The Journal of Cannabis in Clinical Practice

Medical Boards’ Restrictive Practice Guidelines
Challenged by Society of Cannabis Clinicians

By Fred Gardner

Physicians in the United States are licensed by state medical boards. Licenses can be suspended or revoked when a board deems physicians guilty of serious infractions.

Typically, members of a state medical board have been appointed to a two-year term by the governor. (Many have contributed money to the governor’s party.) They meet quarterly and vote on policy matters. The board’s decisions are conducted by a career bureaucrats and gun-carrying “peace officers” who investigate complaints against physicians. We, the people, count officers “aye” for the California board were six lobbyists and other states.

At the FSMB convention in San Diego in April 2016, delegates from all 50 states and 20 US Territories agreed unanimously that their medical boards should take steps to adopt the federation’s guidelines. Voting “aye” for the California board were Executive Director Kimberly Kirchmeyer and Howard Krauss, MD, a Los Angeles ophthalmologist who has never approved cannabis use by a patient. FSMB president Humayun Chaudhry, DO and two co-authors then published an article entitled “Medical Board Expectations for Physicians Recommending Mari-juana” in the prestigious Journal of the American Medical Association (JAMA). Their “viewpoint” essay ran online June 16 and in the print edition August 9, 2016.

The Society of Cannabis Clinicians (SCC, a doctors’ group founded in 2000 by Tod Mikuriya, MD) urged the Medical Board of California (MBC) to reject the federation’s approach.

At a July 2016 meeting of the California Medical Board of California, warned that proposed “model guidelines” would lead to special-ists being targeted by the board’s Enforcement Division and pressured to not use cannabis as medicine themselves. At right, board members Katherine Feinstein and Michael Bishop, MD.

"It wasn’t just marijuana that got prohibited, it was the truth about history."
— Stephen Robinson, MD

"The use of medicinal canna-bis is not prima facie evidence of impairment or abuse."
— Stephen Robinson, MD

"We clinicians see people coming in with chronic pain, and we feel obligated to do something to help them. After patients fail to respond to more conservative and often ineffective treatments, doctors turn to opioid medications because they’re out of alternatives — or so they think."

"Thankfully, there is an alternative, an op-tion that has been proven safe and effec-tive in the treatment of chronic pain: can-nabis.

But most doctors don’t know about that options."

"Continued on page 17"
option. They find themselves face-to-face with patients who say, “My pain is worse.” The opioids aren’t working, I need more. If I don’t get them I’m not going to be able to go to work. I’m not going to be able to support my family, I’m not going to be able to function…” It’s hard for clinicians to say ‘no,’ because they don’t have another tool.

Cannabis can prevent opioid tolerance-building and the need for dose escalation. Cannabis can treat the symptoms of opioid withdrawal. And cannabis is safer than other harm-reduction options for people who are addicted to or dependent on opioids.

My goal is to carry the message that there is another tool. Cannabis can replace and reduce the dose of opioid medications needed to control pain. Cannabis can prevent opioid tolerance-building and the need for dose escalation. Cannabis can treat the symptoms of opioid withdrawal. Cannabis is safer than other harm-reduction options for people who are addicted to or dependent on opioids.

Randomized, placebo-controlled trials—RCTs, considered the gold-standard by medical scientists—show that cannabis can be used to treat chronic pain.

In contrast to the Annals of Internal Medicine article that found no evidence supporting the use of long-term opioids, a June 2015 review article by Mary Lynch and Mark Ware in the Journal of Neuroimmunology Pharmacology evaluated 11 randomized clinical trials published in 2010-2014. “The quality of the trials was excellent,” they wrote. “Seven of the trials demonstrated a significant analgesic effect.

Several trials also demonstrated improvement in secondary outcomes (e.g., sleep, muscle stiffness and spasticity). Adverse effects most frequently reported, such as fatigue and dizziness, were mild to moderate in severity and generally well-tolerated. This review adds further support that currently available cannabinoids are safe, modestly effective analogues that provide a reasonable therapeutic option in the management of chronic non-cancer pain.”

