Management of Cannabis Use

OVERVIEW

TIMELINE	COMMON PRESENTATIONS
Withdrawal Onset: Within 1–3 days of last use Peak: Within 4–6 days of last use Duration: 12–16 days	**Cannabis overuse** Anxiety, mood disorder, suicidality, chronic bronchitis, lung cancer, myocardial infarction, arrhythmias, cognitive impairment (including decreased impulse control, memory, and executive functioning), cannabis hyperemesis syndrome, triggering/exacerbation of psychosis (risk greater for youth) Use during pregnancy can lead to preterm delivery and low birth weight
	Cannabis withdrawal Psychological: Extreme anxiety, insomnia, vivid dreams, irritability, depression, cravings Physical: Loss of appetite, headache, abdominal discomfort, nausea, sweating *High % THC use, frequent use, and high dosing are associated with more severe withdrawal symptoms

ASSESSMENT

- Intake & vital signs
  - Complete substance use history will guide monitoring and treatment
  - Polysubstance use increases OD risk and concurrent withdrawal syndromes may be present
  - Wake clients for assessment during their first 6h of their WMS stay
- The Marijuana Withdrawal Checklist[1] can be used to track occurrence and severity of withdrawal
- Assess for depression and suicide risk at intake
- Level of agitation (LOA) scale can be used to monitor clients that are showing signs of irritability/anxiety

TREATMENT OF WITHDRAWAL

- No approved medication for management of withdrawal
- Some evidence for gabapentin and cannabinoid agonists (nabiximols, CBD oil, nabilone)
  - Nabiximols and CBD oil not commonly used in WMS due to expense/difficulty of administration
  - Trial of nabilone or gabapentin recommended during WMS stay

[1] https://www.phenxtoolkit.org/toolkit_content/supplemental_info/saa_assessments/measures/Marijuana_Withdrawal_Checklist.doc

	NABILONE	GABAPENTIN
Action	Cannabinoid agonist	GABA analogue
Dose	1mg TID, titrate to effect to a max of 6mg/day	1200mg daily in divided doses
Side effects	Sleepiness, dry mouth, ataxia	Somnolence, dizziness May exacerbate depression and suicidal ideation (depression)
Considerations	Slower onset and longer duration of action than smoked cannabis	Doses of 18+mg associated with pedal edema Risk of dependence
Contraindications	Pregnancy or breastfeeding Use caution with renal or hepatic disease	Renal insufficiency Third trimester of pregnancy Use caution in early pregnancy, elderly clients, with use of other sedating medications, or in clients with depression/ suicidal ideation

LONG-TERM TREATMENT OPTIONS

- The Cannabis Use Disorders Identification Test–Revised (CUDIT-R)[2] can be used to screen for high-risk cannabis use
- Use DSM-V criteria to clinically diagnose cannabis use disorder
    - Main clinical features to look for: Daily use, increasing amount/strength/frequency over time, inability to stop, withdrawal or strong cravings to use when trying to stop, smoking in place of social activities with friends/family
- Best evidence for cannabis use disorder: Motivational enhancement therapy, cognitive behavioral therapy, and contingency management
- Assess and manage underlying anxiety and mood disorders
- Consider behavioural strategies to avoid future use:
    - Identify situation where the client is at increased risk of use (boredom, certain social settings)
    - Make a list of activities to do when struggling with cravings (exercise, call a friend)
    - Quit tobacco, as this is often a trigger for and associated with cannabis use (offer NRT)
- Provide advice for lower-risk use (e.g., use lower THC content, use a vaporizer/edibles rather than smoking, avoid driving after using cannabis)[3]
- For clients using cannabis for an underlying condition, use motivational interviewing and patient education in discussions about appropriate and safe medical cannabis use

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[2] http://mycannabisiq.ca/wp-content/uploads/2018/07/2010_CUDIT-R-revised-with-scoring-EN.pdf

[3] https://www.camh.ca/-/media/files/pdfs---reports-and-books---research/canadas-lower-risk-guidelines-cannabis-pdf.pdf