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ASAM Practice Pearls Transcript

Navigating Cannabis and Cannabinoid Use in Today's Clinical Practice

Dr. Stephen Taylor: Welcome to ASAM Practice Pearls, where we turn clinical expertise into everyday addiction care one conversation at a time. I'm your host, Dr. Stephen Taylor.

I think we have all heard this comment before. "Cannabis isn't dangerous. You can't get addicted to it." And yet, about 10% of people who start smoking cannabis will become addicted. And roughly 30% of current users already meet criteria for a cannabis use disorder. So, how do we break the myth that our patients and so many other folks in the society seem to have about cannabis?

How do we start to address the issue at hand? Well, I would like to welcome our expert, Dr. Takeo Toyoshima, who can help us navigate this discussion on cannabis and cannabinoid use in today's clinical practice. Dr. Toyoshima, thank you so much for joining us. Please say hello to our listeners.

Takeo Toyoshima: Yeah. Hi, thanks for having me here. I'm so happy to be here and be able to talk about cannabis and cannabis use disorder.

Dr. Stephen Taylor: I'm so happy to have you here to help us do that.

My first question for you, Dr. Toyoshima, is this. When a patient mentions using cannabis or cannabinoid products in general, what specific questions should clinicians ask in order to accurately understand what they're using, and how much they're using, and why they're using, just how do we approach those patients?

Takeo Toyoshima: It's interesting because, as people who treat addictions, it is important for us to have a sense of what the products are. How much one might use. cause we can then start to have a sense of, like, okay, this is starting to become or sounding problematic.

I think it's important for us to just recognize we aren't necessarily, and don't have to be experts in exactly how to use a drug. So, there's just that fine boundary right there. When it comes to cannabis, I mean, the main thing is it's a plant. When we're talking about cannabis, we're talking in the psychoactive sense. We're really referring to sativa and indica.

Now, from there, there's particularly Delta-9 THC, the most psychoactive compound in it, that then people can concentrate and make other sort of products out of as well.

I think it's important to think about the route. Is someone smoking it? Is someone vaporizing it? Is someone ingesting it as an edible or otherwise taking it sublingually

like tinctures? And there's topical stuff out there as well. In navigating this boundary of we're not the expert about exactly how to use a drug. And also, it behooves us to try to learn more about how people use substances.

One is just we can be curious, and it's okay for the patients to just explain to us and help educate us about how they use, and also not medical literature sources, but I encourage people to go to places like Reddit, PsychonautWiki, Erowid, Bluelight, and just look up what people are posting in these forums about how they use.

Dr. Stephen Taylor: Yeah, I think that's an important point, in so much of addiction medicine, regarding any substance that people use. We, the addiction medicine practitioners, learn so much from our patients about their experience, their life. What they use, how they use it, how it affects them, including, from their perspective, at least how it benefits them.

And so, I think listening to our patients, learning from our patients about their experiences with substances in general, is incredibly valuable.

With the different products that are out there, the different routes of use, and the different slang terms and the lingo that's used. How do you get clarity if you don't understand what they're saying? I mean, how do you have that conversation if you constantly have to ask your patient to translate what they're saying?

Takeo Toyoshima: This is where, over time and over repetition and or our own research online, I think we all do start to develop a little bit more of an understanding of the nuances. And so, if someone is saying they're using primarily flower and they are rolling a joint, then we're going to have a sense of, okay, well, how much is a typical joint?

And also, for flower, there's going to be a ceiling effect when it comes to the concentration, or rather the potency. We might think somewhere in the twenties at most, kind of thirtieth percent, THC by weight. Whereas if someone tells us that they are vaping THC, or that they're using concentrates, now we're dealing in much, much higher percent concentration amounts.

And with that, the potential for things like tolerance developing. With tolerance, then withdrawal developing. For people, just actually losing track of how much THC they are using compared to when they first started becomes a lot more real. That is something just in terms of lingo, we can start to just ask, "Okay. So, in general, Is it something you smoke? Is it something you're vaping? Is it something you are vaporizing?" Otherwise, "Is it something you're eating?" And from there, if it's some sort of lingo that we really haven't heard about, then we can start to understand what exactly it might be.