Seventeen of 19 animal studies had what Nielsen called an “opioid-sparing effect.”

Cannabinoid-Opioid Synergy

Cannabinoids and opioids have a few things in common. They are both derived from plants with thousands of years of historical medical use. Both mimic substances our bodies produce: endocannabinoids and endorphins. And both change the way we experience pain. Is there a basis for using these two classes of medication together?

Opioid and cannabinoid receptors are present in pain areas of the brain. (Receptors can be thought of as antennae or little keyholes. When an opioid or cannabinoid fits into its receptor, it has some effect on the cell, changing its physiology.)

Both opioid and cannabinoid receptors are present in areas that influence addiction and reward-seeking behavior. Not only are the two receptor types co-localized in these nerve cells, they’re believed to interact with each other, seemingly working together in the great symphony of our human physiology.

Pain medicines that combine cannabinoids and opioids to take advantage of these overlapping receptor system are, in fact, nothing new. One of the most popular compound drugs of the 19th century, Chlor-Aodyne combined morphine, cannabis, and capsicum, taking advantage of the interplay among our three receptor systems that control pain (endorphin, endocannabinoid, and vanilloid), and likely providing better outpatient pain relief than anything available in the pharmacy today.

When combined with THC, the effective dose of morphine was 3.6 times lower and the effective dose of codeine 9.5 times lower. But does this translate to the human experience? In a 2011 study, Donald Abrams, MD, added a low dose of vaporized cannabis to the regimen of 21 patients who were using high-dose opioids (ineffectively) to treat chronic pain in a hospital setting. The cannabis, provided by the National Institute on Drug Abuse, contained 3.56 percent THC—the low potency, given what’s available to US consumers.

Patients vaporizing three times daily reported a significant decrease in pain—27%. Perhaps more potent cannabis and/or a different delivery method would have led to even greater relief. Several subsequent studies have also demonstrated a significant pain relief from adding cannabis in patients with chronic pain that is refractory to opioid drugs.

A 2018 study from Ziva Cooper, PhD, examined the pain-relieving effects of various combinations of cannabis (placeto or 5.6% THC delivered via a joint) and oxycodone (placeto, 2.5 mg, and 5 mg capsules) on healthy volunteers using the “cold pressor test.” Subjects submerged their hand in ice water, rating the time until they did not longer tolerate the pain, and the intensity of the pain.)

Cooper also evaluated whether cannabis increased the degree to which subjects liked the oxycodone and wanted to take it again.

Cooper’s findings confirm the extensive preclinical literature: administered alone, the 5 mg dose of oxycodone increased pain threshold and tolerance compared to placebo, 0 mg of oxycodone did not change these measures.

When combined with active cannabis, however, the 2.5 mg dose of oxycodone did increase the pain threshold and tolerance compared to placebo, 2.5 mg of oxycodone did not change these measures.

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Cannabis/Opioids from previous page

bis made an ineffective dose of oxycodone into an opioid.

Furthermore, adding cannabis to the 2.5 mg oxycodone dose increased the degree to which subjects liked the capsule and wanted to take it again. Coopeine noted that adding cannabis to oxycodone not only poten
tiates the analgesia, it may also increase its efficacy and reduce its duration of action — and its abuse liability.

While cannabis amplifies the analgesic
effect of opioids, it in no way amplifies their dangerous effects.

Treating Chronic Pain

A study conducted in Israel by Simon Haroutounian and colleagues at Hadassah-Hebrew University Medical Center, pub
dished in 2016, looked at 176 patients with chronic pain. There were no controls at baseline. They were all given 20 grams of cannabis per month and a choice of how to ingest it, smoked, in cookies, or in an olive oil extract.

Patients were encouraged to decrease their other medications for treating pain if they could. They were given titration instructions — basically “start low, gradually increase dosage, use it three times daily.” And by the seven-month mark, 44 percent of those who wanted to take it again. Coopeine noted that com
tinued their opioid therapy.

