



# CANNABIS: FACTS, MYTHS AND MENTAL HEALTH

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BUT FIRST...

A little about us

# ELIZABETH ELLIOTT

- Chicago, Il
- MSW, University of Minnesota
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- Three kids, three cats, five fish, two birds, and a lot of unfolded laundry
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# CHRISTINA KEELAN COTTRELL

- Nashville, TN
- B.A. Psychology, San Jose State University, CA
- Mental Health Advocate with OSMI: Open Sourcing Mental Illness
- Prescribed cannabis in CA for depression, anxiety (2012 - 2016), Advocate
- @christinakeelan on Twitter



# MOLLY HALL

- Chicago, IL
- Bachelors of Science and Education, University of Wisconsin Whitewater
- Masters of Science in counseling with concentrations in marriage family therapy, community mental health, and school counseling, California State University Sacramento
- Worked in the field of education for 6 years and mental health for 11 years
- Owns own private practice in Chicago and specializes in the treatment of trauma



# WHAT WE'LL COVER TODAY

- History and legislation surrounding marijuana
- Approved conditions
- Myths
- Biochemical processes of marijuana in brain
- Neurological concerns
- Clinical overview
- Barriers to treatment, issues working with cannabis users
- Three case studies
- Wrap-up: Thoughts for the future



