Medical Marijuana in Behavioral Health Treatment Settings

Community Behavioral Health Association of Maryland Annual Conference, May 16, 2019

Linda J. Frazier, MA, RN, MCHES
Advocates for Human Potential, Inc.
Conflict of Interest Disclosure:

Nothing to Disclose
Continuing the Conversation for Public Health and Best Practices

2019 NORTH AMERICAN CANNABIS SUMMIT
An objective forum to address public health, science, and health equity

January 28–30, 2019
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Note: The 2019 Summit has no exhibit hall and no ties to the industry.

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+1.978.281.1422
nacs@ahpnet.com
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## Summary of Program

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Health Equity

“How do we inform the law with research and data in order to promote fairness, justice, and economic empowerment with values of which we can be proud?”

—Commissioner Shaleen Title, Massachusetts Cannabis Control Commission

- Correcting disproportionate impacts on public safety for vulnerable populations
- Preventing use among youth, especially those identifying as a racial/ethnic minority
- Addressing the impact of decriminalization on use, particularly among those most heavily affected by its prevalence
- Reducing barriers to minority community participation in new legal markets
- Understanding the effects of cannabis on unstudied/understudied health endpoints
- Establishing regulatory protections to meet the diversity of local needs
State of the States as of March 2019

- Disclaimer: Changes are happening very rapidly.
- 34 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have comprehensive medical use laws (Utah 3/5/19).
  (National Conference of State Legislators, 2019)
- 10 states and the District of Columbia have legal recreational cannabis.
- According to the Pew Foundation, 62% of Americans agree with legalizing marijuana.
  (Hartig & Geiger, 2018)
- Once legislation is passed, it takes up to a year or more for infrastructure, regulations, and tax income to be “in play.”
Recent Legislation and Events

- **Strengthening the Tenth Amendment Through Entrusting States (STATES) Act**
  - Introduced June 2018; blocked as an amendment to the First Step Act December 2018
  - Sought to amend the Controlled Substances Act so that federal prohibition did not apply in states that have legalized cannabis

- **Agriculture Improvement Act of 2018 (Farm Bill)**
  - Passed December 2018
  - Legalized hemp and hemp-based cannabidiol oil

- **Regulate Marijuana Like Alcohol Act (H.R. 420)**
  - Introduced January 2019
  - Proposes removing marijuana from the Controlled Substances Act’s scheduling
Recent Legislation and Events cont.

▪ Barr statement
  – Expressed during January 2019 Senate confirmation hearing
  – Marijuana companies operating legally in states that allow cultivation and sale won’t face Department of Justice action

▪ Safe Banking Act of 2019 (H.R.1595)
  – Introduced March 7, 2019
  – Latest action: April 8, 2019, House referred it to the Subcommittee on Crime, Terrorism, and Homeland Security for further research
  – Aims to allow banks to work with legal marijuana companies in state where cannabis has been legalized
Prevent distribution to minors
Prevent revenue from funding criminal enterprises; gangs or cartels
Prevent moving out of states where legal
Prevent legal sales as a cover for illegal activity
Prevent violence/firearms use with growing distribution
Prevent drugged driving or other public health consequences
Prevent growing on public lands
Prevent possession or use on federal property
The Paradox

- Marijuana remains illegal at the federal level under the 1970 U.S. Controlled Substances Act (CSA)
- Classified as a Schedule I drug, which defines it as having no medical value or use (like heroin and LSD)
- Trend began when California enacted Proposition 215 in 1996 with 55.6% of the vote
- Growing movement for legalization across the nation
Schedule I Classification Overview

- Substance with no medical value (THC & CBD)
- U.S. research production and research approval overseen by the Drug Enforcement Administration (DEA)
- Federal Drug Administration (FDA) has no authority to regulate but is raising issues with CBD after Farm Bill
- Production and sale of cannabis products regulated by each state
Implications of Schedule I Classification on Research

- Barriers to marijuana and cannabis research
- Questions re: relevance of research to current products (potency/formulations)
- State regulatory oversite of pesticides and molds
- State oversite of labeling and sale of edibles that look like gummy bears or candies, tinctures, etc.
Overview of Quality Cultivation

- Ideally, cultivated organically according to Mendelian selective breeding techniques without the necessity of genetic modification or CRISPR technology
- Cultivated according to Good Agricultural Practice (GAP); extracted and processed under Good Manufacturing Practice (GMP)
- Made available to consumers with full information as to cannabinoid and terpenoid profiles
- Certified free of pesticide, microbial, or heavy metal contamination
Issues