Dr. Stephen Taylor: That's great. Now, you know, you can't have a conversation about cannabis, unfortunately, without talking about the legal system. cause the fact

of the matter is, that's what people talk about so often is so controversial, and we know that cannabis laws vary widely from state to state as well as federally.

So, what legal and regional differences should clinicians understand, and how do those differences influence the type of products that are being used? and as well as the potency and, you know, illicit sources, et cetera.

Takeo Toyoshima: This is where it's interesting, being in the United States because there's the federal law and then there's also the individual state laws as well. And so, there's a lot of variability from state to state. Many states now have legalized adult recreational use. Even more have actually legalized medical use in certain cases. And then also some other states have pursued decriminalization for cannabis as well. So, if you practice in one or multiple states, I do think it's worth noting and knowing some of those laws. And also, just keeping track federally as well, because currently it is technically still schedule I, but a couple years back, still under the Biden administration, there was a push to maybe start the process of rescheduling this to schedule III, so more to come. Now, the legal status is going to affect generally the supply as well. In places like California, where I am, where adult recreational use is currently legalized, it's quite easy to access THC in delta nine and THC, in particular. Whereas in places where THC is still illegal for recreational use or even medical use, you might find that there's regionally higher prevalence of ways to try to circumvent. And so, you might see people trying to advertise Delta-8 or Delta-10 as this sort of legal thing, even though it's technically not.

And then also you might see higher prevalence of things like K-2 or Spice. So, the synthetic cannabinoids in that case.

Dr. Stephen Taylor: Yeah. And I think that's such an important point because obviously, for most of our understanding, those synthetic cannabinoids. Like, so-called K-2 or Spice are in, quite a number of ways, more toxic, more immediately psychotogenic, for example. and for some people, more highly addictive than the regular cannabis plant. And it's something that clinicians need to be aware about, wouldn't you think?

Takeo Toyoshima: Yeah, the K-2/Spice, the synthetic cannabinoids are generally full agonists at the CB1 receptor. The main kind of psychoactive effect-causing receptor for cannabinoids, whereas THC is a partial agonist there, so really that is at least partially, and maybe even largely, to explain why synthetic cannabinoid intoxication can present that much more severe than Delta-9 THC intoxication.

Dr. Stephen Taylor: Absolutely. Let me ask you this though, because we're talking about the harms, and there's a great discussion to be had on that.

I mentioned earlier those folks that we encounter who feel that they've experienced benefit from their use of cannabis and other cannabinoids. To what extent have you

encountered patients whom you believed or who were able to convince you, at least to some degree, that they were genuinely deriving some benefit in one way or another from their use of cannabis?

Takeo Toyoshima: That number is probably close to a hundred percent because otherwise they wouldn't be dealing with an addiction, a substance use disorder, or a cannabis use disorder, in this case. For cannabis and many other substances, the reality is we just have to make sure to talk about the patient's subjective pros and cons. And then with education, training, experience, we start to get an understanding of what is usually expected for the pros and cons as well. And then that's where we can help the patients navigate this.

For example, in my work at the VA. There's a fair number of veterans who say, "Cannabis is helpful for me because for me it gets rid of the nightmares. I don't dream when I use THC products." I'm like, okay, that's a legit thing. And there's something else we could do. We could try other medications, and also let's just make a balanced calculation of, alright, you're having these benefits that you say. But you're also now smoking daily, and you're having to smoke first thing in the morning, which makes me think about withdrawal. And you're talking about lighting up multiple times during the day. So, why don't we have a discussion is generally how it might go.

Dr. Stephen Taylor: That's a powerful example you brought up because I also work with a lot of veterans, and it's a difficult subject, to talk to a veteran about something that they believe is helping them deal with PTSD symptoms. Like nightmares, for example.

The last thing I want to do is try to take away the strategy that a veteran has come up with to help cope with PTSD symptoms without providing a strategy that is healthier and that replaces the strategy that they're using. That's a line we always have to walk in general with addiction medicine, but certainly when it comes to this particular population. So that's really helpful. And of course, what you just described in a nice example was motivational interviewing, the kind of work that is key to what we do, in so much of our work.