# HISTORY, LEGISLATION, MYTHS

Christina Keelan Cottrell

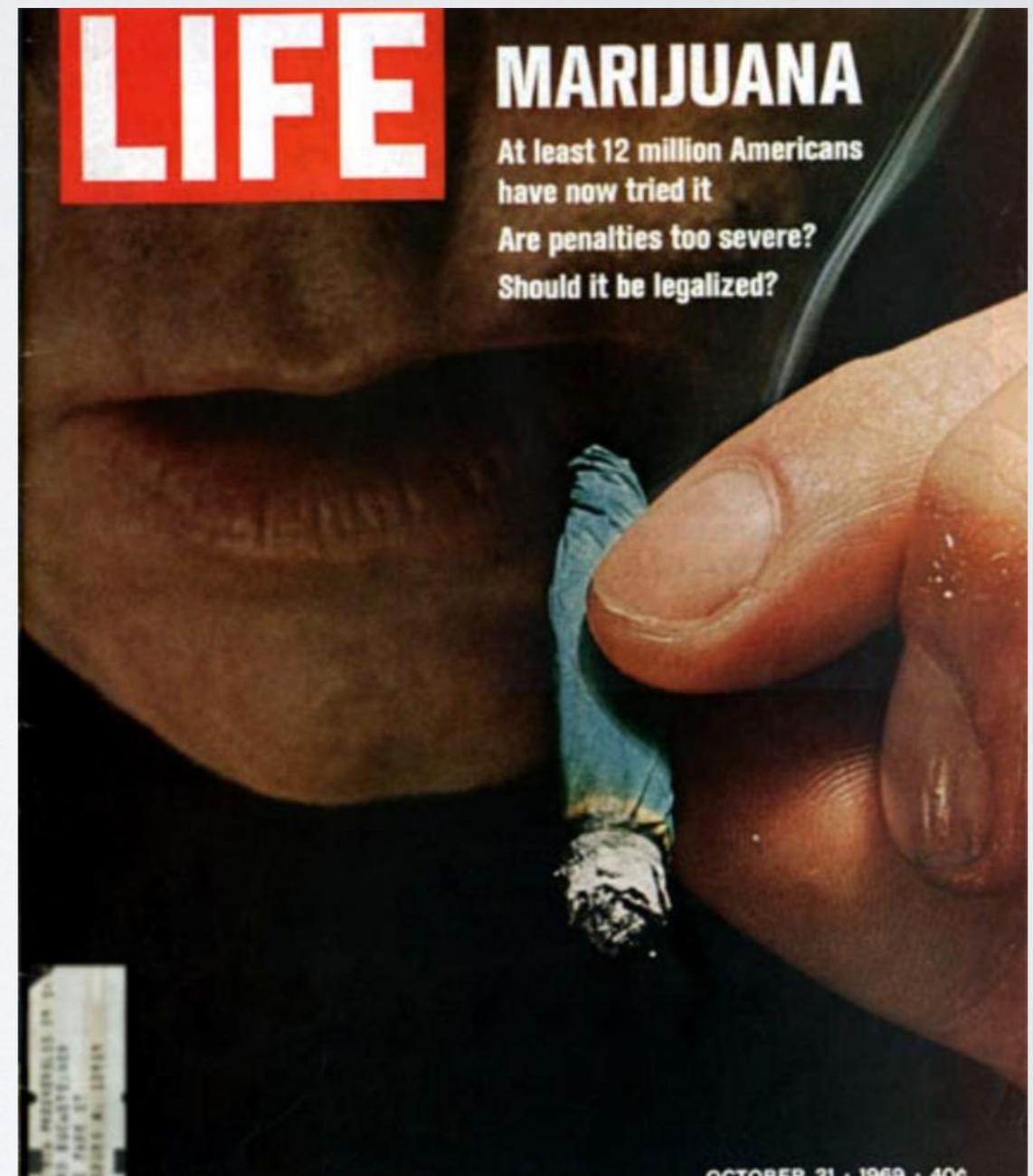
# HISTORY: 2700 B.C. - 1940S

- Medical references from China date back to 2700 B.C.
- Spread to India, N Africa, then Europe.
- **1500s** - Spanish introduced to the New World.
- **1600s** - English introduced it in Jamestown. Became a major commercial crop alongside tobacco and was grown as a source of fiber.
- **Late 1800s** - Replaced by cotton as a major cash crop in southern states.
- **1920s** - Some say rec use escalated in response to prohibition. Popular in Jazz community.
- **1850 - 1942** - Listed in the United States Pharmacopeia. Prescribed for various conditions including labor pains, nausea, and rheumatism. Also popular intoxicant.



# HISTORY: 1930S - CURRENT

- **1930s** - U.S. Federal Bureau of Narcotics sought to portray marijuana as a powerful, addictive “gateway” drug.
- **1950s** - accessory of the beat generation.
- **1960s** - popular amongst college students and hippies + symbol of rebellion against authority.
- **1970** - The Controlled Substances Act
- **1970s - 1980s** - Nixon declared “war on drugs”, DEA ramped up. Use declines.
- **1996** - California legalizes medical marijuana, more states follow.
- **2012** - Colorado and Washington legalize recreational use for adults 21+, more states follow.



# MARIJUANA LEGISLATION

- **1937:** The Marijuana Tax Act is passed, effectively prohibiting all use of cannabis on a federal level.
- **1970:** The Controlled Substances Act is passed, prohibiting cannabis federally along with several other drugs and replacing the 1937 act. Considers cannabis highly addictive, no medical use.
- **2014:** The Rohrabacher–Farr amendment passed requiring annual renewal, it prohibits the Justice Department from interfering with the implementation of state medical marijuana laws.

# LEGAL STATES

- **Medical:** Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Vermont, Washington (conditions vary by state)
- **Recreational:** Alaska, California, Colorado, Oregon, Massachusetts, Nevada, Washington

# APPROVED LIST OF CONDITIONS COMMON IN MOST STATES

- *AIDS* - Reduces nausea, vomiting, pain. Increases appetite.
- *Cancer* - Reduces nausea, vomiting, pain. May fight cancer cells, reduce spreading.
- *Epilepsy* - Control seizures.
- *Glaucoma* - Reduce pressure, slow progression.
- *Multiple Sclerosis* - Reduce muscle spasms, pain, tremors, bowel dysfunctions and more.

# COMMON IN MENTAL HEALTH TREATMENT

- *Anorexia* (CA, NM, WA, WV)
- *PTSD* (AR, AZ, CT, DE, FL, IL, ME, NM, ND, PA)
- *Depression, Anxiety, Bipolar* - More complex. Can be legally approved as “debilitating” in some states. Used historically as treatment. More current research needed.

# RESOURCES

- <https://www.leafly.com/news/health/qualifying-conditions-for-medical-marijuana-by-state>
- <https://www.medicalmarijuana.com/expert/medical-marijuana-as-a-treatment-for-depression/>
- <https://www.marijuanadoctors.com/content/ailments/index>
- <http://www.narconon.org/drug-information/marijuana-history.html>
- [https://en.wikipedia.org/wiki/Timeline\\_of\\_cannabis\\_laws\\_in\\_the\\_United\\_States](https://en.wikipedia.org/wiki/Timeline_of_cannabis_laws_in_the_United_States)