Also in 2016, a survey of 244 pain pa
tients in Colorado of people buying cannabis for medical use other than pain. The questionnaire included five categories: pain, quality of life, and education? We can’t wait around for

In the clinic, If I’m prescribing someone

80 milligrams of morphine three times a day, and I get him down to 10 milligrams of morphine three times a day, that’s a huge improvement. But he’s filling the same number of prescriptions.

People defining their use as recre

ution: “Marijuana liberalization alone cannot solve the opioid epidemic. It is but one potential aspect of a comprehensive package to tackle the epidemic.”

In the same issue of JAMA Internal Med
icine an article by Ashley Bradford and University of Georgia co-authors (includ
ing her father) looking at Medicare Part D prescribing associated with state-level medical cannabis laws. They found a 14.4 percent reduction in states that allowed dispensaries and a 6.9 percent reduction in states that only allowed home
cultivation.

In most states with medical marijua

ana use disorder is not even a qualifying condition

Bradford et al documented significant de
creases in hydrocodone and morphine pre
scriptions. They were looking at prescrip
tions by drug name and did not convert the doses into morphine equivalents. So, again, we’re not looking at dosage-reduc
tion data, which would reveal a lot. People are decreasing their dose — that’s what I’m looking for in the clinic.

Bear in mind that medical cannabis laws are associated with people getting off opio
doids even with no specific program helping them do so. The states offer no education, no encouragement to use cannabis to re
duce opioid use. In most states with medi
cal cannabis laws, Opoid Use Disorder is not even a qualifying condition.

There are more than 115 people dying of opioid overdose in the US every day. How many lives could be saved with a program and education? We can’t wait around for this, it has to happen now.

Colorado’s legalization of recreational cannabis sales and use in 2014 led to a 0.7% decrease in opioid-related deaths per month, according to a paper in the Ameri

can Journal of Public Health.

A graph of opioid deaths per month be
tween 2000 and 2015 (below) shows the trend beginning to reverse.

Imagine if we had rescheduling and fed
eral legalization! How many fewer people would be dying every day?

Safety and Efficacy

While cannabis amplifies the analgesic effect of opioids, it does not amplify their most dangerous effects. Opioid receptors in the cardio-respiratory centers — the part of the brainstem that controls heart rate and breathing. Too many opioids kill by drowning those centers. Because there are virtually no cannabi
noid receptors present in those areas, can
nabis does not share opioids’ lethal side effects. By adding cannabinoids to opioids in the treatment of pain, we produce a greater therapeutic index: the lethal dose of the opioid stay
s the same, but the effective dose goes way down. So it’s actually safer for patients to use the combination than opioids alone.

One of the biggest problems with long-
term opioid treatment is that it stops work

ing. People build up tolerance to opioids. They come back every three to six months saying, “I want more, I need more.”

I saw this in my medical training, es
pecially during residency. It was the bane of the primary-care provider’s existence. What to do about these patients for whom we don’t have a better solution?

Every once in a while I would see a patient who came in on a stable dose of opioids — for example five milligrams of oxycodone three times a day — and never asked for a dosage increase. I would wonder, ‘Why are these patients so differ
cent from all the other patients that are tak

ing opioids?’ And I started to ask them di
rectly and was surprised when they’re treated patients had a clear understanding of their strategy to prevent opioid tolerance and dose escalation.

I was told, ‘This is what I’m doing, Doc. I’m using cannabis in combination with the pills and it makes them more powerful, it makes it so I don’t need more.’ One patient in particular that pulled his cannabis out of his pocket to show me and insisted that I smell the answer to my question.

When I looked at the prima

try literature, I found that my patient’s strategy is a valid scientiﬁc basis. Diana Cich
ewicz and colleagues reported that animals treated with com
bination THC and morphine avoid tolerance to the opioid, maintain analgesic eﬀect, and actually have increased numbers of opioid receptors in the spinal cord.

This is the opposite of what happens when they’re treated with morphine alone. The dose of THC needed to pre
serve the effectiveness of morphine

The American Medical Association has com
mented on this next page.