So, let's get specific about cannabis use disorder itself. How do you make that assessment? How do you approach that conversation when it's fairly clear that a person has a cannabis use disorder, and yet they don't have that notion, they don't have that insight, they don't even see it as a drug? How do you approach that conversation beyond the initial steps of motivational interviewing that you just outlined?

Takeo Toyoshima: Well, in terms of just sussing out a cannabis use disorder, whether it's applicable or not, main thing we go to is the DSM-5. In the DSM-5, there's 11 potential criteria. If you have two or more that apply, there's an addiction, there's this

cannabis use disorder, and two-three is mild, four to five is a moderate six or more severe. It's nice and cookie-cutter to be able to say that, but it looks different in practice. And so, in my work with trainees, where I end up going to is, you know what, no need to, like, remember the DSM-5 Criteria. Just remember that there's 11 of those. And then think about the three C's: control, consequences, and cravings.

Start getting the patient's own narrative about their relationship with cannabis, and start understanding are their issues around control, failed attempt at control? Are there negative consequences that have happened or near misses for potential consequences? And with the cravings, what are the times, the situations in which people have feelings, thoughts, anything else that maybe draws them a little towards using some THC? Afterwards, go back and apply that to those 11 criteria. And oftentimes I'm sitting there with the patient. If it's virtual, I'm screen sharing and showing the 11 criteria. If it's in the office, I'm showing them on the computer screen and showing them, "Hey, I thought these five applied for your case. I only have what you've told me. So, this is not some ulterior motive, trying to diagnose you with an addiction. I'm just going solely based off the information that you've given me, and I thought five of these applied. What do you think?" Usually, patients have told me that's a lot more palatable than later on. They look at their chart or after-visit summary, and they're told, "You have a severe cannabis use disorder," and they're like, "What?"

Dr. Stephen Taylor: It's very powerful to cooperatively go through the criteria and have the patient themselves acknowledge what they are experiencing and how it is, really affecting them, in order to get to a diagnosis that the patient and I together can agree upon. So, I think you're absolutely right about that.

But then, okay, let's assume you have a patient who, you have, either convinced or you have collaboratively agreed upon that as a diagnosis, but the patient says, "But you know what, it's not really hurting my life that much. I don't want to stop." What's your approach with those folks?

Takeo Toyoshima: I think my approach is just on one hand to try to hold the patient's truth and the patient's experience, and on the other hand, try to hold my, as much as possible, objective medical experience and medical decision-making. If a patient's saying I'm not having any consequences yet, I'm hearing consequences in the patient's own narrative and or a use pattern that is, for example, daily multiple re-dosing over the course of a single day, using first thing in the morning, using amounts of concentrates that are in the upper quartile or even higher, I'm still going to have a high suspicion that there is a cannabis disease disorder and still, if I lecture them, are they going to want to come back? Probably not. So, in those cases, the approach becomes, all right, "Hey, well, this is my understanding, this is your understanding. Can we keep the conversation going? Can we schedule a follow-up?"

One of my really good mentors gave me this little teaching that in psychiatry, the modal number of appointments is one, and I've stuck to that. I think it's important that as long as we get our patients to come back, we can keep the conversation going. And at some point, there might be some kind of event, something might change, where it actually leads to the patient to also rethink their relationship to that particular substance, such as cannabis.

And then if we have a relationship already, it's a lot easier to do something with that.

Dr. Stephen Taylor: That's so true, cause a lot of what you're talking about is how we work collaboratively with our patients, how we develop a rapport and have a good, effective treatment relationship.

And then there's this thing called drug testing, which for so many patients feels like something you're doing to them. And it feels, if not punitive, then at the very least, like you're treating them like a suspect whose word you don't trust. How do you approach that whole issue with your patients, particularly given the complication with cannabinoids that are kind of unique among substances, where the metabolites can be detectable for, in some cases, weeks after use has stopped.

Takeo Toyoshima: I think I've had even longer now, now that I've had patients using concentrates, but even, especially more so vapes and using THC vapes very heavily. I just frame it as, "Look, this is a standard practice in addiction treatment, and my goal is to not catch you. I'm not a probation officer or police officer. This is just another way for you to be honest with me." If it's negative, great. If it's positive, that also we interpret appropriately because as mentioned earlier, for some people who were using heavily, because THC is so lipophilic and sticks around in the fat stores and continues to leach out, it's not unheard of that people can go weeks still with a positive urine drug screen for cannabinoids, and yet they're really not using.