▪ Confusion and misinformation
  – Decriminalization is not enough
  – Unregulated illicit cannabis is dangerous—laced with contaminants
  – Leaving patients to self-medicate appears abnegation of physician/health care ethics

▪ Pain control inadequate for “opioid refugees”

▪ Existing evidence base for cannabis therapeutic efficacy

▪ Equity
2017 Natl. Academies of Sciences Report

- Updates research on the known health impacts of cannabis
- Evidence supports cannabis as an effective treatment for chronic pain, chemotherapy-induced nausea and vomiting, and multiple sclerosis spasticity symptoms
- Identifies additional research needs: therapeutic and harms
- Cites regulatory barriers that limit current research on the therapeutic value of cannabis or the potential health risks
Therapeutic Uses of Cannabis

Evidence Supports
- Chronic pain*
- Nausea and vomiting
- MS spasticity
- 240 other conditions
  - HIV/AIDS
  - Crohn’s disease
  - Epilepsy
  - Glaucoma

Allowed by States
- Claims that it treats ≥400+ conditions
- Varies by state
- No clear analysis comparing what various states allow
There is substantial evidence that cannabis is an effective treatment for chronic pain in adults

- Supported by well-controlled clinical trials
- Very little is known about
  - Efficacy
  - Dose
  - Routes of administration
  - Side effects

Medical Dosing

- Cannabis need and tolerance depends on prior patient experience and underlying endocannabinoid tone
- Start low and go slow
- Doses >20–30 mg THC/day before tolerance risk psychoactive and other adverse reactions
- Patients should be educated about psychoactivity and efficacy
- Correct dose is lowest dose that produces therapeutic benefit without ADR
- Adding CBD to THC preparations may attenuate THC associated anxiety and tachycardia
- CBD may be required in higher dose than THC for effect
  - Initial CBD may differentially moderate THC
Health Effects/Clinical Issues

Cannabis and . . .

- The opioid crisis
- Pain management
- Risks (e.g., secondhand smoke)
- Specific populations
  - Cannabis use disorder among the elderly
  - Youth use: psychosocial, cognitive, and emotional outcomes
  - Physician perceptions
Health Equity Concerns

- Decriminalization, medical, and adult use legalization are all separate and distinct acts at the state level
- Decriminalization does not expunge criminal records
- Minority and low SES risk loss of federal benefits
  - Public housing
  - Supported living
  - Veterans
- Impact of stigma
- Cost of medical certification and product can be a burden
Tolerance

- Pharmacodynamic phenomenon
- CB1 (mostly) changed availability of the cannabinoid receptors, to signal:
  - Receptor desensitization
  - Receptor downregulation
  - Heavy use
  - Appears reversible
Dependence

- **Physical symptoms**
  - Craving
  - Anger or aggression
  - Irritability
  - Anxiety
  - Nightmares/strange dreams
  - Insomnia/sleep difficulties
  - Headaches
  - Restlessness
  - Decreased appetite or weight loss

- **Psychological symptoms**
  - Primary, chronic, neurobiological disease
  - Genetic, psychosocial, and environmental factors
  - Characterized by behaviors
    - Impaired control over drug use
    - Compulsive use, continued use despite harm
    - Craving
CUD Treatment

- Motivational Interviewing
- Cognitive behavioral therapies
- Mutual support groups
- Aim may be to reduce use rather than achieve abstinence
Contraindications

- Youth
- Pregnancy
- Unstable cardiac disease
- Schizophrenia/psychosis
- Substance use disorder
Case Example—Maine Cannabis Law:

- **2008**: Marijuana possession, distribution, and cultivation are illegal
- **2010**: Medical marijuana rules promulgated (caregivers may cultivate up to 6 flowering plants per customer and distribute to no more than 6 customers with medical certificates issued by a licensed physician; certificate holders may not purchase more than 2.5 oz./wk.) (8 statewide dispensaries established)
- **2016**: Recreational marijuana law passed by peoples’ referendum (adults 21 and older may possess up to 2.5 oz, cultivate up to 6 flowering plants; when dispensaries are open for recreational purchases, the same age and quantity rules apply)
- **2019**: Rules now being promulgated
Clinical Challenges: Workforce
SUD, MH, and MAT

- Staff are divided. This has been a longstanding practice variation within MH and SUD treatment staff.

