.

The second point highlighted by Dr Miller about the definition of rarity is helpful. Unfortunately any calculation used to suggest that cannabis psychosis crosses this threshold relies on epidemiological data that has significant limitations. A point acknowledged by McGrath and colleagues whose work Dr Miller cites 1. Any calculation based on estimates of ‘heavy users’ is problematic, although used frequently in the literature it has no standardised meaning.

Dr Miller raises the role of treatment programmes in preventing use of cannabis. Prevention would need to extend beyond treatment programmes if any impact on uptake of cannabis use at a population level were to be realised. Unfortunately positive evaluations of drug prevention programmes do meet most people’s definition for ‘rare’ 2. Economic evaluation of such programmes are rarer still. This is unlikely to entice policy makers to invest in such programmes as they currently stand.

Dr Miller refers to the strength of cannabis that was prevalent in the last century. We need to be careful when referring to lower strength cannabis as the increasing cannabis potency narrative has developed without much empirical analysis. Most of what we know about cannabis potency is based on proxy measurement which used the analysis techniques of the day 3. More sophisticated methods of analysis such as gas chromatography have been developed in recent years 4. Add to this that even the specific studies exploring cannabis and psychosis restrict definitions of cannabis exposure to used or not used, with no detail about potency or type.

These aspects not only represent a challenge to research but to clinical practise. For example how would a clinician determine if cannabis exposure should be attributed as causal for the person presenting with psychosis ? What level of exposure in terms of frequency, dose and duration should be factored in ? These among many other questions would be useful to investigate as would the working criteria that clinicians actually use to determine such a diagnosis 5.

I support Dr Millers enthusiasm for a public health campaign which highlights the health risks of cannabis use, the one aspect that we can communicate with confidence is the risk to health of combining cannabis with tobacco. Communicating more exact risks to mental health remain difficult at the population level and we risk losing credibility if we are not clear about the many blind spots that we still have. Understanding could be improved by asking more detailed questions about type and potency of cannabis in the clinical and research settings.

References

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