In those cases, we also know that we can actually get the actual concentration and calculate a creatine corrected THC concentration or metabolite concentration, rather, and trend that to make sure it goes down. Ultimately, I think it is just making sure that the patients understand we are doing this as a part of treatment, that this is not punishment. We do trust them. And also, there are times when it's harder to be honest, and if so, hey, this is one way to be honest with us too.

Dr. Stephen Taylor: That's great. So, you mentioned treatment. What are some of the treatment options that are recommended for cannabis use disorder?

Takeo Toyoshima: So, this is where we have no FDA-approved medications for cannabis use disorder. The two mainstays I would say, really, are gabapentin. This is from Mason et al. So, 1200 milligrams per day, usually split up in a 300 in the morning, 300 midday, 600 evening, kind of schedule. But we can adjust that as necessary.

And then N-acetylcysteine by Gray et al. as another one for 1200 milligrams twice a day. That one had a little more mixed results, especially in adults. But these are really the go-tos when it comes to cannabis use disorder.

I do want to say that more important I believe is the process of engaging someone and then also understanding any co-occurring diagnoses and make sure that we're treating those because if there's a co-occurring major depression, generalized anxiety disorder or panic disorder that isn't cannabis induced, then Well, that may be factored into the pros and cons of why that person was using. And if we can present a reasonable treatment and help them get over those co-occurring conditions, the odds for remission with cannabis use disorder also goes up.

Maybe the last thing I'd bring up here is just the psychotherapy side of things. Cognitive behavioural therapy for substance use disorders, group therapies of different sorts, motivational interviewing just as a technique. Peer support groups, even though technically outside of the realm of medicine, is something that I do include in the treatment plan. And increasingly, there's also contingency management that has been offered for cannabis as well. So, some things to keep on the lookout for.

Dr. Stephen Taylor: That is so important, and so many of the treatment options and the treatment considerations you mentioned, we've actually covered in other podcast episodes. So, we did a whole podcast episode on contingency management. We did another one on co-occurring psychiatric and substance use disorders.

These are all interrelated, and it absolutely makes sense that these are important things to remember when approaching the treatment of folks with cannabis use disorder as well.

The other issue that I wanted to mention is the whole issue of cannabis withdrawal. What does that look like? How can clinicians recognize it, help patients to recognize it and then manage the symptoms?

Takeo Toyoshima: Cannabis withdrawal can manifest in both psychiatric and physical ways, so some people can experience changes to their appetite, to even nausea and vomiting, some milder tremors, temperature dysregulation, irritability, anxiety, mood changes. And what happens is in the first couple of days after one stops using THC when they were previously using regularly, these symptoms can start to happen.

And typically, symptoms peak one to two weeks in. And by the fourth week, they are largely resolved, at most. For a population that might be using on a daily basis. Really, we've seen studies showing in the range of 20, even up to 40-something nearing 50% of those people likely experiencing some amount of cannabis withdrawal.

It's just important we educate people that this phenomenon exists. What they think they might be treating with cannabis, their anxiety, their irritability, appetite issues

might actually be cannabis withdrawal. And I think that helps just frame both the tolerance and the addiction diagnosis, the cannabis use disorder diagnosis, a little more palatably as well.

Dr. Stephen Taylor: Yeah, I think that's true. I mean, let's face it. For so many substances, what is more effective for treating the withdrawal syndrome, then going back and using the substance again? And yet so few people recognize that that's essentially what they're doing. And it's, helpful for our listeners to know, that we need to spot that and then help our patients understand that that's what you're doing. You're really helping treat a problem that that substance has created for you in the first place, and so that can help people understand and get a little more motivation to perhaps stop using.

