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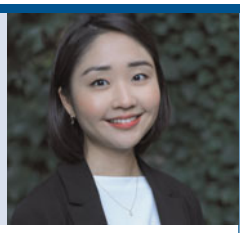
Editorial

Cannabinoids in psychiatry: they are here to stay



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Summary

Cannabinoids are commonly perceived by the public as safe and effective for improving mental health, despite limited evidence to support their use. We discuss reasons why cannabinoids may be particularly compelling for our patients and provide strategies for how psychiatrists can counsel and educate patients on the evidence regarding cannabinoids.

Keywords

Cannabis; drug interactions and side-effects; drugs of dependence disorders; marijuana; education and training.

Case vignette

A young man sits in his psychiatrist's office. After being counselled about his diagnoses of depression and panic disorder, he is informed about first-line treatment options, including selective serotonin reuptake inhibitors (SSRIs). He replies 'I've tried those medications before, and they were never as helpful as cannabis. I feel like cannabis is more natural and safer. Can't you give me a prescription for cannabis?' The psychiatrist states that she will not prescribe cannabis as it is not efficacious for treating mood or anxiety disorders, but the patient is adamant that it has been helpful and declines SSRIs. The psychiatrist and the patient both walk away feeling frustrated and unheard.

Rising prevalence of cannabinoid use

As cannabinoids become legalised and more widely available, interactions such as this are increasingly common in physicians' offices worldwide. Cannabinoid use is widespread among the public, but even more common among people with psychiatric disorders. In the 2019 National Survey on Drug Use and Health, 35% of adults with mental illness in the USA reported using cannabinoids in the past year, compared with 14% of adults without mental illness.[1] A large number of cannabinoid users report self-medicating for mental health-related issues, including mood, anxiety and sleep.[2] In the UK, there is growing off-license use of medical cannabinoids for psychiatric indications such as anxiety, depression, eating disorders and obsessive–compulsive disorder. At the same time, many psychiatrists remain wary of the therapeutic potential of cannabinoids and concerned regarding its risks. This raises a key question for clinicians: how do we counsel patients about cannabinoids and their effects on mental health?

The patient perspective

Cannabinoids may be particularly appealing to psychiatric patients for many reasons. Cannabis is an ancient plant that has been used for recreational and medicinal purposes by various cultures for millennia. As a result, it is often perceived as more 'natural' and therefore safer than other compounds. Legalisation has further contributed to the public perception that cannabinoids are safe and effective in improving ailments ranging from pain to anxiety, depression and insomnia.[3] Some patients anecdotally report that cannabinoids offer fast-acting relief for their symptoms, in contrast to most psychotropic medications, which take weeks to exert their effects. Legalisation has also lowered the barriers to acquiring cannabinoids; consumers can simply walk into a store and make their purchase, without consulting a medical professional. Cannabinoids can be consumed in a variety of ways and are often marketed using trendy branding and packaging. These qualities may allow patients to feel a sense of agency and individuality in their cannabinoid consumption that is lacking in their interactions with psychiatry.

The clinician's perspective

In its 2019 position statement, the Royal College of Psychiatrists identified that there is scarce, poor-quality evidence to support cannabinoids as a therapeutic agent in psychiatric conditions.[4] Although there are limited data on the long-term safety of medical cannabinoids, both delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) have been linked with long-term risks in the recreational context. Chronic recreational THC use is associated with increased risks of depression, anxiety, suicidality, psychosis, dependence and impaired driving; and youth and young adults are particularly vulnerable.[3] CBD has been associated with somnolence, impaired coordination and weight gain.[3] CBD and THC are both metabolised by and inhibit cytochrome P450 (CYP) enzymes involved in the metabolism of most antidepressants and antipsychotics – raising the risk of drug–drug interactions. Indeed, no cannabinoid product has been approved for a psychiatric indication by a regulatory body. Therefore, patients seeking medical cannabinoids would be paying out of pocket for costly products of questionable therapeutic value and considerable potential harm.