# COMMON CANNABIS MYTHS

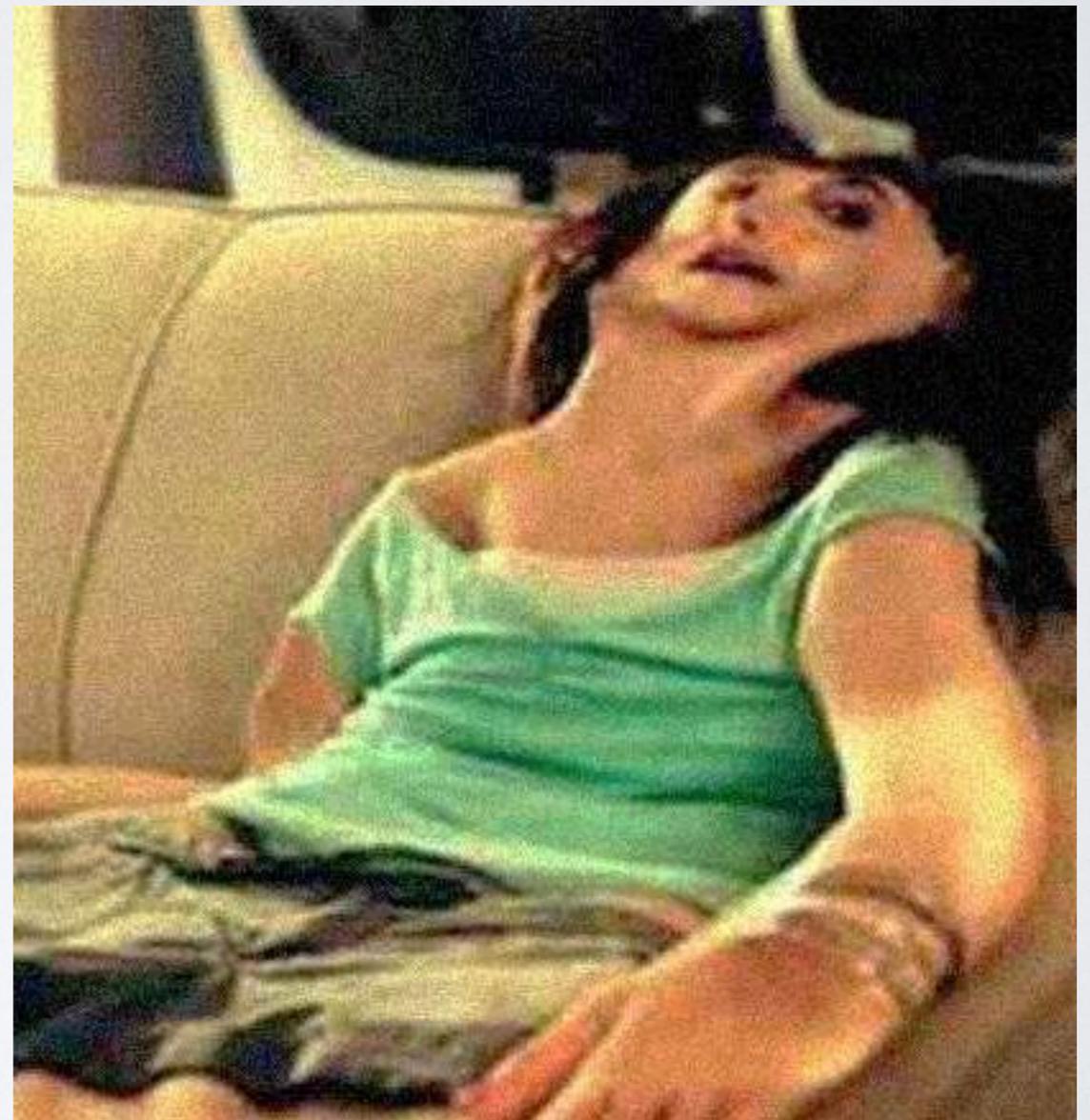
# MYTH: Cannabis use causes memory loss and a general reduction in mental ability

- FACT: Tests have shown that cannabis diminishes short term memory, but only when intoxicated. No scientific evidence to suggest that it is a long-term or permanent problem when sober.
- FACT: There is no scientific consensus on cannabis use, and no scientific proof that casual use is dangerous to health.
- FACT: Cannabis does not cause any profound changes in a person's mental ability.
  - After consuming, some people can experience panic, paranoia, and fright. These effects pass and do not become permanent.
  - Very rarely, it is possible for a person to consume so much that they suffer from toxic psychosis. This is not unique to cannabis.