The other thing that I wanted to touch on very briefly, because you said something that perked up my ears and, is a part of the experience I've had. You said you talked about N-Acetylcysteine, "Especially in adults," I believe is what you said, which of course made me, as a child and adolescent psychiatrist, think, Yes, that's right because we do know that in adolescence that's more often used and the data is somewhat better. I just thought it was important to mention because so much of what we have been talking about in terms of the morbidity that we have to be concerned about, the fact that cannabis can be a precursor to developing a psychotic disorder. Those are risks that particularly are important in the adolescent age range, and it's something that our listeners need to keep in mind and be willing to at least start asking those questions, with those 16, 17-year-olds that we see. And for those of us who encounter and work with younger age ranges to also be looking for that condition and that syndrome in those younger age ranges.

So, I just wanted to make mention of that. But you're right, N-acetylcysteine has been used in both adolescents and adult populations. And it's something that we all need to be aware of.

Takeo Toyoshima: Actually, you bring up a good point because in terms of the cons, I think a couple things people should be aware of are, of course, the potential for an addiction, potential for withdrawal, and that that is actually a thing. The most common psychic sequelae include things like anxiety and panic, which people often talk about using it for. Yet the more they develop the tolerance and start using higher amounts they can experience increasingly. And especially the one that I harp on most with my trainees is psychosis, as Dr. Taylor you said, because there's good data out there around cannabis use frequency, the potency of the product, and the risk of psychosis.

And with that, I think there's two particular papers. There's Starzer et al. in the American Journal of Psychiatry. That one showed a 40-something percent conversion to a schizophrenia diagnosis following the cannabis induced psychotic episode.

Similar data has been substantiated in other studies, including, Rognli et al., also in the American Journal of Psychiatry in 2023 or so.

So, if people are curious, those are things you should really look at. And when a patient presents in a cannabis-induced psychotic episode, I worry for that person, and it really goes to harm reduction counselling and ideally abstinence as well.

Dr. Stephen Taylor: What are your thoughts on some of the ways that we can take a harm reduction approach to our patients that we work with who are using cannabis?

Takeo Toyoshima: For harm reduction, it's really meeting patients where they're at, and for some cases that's going to be abstinence, and in other cases it's just trying to lessen the harms, the consequences, and help them have better control. For cannabis and THC products, the most palatable way, the easiest way actually, that I've had success is encouraging people, "Hey, what about buying lower potency stuff? What about buying some stuff with some CBD in the mix and just lower THC? Why don't we go from the 30% or the high twenties to go for something in the initially low twenties to eventually get it down to the teens?" And with that, if they keep their general use patterns the same, without too bad of cannabis withdrawal symptoms, people have been able to reduce the total amount of THC exposure per week. I also do recommend that people do try to build in breaks over the course of a week, a month, and for some patients they do a sober January, and they just set it as a reminder of, "I want to make sure that I have control over this substance rather than the other way around."

For the route, patients are particularly susceptible to the smoke, and we just had limited research into cannabis because it's been schedule I, but with the prevalence, which is ever so increasing, we've seen patients have other ear, nose, and throat cancers, for example, somewhat going up as well in the context of smoked cannabis. Interestingly, not so much COPD, but upper airway disease, we have seen increase as well. So, the route of use is something else that we can counsel patients on.

Other things are just, again, legality. There is still technically the Drug Free Workplace Act. There's risks around driving under the influence and state laws surrounding cannabis use in the context of driving. And accidental exposures is probably another big one just to mention, because if there's children at home and if there's a cookie or something else that looks tasty or just something is not quite secured, that's a vulnerable age to potentially be exposed to something like Delta-9 THC, or other cannabinoids. And that is something just for anyone with kids in the vicinity should be really careful of.

Dr. Stephen Taylor: That is so important, especially since so many of the products can be packaged in ways that are kind of colorful, maybe a little bit enticing to children who may not know any better. And that really represents a potential danger.

I also wanted to ask you to speak a little bit again about toxicity and specifically the whole issue of what does a clinician need to think about with someone who may be presenting to an emergency department, with complications of cannabis use or signs of cannabis toxicity. What does that look like? What are the presentations likely to be? What do clinicians need to think about?

Takeo Toyoshima: I may be a little biased, being an addiction psychiatrist, but, in general, cannabis, even in toxicity and overdose, and THC products and overdose typically are not life-threatening. Now with that, also just, psychiatric sequelae are oftentimes the one that drive people more often to go to the emergency departments.