Implications

This growing discrepancy between clinicians' and patients' perspectives on cannabinoids can be extremely damaging to the therapeutic alliance. Much like our patient in the case vignette, when patients' perceived benefits of cannabinoids are dismissed out of hand by psychiatrists, they are left feeling unheard and frustrated. This could, in turn, reduce adherence with gold standard psychiatric treatments and hinder follow-up and engagement with care. Worse yet, the natural consequence of feeling judged and shamed about one's cannabinoid use may be to underreport or to deny use altogether. As a result, patients may be using cannabinoids without the knowledge or guidance of their psychiatrist, impairing

diagnostic clarity, reducing treatment efficacy and causing unknown interactions with psychotropic medications.

How to move forward from here

The bottom line here is that, despite the uncertain evidence base, some of our patients will continue to use cannabinoids. Instead of providing a blanket statement that 'cannabis is bad', we must play an active role in educating and counselling patients. The first step in doing so would be to simply ask more questions. Substance use history is a vital aspect of any psychiatric assessment, but one that too often turns into a checklist of closed questions. It would be worthwhile to go a step further than simply asking about the amount, frequency and duration of cannabinoid use. What kinds and concentrations of cannabinoids are they using? What benefits do they perceive from cannabinoids? What is their understanding of the efficacy and risks of cannabinoids in managing their mental illness? And how does that compare with their perceptions of psychiatric medications?

Questions such as these could go a long way in creating an environment where patients feel understood; one in which constructive discussions and education can take place. Better understanding of our patients' patterns and perception of cannabinoid use would allow us to shape our psychoeducation accordingly. An individual who uses CBD oil at night faces different risks and psychoeducational needs than someone who consumes high-potency THC edibles every morning, for instance.

Perhaps more transparency and humility are also needed from clinicians. We can let our patients know with relative confidence that (a) there is limited evidence that cannabinoids are effective in treating mental illnesses and (b) there is convincing evidence to suggest harms of regular, long-term use of cannabinoids, particularly THC. Beyond that, our current knowledge of cannabinoids is quite limited. A single cannabis product can contain hundreds of cannabinoids, and there is little understanding of their pharmacokinetic or pharmacodynamic properties either alone or in combination. The literature on cannabinoids in psychiatry is still evolving. Currently there is ongoing, active research showing potential benefits of CBD for anxiety, post-traumatic stress disorder, psychosis and substance use disorders.[4] Considering this, blanket statements such as 'Cannabis is ineffective and dangerous' should perhaps be replaced with more honest, nuanced discussions such as 'We still don't know much about how different cannabinoids affect those with mental illness, and there is ongoing research on this area. For now, the long-term risks from certain cannabinoids – like THC – appear to outweigh their known benefits, although this may change in the future'.

Moreover, although many patients perceive benefits from using cannabinoids, the true effects of cannabinoid use may vary from their own perceptions. A part of the psychiatrist's role is to help patients better understand and acknowledge the harms as well as benefits of their substance use. This is a fine line that we must walk, between paternalistic attitudes and uncritical reinforcement of potentially harmful behaviour. We must always listen to our patients in an open-minded and respectful manner, but at times we cannot take everything at face value; and when opinions about cannabinoid use collide, we can provide feedback in a way that feels constructive and helpful as opposed to patronising and dismissive.

The suggestions we make here all return to the basic principles of motivational interviewing: to be open, empathic and non-judgemental; to seek to understand both overt and hidden motives of behaviour; and to make patients feel heard. These qualities form the basis of our training, but are often easier said than done; and it is worth reminding ourselves of them as we face new challenges within our field.

At the systems level, George et al have provided recommendations related to cannabinoid legalisation and psychiatric populations, based on the lessons learned during Canada's legalisation process.[5] Some of their key recommendations were: a national strategy for public education; clearer labelling of cannabinoid products; limits on THC potency; national surveillance on key indicators such as impaired driving rates; and more robust medical education regarding cannabinoids. These approaches will be needed in conjunction with the individual-level strategies mentioned above, to ensure that cannabinoids are introduced to both the public and psychiatric populations in a safe and ethical manner.