**Daily Dose Prescribed for Opioids through Medicare Part D**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Average Daily Dose (mg)</th>
<th>Pre-Legislation</th>
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<td>67</td>
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<tr>
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**Medical Cannabis Dispensary Open**

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<td>15.2</td>
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<tr>
<td>Other opioid</td>
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**Comparison Group**

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**Medicaid Use Dispensary Home Cultivation Allowed**

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that the Vicodin that an associate obtained for him had been laced with fentanyl.

Prince Rogers Nelson, a brilliant musician who lived with chronic pain (and had a valid medical diagnosis), died of an opioid overdose in April 2016. He did not know that the Viconid that an associate obtained for him had been laced with fentanyl.

Mainstream medicine employs two opioid drugs as harm-reduction alternatives in treating opioid dependence: methadone and buprenorphine.

Instead of insisting on abstinence, we can replace a harmful substance with a safer one. This approach is known as "harm reduction." Mainstream medicine employs two opioid drugs as harm-reduction alternatives in treating opioid dependence: methadone and buprenorphine (synthetic opioids that hardly cause a high).

Buprenorphine combined with an opioid blocking drug called naloxone is sold as Suboxone. These two drugs are the cornerstone of "Medication Assisted Treatments," an approach to opioid abuse that combines FDA-approved drugs (of the same industry that started this problem) with counseling and behavioral therapies.

How effective are methadone and Suboxone? A 2014 review by the Cochrane Database on the efficacy of these harm-reduction options found that only high-dose buprenorphine (16 mg) was more effective than placebo in suppressing illicit opioid use. Methadone was found to have equal efficacy in suppressing illicit use, and was superior to buprenorphine in retaining people in treatment.

It’s important to note that while suppressing illicit opioid use is the goal, retaining people in treatment may alone be a helpful outcome. Unfortunately, many critics point out that Suboxone is effective at suppress the most unpleasant aspect of opioid addiction and abuse – the withdrawal symptoms– which simply allows addicts to feel well until they can get another dose of their drug of choice.

Both drugs can lead to overdose deaths. Methadone was responsible for about one-third of opioid overdose deaths in 2009, according to the CDC.

While Suboxone is safer than methadone, it can still cause a fatal overdose, especially if taken with other drugs that suppress cardio-respiratory function, such as fentanyl, which are often prescribed to treat anxiety and sleep disturbance right alongside the Suboxone.

How does cannabis compare to methadone and Suboxone as a potential harm reduction agent?

It has a lower risk of dependence than any other psychoactive substance. Most people who stop using cannabis are able to do so without any formal treatment. And cannabis has a low risk for abuse and diversion, especially in non-smoked forms such as tinctures and sprays. The slower onset makes the cancer less rewarding and thus less prone to abuse. For example, in more than 30,000 patient years of randomized control trial data of nabiloxones (Sativa), a standardized cannabis extract from GW Pharmaceuticals, there has been no evidence of abuse or diversion.

In 2014, Marcus Bachhuber and colleagues published a study in the Journal of the American Medical Association that evaluated various attempts to reduce opioid dependence and overdose deaths. One approach was a prescription-drug monitoring program adopted by most states that as a provider to log in, lock up a patient, and find out which controlled substances they’ve been prescribed, where and when the prescriptions were filled, and so forth. The monitoring program was not associated with decreased opioid overdose deaths.

States that simply passed a medical cannabis law reduced opioid overdose deaths by 24.8 percent on average!

Laws requiring or allowing a pharmacist to request patient identification were found to have no association with the rate of opioid overdose deaths. Increased state oversight of pain management clinics also demonstrated no significant impact.

But states that simply passed a medical cannabis law reduced opioid overdose deaths by 24.8 percent on average!

The paper by Bachhuber et al inspired "repetition studies" by a RAND Corporation group led by Ronaldo Licozcu Pacula. They reported in the Journal of Health Economics that access to legal cannabis dispensaries was the key factor in driving down opioid-related mortality.

Pacula reported a corollary finding: states with the most restrictions on patients’ access to cannabis achieved the least reduction in opioid-related mortality.

Other studies have shown that medical and adult use cannabis laws are associated with lower opioid-related/discharging/fewer opioid-related emergency room visits, and significant cost savings for states and the federal government.