So, for example, severe forms of anxiety to even panic, and then also psychosis, delusional sort of thinking, paranoid delusions, first-time experience of hallucinations. I have a private practice patient who has a severe cannabis use disorder. And whenever he would relapse, the cannabis would go into really bad, just self-flagellating, bordering on psychotic level of state, and with that would have suicidal thoughts and sometimes even need to call 988 for immediate support. So those are some of the things to watch out for in terms of the psychiatric toxicities.

Whereas for the non-psychiatric toxicities. For the Delta-9 THC, the more common one might be syncope because it does lower people's blood pressure with acute use. For the synthetic cannabinoids then, there have been cases of people experiencing seizures. Again, as a full CB1 one receptor agonist as well people entering very severe delirious states in the context of an overdose have been reported.

The last one maybe worth mentioning here is the cannabis hyperemesis syndrome. I still remember, as an intern, seeing someone who would repeatedly come back to the emergency department, nauseated and severely vomiting in the context of a severe cannabis use disorder. It was hard for this person to hear that this may actually be now a sequela and consequence of the cannabis use, but eventually it led them to actually re-contemplate their use and ultimately choose to try to stop using cannabis as well.

Dr. Stephen Taylor: You mentioned synthetics, and I think it's important that you did because we may be talking about cannabis, but the reality of it is we are in a time in history when even the patient who may be using a substance may not realize what they're actually using.

So they may think they're using actual cannabis, but instead they're using a synthetic cannabinoid. They may think that they're using just cannabis, but instead it's cannabis that's laced with something that's even more psychotogenic, like cocaine or what have you. So I think it's really important that we prepare our colleagues who may be

working in an emergency department to think about all of those are possibilities that have to be included in the differential.

Takeo Toyoshima: Yeah, a hundred percent. And I think with that, too, it is important to educate our colleagues about the benefits and also the limitations of using urine drug screens or toxicology screens, because screens are just screens and the cannabinoid screen is rather sensitive and specific, but it's not gonna detect the synthetics. Also, depending on which screens are in there, if there's a fentanyl screen, it'll detect fentanyl. But if there's no fentanyl screen, it's not gonna detect any Fentanyl. Opiates might just be negative. It is important if Someone is presenting in a way that looks like a certain toxidrome, then we should think about encouraging our colleagues and/or ourselves ordering the urine drug screens.

And if we're suspecting synthetic cannabinoids or other products, making sure that the proper screens and/or confirmation testing is ultimately ordered.

Dr. Stephen Taylor: Absolutely. Thank you so much for mentioning that it's so important. We've had a great discussion of a lot of different topics related to cannabis. What would you say are the main practice pearls or action items that clinicians should take away from our discussion today?

Takeo Toyoshima: Well, I guess the first one is, I really do encourage listeners to not have to try to be the expert of everything. It is okay to work collaboratively with the patient, but do have the sufficient expertise to know and be able to hold your subjective medical truth in addition to the patient's truth, because if there's discrepancy, that's where we need to be able to educate the patients and try to help them understand what is actually going on. What they're treating, again, might be withdrawal, might be an aspect of a cannabis use disorder, might be the co-occurring disorder.

Another one is just that when it comes to cannabis, there's a lot of products out there. There's a lot of different cannabinoids out there, and increasingly, we may start to see the market just changing even further. The average THC potency a couple decades ago was 5-10%, and here we are with 20 to 30 percentile flower. With that, just really staying afloat on what is happening and hearing from the patients, what is this all like?

The last one I would say is when it comes to then talking with the patients, take a harm reduction approach, that is okay. Abstinence does not have to be the one and only goal. And, for some people, maybe they don't want that right now, and if you can get them back and keep them engaged and build that therapeutic alliance, maybe that's a better goal.

Dr. Stephen Taylor: That's so true. We can't treat patients that we don't see, and so if we can get them coming back to us, we always have a chance at least to help them. So that's great. Thank you so much for that.

For more information on cannabis and cannabinoid use, be sure to attend ASAM's 57th Annual Conference session High Risk at Every Stage: Cannabis Exposure During Critical Periods of Development. Don't miss out, register for the conference today.

I wanna thank our expert, Dr. Takeo Toyoshima, for sharing his knowledge on this topic. Remember, visit ASAM's eLearning Center to claim your CE credits for this episode.

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