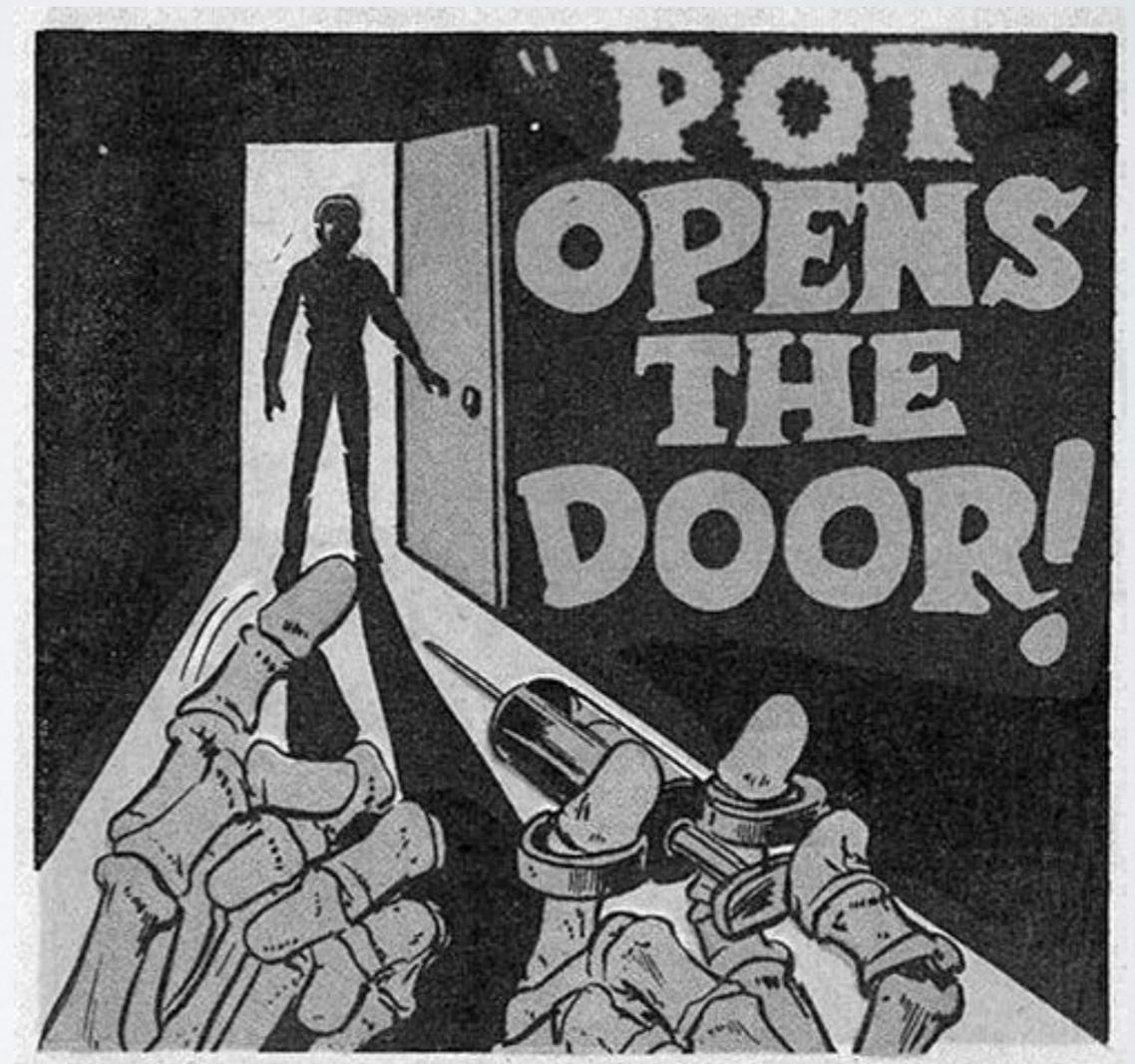
# MYTH: Cannabis use causes apathy and a lack of motivation

- FACT: Studies where subjects were given a high dose of cannabis regularly over a period of days or weeks found there was no loss in motivation or ability to perform.
- **Abuse** of any substance over long periods will reduce a person's ability to function normally. This is not unique to cannabis.