Dr. Rachel Naltrexone for Opioid Dependence is being released by the U.S. Food and Drug Administration for treatment of opioid dependence. Naltrexone can be given in clinics, or patients can receive it in pill form at home.

Naltrexone, a drug that blocks the opioid receptor, is another medication-assisted approach to opioid abuse, but in this case, a way to support opioid abstinence. Cannabis use has been associated with improved naltrexone treatment retention.

A 2014 study from Ronald Raby and colleagues at Columbia University in New York found that intermittent cannabis use in patients with chronic pain reduced “the feeling of pain” more than chronic use. Patients who didn’t use cannabis at all lasted only 47 days. The investigators also found that intermittent cannabis use helped the consistent cannabis users but didn’t help the non-users at all.

Other studies have shown that THC reduces opioid withdrawal symptoms and cannabis users are more likely to come back for a second injection of long-acting naltrexone, and that opioid injectors who use cannabis have lower monthly injections than their non-cannabis using peers.

Cannabis can not only keep people in treatment, reduce and replace opioid use, take, improve the pain relief that opioids provide, prevent opioid dose escalation and tolerance — it also treat the symptoms of opioid withdrawal: nausea, vomiting, diarrhea, abdominal cramping, muscle spasms, anxiety, agitation, restlessness, insomnia, runny nose and sweating — all symptoms that cannabis is well-known to ameliorate.

Cannabis has repeatedly been shown to promote neuroplastic changes in the brain — structural alterations related to new patterns of thought, perception, and behavior in animal models of addiction, depression, and memory impairment, cannabinoid-induced neurogenesis is associated with behavioral improvements. These are precisely the types of changes needed to get someone out of the cycle of addiction and into a new phase in their life in which they can say, “Okay, that’s the sensation, and here’s the judgment. I call that pain. And here’s the anxiety about that pain.”

That unbundling is extremely therapeutic. Why are my patients different from the patients in the cohort of the study? I think there may be a selection bias in the patients that come to me. They are early medical cannabis adopters. They want to use cannabis to get off opioids.

Self-efficacy is the belief in one’s ability to succeed at a given task, a ‘can-do’ attitude, a sense of optimism and control over one’s environment.

Wilson and colleagues also published an abstract this year in the Journal of Pain, with a different cohort: 150 people with opioid use disorder, and another 150 people with pain— it pairs.

This time they controlled for "self-efficacy." They found that cannabis users had more confidence, better sleep quality and less pain intensity.

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"Self-efficacy" is the belief in one’s ability to succeed at a given task, a ‘can-do’ attitude, a sense of optimism and control over one’s environment. It determines whether or not one can rise up after being knocked down. Improving self-efficacy is an important goal, because people with higher levels of self-efficacy tend to be more successful reducing opioid use by using cannabis — and more successful overall.

Might a certain dose and frequency of cannabis use enhance self-efficacy, while a higher dose and frequency do so without any formal treatment. And why some cannabis users are more likely to find success in treatment for Opioid Use Disorder.

Pain worsens depression and anxiety

In a paper published in Addictive Behavior, Marlon Wilson and colleagues at Washington State University reported that frequency of cannabis use heightened the incidence of both pain and depression and pain and anxiety.

Wilson’s team interviewed 150 patients being considered for opioid substitution treatment at a medication-assisted treatment clinic. They found 87 percent of cannabis use patients in British Columbia were using cannabis as a substitute for something else — 80.3 percent using it as a substitute for prescription drugs; 51 percent for alcohol; 32 percent for illicit substances. The reasons they gave were: more effective, fewer and less severe side effects, lower risk of dependence and addiction.

Several other studies have shown similar results.

Patients with “Opioid Use Disorder” crave pain. There is strong evidence that cannabis can be safely used to reduce and replace opioid medications in patients with chronic pain. What about patients with “Opioid Use Disorder” who don’t have chronic pain?

Unfortunately, the clinical evidence is scant, but some data plus the anecdotal reports of patients and clinicians on the front lines supports more research in this area.