Future research

The scarcity of current evidence on this topic is a disservice to our patients and the evidence-based care we aim to provide. More research is needed not only on the efficacy and safety of cannabinoids in treating psychiatric conditions, but also regarding the predictors of treatment outcomes. It would be worthwhile to ascertain which psychiatric patients are most likely to benefit from medical cannabinoids and which are the most vulnerable to their adverse effects. Moreover, the true prevalence of self-medication with cannabinoids among psychiatric populations is still poorly understood, let alone the demographic and clinical characteristics of those who are self-medicating. More research is also needed to explore perceptions regarding the benefits and harms of cannabinoids among the general public as well as psychiatric patients. Doing so would allow us to enhance patient-centred psychoeducation, provide public awareness campaigns to help separate fact from fiction, and work towards therapeutic collaboration.

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Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

Z.S. conceptualised the idea behind this editorial. J.W. drafted the manuscript, with critical input and revisions from E.v.R., S.B. and Z.S.

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Psychiatry in Literature

'The state spoils them'

Owen P. O'Sullivan

Edna O'Brien's *In the Forest* (2002) describes the life of Michen O'Kane and a triple homicide in the west of Ireland. Eight years on from the tragedy, O'Brien's novel is a fictionalised account of the deaths of Imelda Riney (28), her son Liam (3) and Father Joseph Walsh (37) at the hands of Brendan O'Donnell in 1994. In 1997, following an adverse anti-psychotic reaction, O'Donnell died aged 23 in the Central Mental Hospital, Dundrum.

In the novel, Michen O'Kane experiences early loss, institutionalisation, abuse, imprisonment, worsening mental health and a deepening alienation from his rural community. His nomadic lifestyle and erratic behaviour are met with varying acts of compassion and anger. Some criticise the police for not doing enough; others do not report him for fear of reprisals. After abducting the young mother and her son, driven by an infatuation with her, O'Kane's mental state, and O'Brien's stream-of-consciousness style, belie failed opportunities for intervention:

> 'Furious now he snatches the letter back and shouts, "Giveusthephone giveusthephone giveusthephone." He bellows his orders into it – "Reported on sick parade … metal in Vomitus. Released from medical centre. Reunited with family at front gates. Energy level terrific. Chlorophyll feed. C and D not necessary. Proceeding north west as per coda. Over. Over." He is looking at them but not seeing them, arguing furiously with a host of voices, his answers clotted, indeterminate.'

He goes on the run and is eventually apprehended:

> 'The state spoils them … little creep, little coward.'
>
> '"He has been laughing now seventeen minutes," the superintendent says holding up his watch. "I make it eighteen sir." "Eighteen minutes of animal laughter." "Bizarre." The laughter went on unabated and there was something terrible, something eerie in it, as if it would never end […]'
>
> '[…] he has gone back into himself, into a hulking frozenness.'
>
> '[…] hooves and horns and all […] everyone willing to help you […] St Michael's, St Joseph's, St Bridget's, St Patrick's, St Finian's, St Teresa's, St Anne's, Spike Island, Clonmel, Rugby, Featherstone, Wolverhampton […]'

His periods in prison and hospital are fraught with challenging behaviour and his sister visits him:

> '"Why did I kill them people?" he asks vacantly.'
>
> '"Keep back now miss … keep a distance … this could be dangerous" and that was the loneliest moment of all, to see him gone into himself, dead to the world around him.'

The author encapsulates how tragedy can weigh so heavily on a small nation:

> '[…] the judge […] hoped in his heart that the case would not drag on as it had done, it had opened wounds that were too deep, too shocking, too hurtful, it had been a human haemorrhaging and the country was depleted from it.'

O'Kane lingers in his doctor's mind, who recalls him asking in a poignant island of lucidity:

> '[…] for his brain to be taken out and washed and then buried thousands of feet in some bog where neither man nor machine could dislodge it […] during those endless hours when they tried to pick out the pieces of his life, the milestones large and small that culminated in the abyss.'

The release of *In the Forest* caused controversy in Ireland. Fintan O'Toole, for *The Irish Times*, said its author had 'broken an unspoken rule and crossed the boundary into private grief' and that the novel was a 'moral mistake'. Unsurprisingly, the same newspaper extensively covered the tragedy. It is interesting to consider why – or how – a literary novel is distinct from the inevitable wall-to-wall press coverage at the time of such a tragedy and any subsequent trials, and who delineates and marshals such boundaries. Perhaps Edna O'Brien's stature as a novelist was a factor and maybe with that came certain implicit responsibilities felt to have been transgressed by rendering a rural tragedy in a close-knit community suddenly international.

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