- During times of illegal status, cannabis use among pts. largely viewed as relapse by SUD staff and as either extraneous or exacerbating of an existing MH diagnosis by MH staff.

- Medical laws and recreational laws have increased the divide among staff in both MH and SUD treatment.
Clinical Challenges: Workforce SUD, MH, and MAT cont.

- Increased time/dialogue/debate in staff meetings. Redefining recovery, relapse, and progress (e.g., complex pts. making significant progress while consistently testing positive for THC).

- The blurring of these long-standing, often alumni-driven concepts can impact staff satisfaction and retention. Staff find the lack of clarity and amount of time taken without direction destabilizing to their work.

- MH staff and prescribers more likely to start medication management w/known cannabis use than prior to medical and recreational laws.
Clinical Challenges: Workforce SUD, MH, and MAT cont.

- Medical and recreational laws have changed the gravity of cannabis use within law enforcement and community probation.

- Positive THC UDS will not impact probation status. Changing traditional leverage points in SUD tx. THC may not be tested for substance within community probation.

- Staff are divided; some feeling the need to shift policies and practices to align with changing social and corrections norms and standards.
Clinical Challenges: Key Drivers of Workforce SUD, MH, and MAT

- Greater volume of patients with medical certificates (over 90 allowable conditions). Greater volume of patients with regular consumption and increased social acceptance (30% of Maine perinatal pts.).

- Changing social norms driving philosophical divide among staff and the public seeking services.
Cannabis use disorder—changing norms complicate patients’ desires to abstain

Substance use disorders are based on a pathological set of behaviors related to the use of that substance. These behaviors fall into four main categories:

1. Impaired control
2. Social impairment
3. Risky use
4. Pharmacological indicators (tolerance and withdrawal)
In the United States, approximately 5% of people age 12 and older meet the criteria for a cannabis use disorder. Cannabis use disorder is more common in males than females. Marijuana can interfere with the ability to carry out daily routines. Regular cannabis use is associated with amotivational syndrome (AS). AS describes a lack of ambition or desire to accomplish anything.

Because marijuana intoxication does not produce many readily observable symptoms, people often smoke marijuana throughout the day. Cannabis use disorder among adults typically involves daily use despite harmful problems.
Many patients w/daily cannabis use experience increased feelings of anxiety, agitation, and difficulty sleeping. Patients also struggling with baseline difficulties with these and other MH symptoms often experience exacerbation of these co-occurring conditions.

A smaller portion of patients make significant progress with cannabis use reduction yet struggle greatly to completely abstain. (Sleep and PTSD symptoms are most frequently cited as reason in both MH and SUD services.)

Ease of access, strong folk-messaging, reducing costs, loosening social control, and limited data on bona-fide efficacy as well as ongoing stigma contribute to patient-level barriers toward recovery.
Experience illustrates a relationship between patient-level struggles, workforce satisfaction, and care variation around cannabis.

Institutional stigma exists when social norms, the state of science, and service delivery occur in misalignment.

Strategies for mitigating patient-level and workforce challenges in a shifting landscape require teamwork.

Dedicating time for a small group of opinion leaders to improve clarity on clinical practices to include expectations, limitations, norms, interventions, training, and policy can greatly reduce strife and debate in venues unable to accommodate it.
Teamwork
Change Teams: Role of the Executive Sponsor

- Senior leader in the organization
- Must see change/improvement as a priority
- Identifies the problem and articulates the vision
- Demonstrates commitment to the process (time, resources)
- Empowers the change leader
- Aware of data and performance
Change Teams

- Who will be on the change team?
  - Change leader
  - 3–5 members
  - Work together until success is achieved

- Instructions for the team
  - Clear statement of problem with data
  - Priority for improvement
  - Clear objective
  - Promise of support and commitment
Change Teams: Selecting a Change Leader

- Person has enough power and respect to influence others at all levels of the organization.

- Person has the ability to instill optimism, has big-picture thinking, is focused and goal-oriented, and has a good sense of humor.