Naltrexone, a drug that blocks the opioid receptor, is another medication-assisted approach to opioid abuse, but in this case, a way to support opioid abstinence. Cannabis use has been associated with improved naltrexone treatment retention. They are early medical cannabis adopters. They want to use cannabis to get off opioids.
Cannabis/Opioids from previous page

In cannabinoid medicine we see many bi-directional effects — cannabis producing one result or the opposite result, depending on dose, frequency, and “set and setting,” meaning the attitude of the person and the environment in which they use it. If you take the same dose of cannabis on your couch with a friend, versus at the oral surgeon’s office, you’re going to have a different experience. You could say that’s a way to approach cannabis use that would enhance self-efficacy. I believe the answer is yes, especially if we give it to patients with that intention.

There are big populations of people who haven’t heard about using cannabis to reduce opioid use. They have low self-efficacy. They don’t love or know about cannabis. They’re not fed up with the medical system. They still trust the people giving them methadone. What can we learn from our patients, our successes, and help apply that to the rest of the population?

When we get to the roots of the opioid problem, we’re getting to the roots of many other problems that are leading to morbidity, mortality, and more healthcare spending.

If we want to solve a problem that’s killing 115 US Americans a day, we have to get to the roots of it. And when we get to the roots of the opioid problem, we’re getting to the roots of many other problems that are leading to morbidity, mortality, and more healthcare spending.

The CBD Era

The medical cannabis movement has led to a whole new set of cannabis users — patients who want symptom relief. They want the medical benefits, but they don’t want to get high. Published in 2008 the advent of analytical labs enabled growers to identify cannabis strains in which non-imparing cannabinoid — CBD, a sister molecule of THC — was the predominant cannabinoid.

Cannabis dosing to support opioid reduction

Cannabis can be used in so many different ways to individually tailor a treatment depending on one’s needs. Could specific approaches to dosing further increase the effectiveness and reduce the potential harm of cannabis in the setting of opioid dependence? Here are the guidelines I provide to my patients in Maine:

1. Always take a small dose of cannabis, preferably using a non-inhaled delivery method, with every dose of opioids. Many people make the mistake of thinking they should choose one or the other, but it’s clear for all the reasons discussed in this article that the combination works best. In most people, only a low dose of THC is needed to augment the effects of the opioids, so I instruct my patients to start at 1-2 milligrams of THC per dose and gradually increase until they notice the opioid pills are starting to feel much stronger. Once reaching this dose of THC, many will begin taping the opioid drugs by cutting tablets in half and/or taking them less frequently.

2. Use inhaled cannabis to manage breakthrough symptoms and to reduce cravings. The rapid onset of vaporized or smoked cannabis makes it perfect for addressing these challenges that so often interfere with successful opioid tapering. I encourage my patients to reserve inhaled cannabis for when it’s needed most, ideally three times daily or as needed, and keep the lowest effective dose, taking one or two puffs and repeating every five minutes as needed, to prevent building tolerance to cannabis.

3. Use cannabis to promote regular sleep patterns. Reducing and discontinuing opioid drugs is a challenge at every level of our being: physical, mental/emotional, and spiritual. There is no medication or herb that can make this easy, and people dedicated to choosing the way of strength, determination, and resilience they can muster. This is why restorative sleep is essential and should be addressed at the beginning of this process. Only sedating strains of cannabis should be used in the evening, and an oral dose of cannabis (e.g. capsules) should be taken before bed if needed. While proper use of cannabis is often enough for most people to achieve healthy sleep, the cannabis can also be safely used in conjunction with other natural and pharmaceutical sleep aids.

4. Use cannabis to enhance health-promoting activities such as exercise, meditation, prayer, journaling and reflecting, and counseling or behavioral therapies. As mentioned above, the enhanced neuroplasticity of the endocannabinoid system can help these essential components of a healing plan work even more powerfully. Many of my patients who are able to participate in these activities when they’re combined with cannabis. So when using inhaled cannabis to treat breakthrough symptoms or cravings (suggestion 2), I tell my patients to take a walk outside, try some of my free exercises and meditations on Healer.com/wellness, or sit down with their journal immediately after using cannabis.

Field-grown plants vs. synthetic and processed alternatives

CBD been shown to reduce the side effects of THC and to enhance its benefits. It has minimal side effects and toxicity, and reduces anxiety, a component of abuse and relapse. CBD has been shown to reduce the rewarding properties of opioid drugs and opioid withdrawal symptom. It reduces heroin-seeking behavior in animals, and reduces heroin-related cue-induced craving in human heroin abusers. And it can do all this without any of its own rewarding properties, so it has no abuse liability.

What is to be done?

Doctors and patients need better access to medical cannabis, especially standardized, dependable formulating, combining both CBD and THC. Laws need to change so the medical community can start using cannabis as an adjunctive treatment for opioid use disorder.

In Maine, until the law changes in December 2018, I am not allowed to use cannabis to treat patients with opioid use disorder unless they have chronic pain that’s failed to respond to six months of conventional therapy. When the new law takes effect, cannabis-prescribing doctors will not be constrained by a list of conditions.

We’re thankful we have a great medical cannabis system in Maine. While there are still many parts of the country and the world where cannabis is completely illegal. Some addiction experts are concerned that liberalizing the cannabis laws will encourage adolescents to perceive it as safe and to start using at a younger age.

A 2015 paper in Lancet Psychiatry concluded reassuringly, “There is no evidence of a differential increase in past month use in youths that can be attributed to state medical marijuana laws.”

And a paper in The International Journal of Drug Policy found “the results of this study showed no evidence for an increase in adolescent marijuana use between the passage of state laws permitting use of marijuana for medical purposes. Concerns that increased marijuana use is an unintended effect of state marijuana laws seem unfounded.”

Case Report: Cannabis Replacing Opioids for Chronic Pain

A 43-year-old man with chronic pain, victim of a hit-and-run motor vehicle-pedestrian accident at age 25, resulting in spinal disc herniation. When he first came in he had already tried cortisone injections, chiropractic, physical therapy, and prescription medications. He did not have satisfactory improvement. He was a high school graduate and worked at an electronics store. He was 15 months old, first-born child. He came in with an average pain level of 6-7 out of 10. He had a little cannabis history, had tried it at age 16, but hadn’t used it in 20 years. He didn’t have any history of adverse affects with cannabis. He simply wasn’t using it. He was on muscle relaxants, two anti-inflammatories, two opioid pain relievers (Tramadol and hydrocodone), an anti-nausea drug because the pain relievers cause nausea, blood pressure medication, and cholesterol medication. He had previously tried gabapentin (an anti-convulsant often used to treat pain) and Lyrica, which is in that same category.

At a return visit six months after cannabis certification, he reported using edible cannabis in the form of cookies — not something I typically recommend. I prefer products that enable you to know how many drops you’re taking. This product, he said, worked in his case, he was on the low end of THC, and the CBD content there was 6 to 30 mg. His patient was also smoking cannabis two to three times weekly, just taking two to three puffs for breakthrough symptoms. Initially he had an adverse affect from the edible — he ate too much — but once he adjusted the dosage he was able to use the cookies without any side effect.

At six months, he had stopped hydrocodone and Tramadol, the two opioids, and also stopped one of the anti-inflammatories. The anti-muscle-spasm medication that he had been using daily was now needed only once a month. His average level was down to 3-4 on the pain scale. He had a significant decrease in muscle spasm.

His physical exam revealed improvement. He had normal strength in the lower extremities and was actually walking normally. Perhaps that’s because he had improved function, or because the muscle spasms had been under control for so long he was able to get back into alignment, or because cannabis has anti-inflammatory properties and reduced the inflammation that was pressing on that nerve root. Probably all of the above. He reported that he was able to carry his son, was able to enjoy fatherhood. And that’s an incredible result!

When I was in my medical training, if I would have seen that happen, I would have thought I was in some alternate reality. How did this patient get such good results? How did he actually come off of all his opioids and medications? This is normal for many patients I’ve seen who have been using cannabis as an adjunctive treatment for opioid use disorder.

What did happen? What is to be done?