- Person understands the relationship between clinical and operational flow and has empathy for all vantage points.
Change Teams: Change Leader Responsibilities

- Serves as a catalyst to develop ideas
- Successful communicator: facilitates change team meetings, consistent, concise (data), creative and engaging (incentives), skilled listener
- Minimizes resistance to change
- Keeps the executive sponsor updated on change team activities
Change Teams: Meetings—PDSA

- As possible, 1 hour per week—meeting as a change team
  - Guideline review and discussion
  - Building internal workflows and schedules
  - Establishing responsibilities and timeframes for data collection and review
  - Assuring role clarity, safety, and competency attainment
  - Fine-tuning processes through use of PDSA cycles
  - Communicating results
Change Teams: Clinical Champion

- Models application of evidence-based practices
- Provide expert clinical input—design and pt. care
- Advocates and supports scaling of process
To clarify the agency’s position and clinical direction for patients’ continued use of marijuana, please refer to the following:

- At 8 weeks post-admission, pts. w/static or increasing THC levels will be engaged in the 4-session intervention noted below prior to staffing for level of care changes and discharges.
- Clients are expected to work toward abstinence from substances of abuse; licit or illicit. This is a stated goal for the Tx. program. That being said, addiction is a chronic medical illness that is manifested by relapse and remission and stops and starts of progress, insight, and growth. All of these are considered expectations from our clients.
- Use of cannabis among patients will be monitored. We will watch to see that levels are going down, both in drug screen results and the client’s response to treatment, and the treatment milieu as well.
- There are also specific clinical interventions that must be employed to assist clients in their struggle toward recovery and abstinence. Prior to discharging someone for continued marijuana use, the chart progress notes and treatment plans must reflect a progression of interventions designed to assist clients in obtaining skills to stop their marijuana use. The following 4 sessions are an example:
  1. A documented note engaging the client in a discussion about where they are in their relationship with marijuana and what they see themselves being willing to do about it; assessing the stage of change/readiness across each substance a pt. may be using
  2. A decisional balance assignment of the pros and cons of continued use and stopping use
  3. Graphing a pts. THC levels and reviewing in the above MI sessions
  4. Use of reduction journals, discuss in group
Change team reviewed ASAM consensus statement and presented the policy and protocol recommendations to full staff, with a plan of piloting for 90 days w/pre- and post-staff satisfaction as well as pt. discharges for cannabis use as compared to the previous 90 days.

Results: Improved staff satisfaction, reporting greater clarity on policy and procedure, interventions to utilize and being more pt. centered; discharges for ongoing cannabis use disorder decreased by half in comparative timeframes.

Continue to monitor impact.
Cannabis challenges:

• Refining care-continuous quality improvement

• We are now in the early stages of how best to manage patients with OUD on suboxone who also use cannabis regularly to address their chronic pain needs

• Our health system recognizes that cannabis is a substance that impairs the mind and carries an addiction potential. Those working in addiction medicine ideally want patients to progress in their recovery so that they use no substances and that they rely on learned coping skills and utilize a social support system to help them manage their triggers and life struggles.
Cannabis challenges:

- Maine has made recreational use of marijuana legal despite federal prohibitions on the drug (it's no longer viewed as a “bad” drug)

- Medical cards are also given if a patient suffers from conditions often co-existing for those who suffer from OUD, including Hepatitis C, chronic intractable pain, IBS, severe nausea, and PTSD, to name a few
Cannabis challenges:

▪ The new law also allows state-licensed clubs to exist where customers can use marijuana in a social, “public” setting. The law may serve to essentially equate cannabis to alcohol, and the use of it may become more socially acceptable, creeping into societal groups that did not have easier access than even 2 years ago. Retail stores are now permissible in cities and towns, and it is up to local governments to decide whether or not they want such businesses within their zones.

▪ Private businesses and media content are promoting using cannabis to treat OUD without a robust evidence-base to back these claims.
Cannabis challenges:

- Potential for patients to get “stuck” in the hub because of their unwillingness to stop using cannabis

- However, what providers agree on is that if a patient can demonstrate stability in other facets of life (e.g., maintaining a job, participating in healthy relationships, having financial security), then we are allowing them to transition to maintenance care at the spoke where we will continue to address the cannabis use

- We are already addressing health concerns around regular use of cannabis at the primary care level because it has become ubiquitous in our practices and community
Resources and Links


- Questions and to register for the distribution list: NACS@ahpnet.com
References


Contact Information:
Linda Frazier, MA, RN, MCHES
Director, Addictions Initiatives
Advocates for Human Potential, Inc.
lfrazier@ahpnet.com
978.261.1453
www.ahpnet.com

Thank You!