# MYTH: Cannabis is a “gateway drug”

- FACT: For most people, cannabis is a terminus drug, not a gateway drug.
- Users of high strength drugs such as heroin or LSD are also statistically more likely to have used cannabis in the past, although correlation does not imply causation.
- When comparing the number of *cannabis users* with *hard-drug users*, the numbers are very small, suggesting that there is no link at all.



# MYTH: Cannabis causes crime

- **FACT:** Research suggests cannabis users are less likely to commit crimes because of its effect in reducing aggression.
- ***Caveat:*** Because of the number of nations that have outlawed cannabis, most users in the world are technically classified as criminals for possessing the drug.



# MYTH: Cannabis is highly addictive

- FACT: Less than one percent of Americans smoke cannabis more than once per day.
- FACT: There is nothing in cannabis which causes physical dependence.
- FACT: Of heavy users, a minority develop what appears to be a dependence and use drug rehabilitation services to stop.
  - This is likely due to habit, not addiction.



# RESOURCES

- Mellinger, G.D. et al. “Drug Use, Academic Performance, and Career Indecision: Longitudinal Data in Search of a Model.” Longitudinal Research on Drug Use: Empirical Findings and Methodological Issues. Ed. D.B. Kandel. Washington, DC: American Psychological Association, 1978. 157-177.
- Johnson, L.D., et al. “Drugs and Delinquency: A Search for Causal Connections.” Ed. D.B. Kandel. Longitudinal Research on Drug Use: Empirical Findings and Methodological Issues. New York: John Wiley & Sons, 1978. 137-156.
- Schreiber, W.; A. M. Pauls and J. C. Kreig (February 5, 1988). “[Toxic psychosis as an acute manifestation of diphenhydramine poisoning]”. Deutsche medizinische Wochenschrift 113 (5): 180–183. PMID 3338401.
- Degenhardt, Louisa, Wayne Hall and Michael Lynskey. “Testing hypotheses about the relationship between cannabis use and psychosis,” Drug and Alcohol Dependence 71 (2003): 42-4.
- King LA, Carpentier C, Griffiths P. “Cannabis potency in Europe.” Addiction. 2005 Jul; 100(7):884-6
- Stephens, R.S., et al. “Adult marijuana users seeking treatment.” Journal of Consulting and Clinical Psychology 61 (1993): 1100-1104.



# MARIJUANA & THE BRAIN

Molly Hall

# YOUR BRAIN ON MARIJUANA

:video:

# MARIJUANA AND LONG-TERM EFFECTS ON MEMORY AND CONCENTRATION

- Short-term effects of marijuana are typically felt within a few minutes, peak within a half hour, and wear off about two or three hours later.
- Lack of rigorous scientific studies on effects, and a greater lack of longitudinal studies.
- A 2012 review of available research found that immediate impairments on memory and concentration are not likely permanent.

# WORKING MEMORY

- A number of studies found no long term effects on working memory.
- Impairment of memory in heavy users was found up to 7 days after marijuana use, but by day 28 memory test results did not significantly differ from control subjects.
- *In conclusion*, even if memory is affected when someone smokes marijuana, after use is stopped it will likely go back to normal with time.

# ATTENTION/CONCENTRATION

## N

- Marijuana impairs light users' attention and concentration but doesn't appear to affect regular or heavy users within six hours of smoking or ingesting it.
- In the long term, researchers found that after 3 weeks or more since last use of marijuana, subjects' attention and concentration return to normal.
- No impairments of attention or concentration were found or noted in 5 of 7 studies in subjects who had been abstinent for 28 days to one year.
- Two other studies did find difference in attention and concentration between heavy and non-users after 28 days, but reviewers noted that disparate findings could be due to measuring different types of processing skills.

# NEUROLOGICAL CONCERNS & MARIJUANA

- Addiction
- Drug Interactions
- Anxiety and Panic Attacks
- Adolescents

# REFERENCES

- <https://www.ncbi.nlm.nih.gov/pubmed/12412835/>
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3037578/>
- <https://store.samhsa.gov/shin/content/SMA16-4973/SMA16-4973.pdf>



# CLINICAL OVERVIEW & TREATMENT

Elizabeth Elliott

# WHO ARE WE?

- **ROLES:**

- Consumers
- Clinicians
- Case Managers
- Family
- Friends
- Activists/advocates
- Clergy
- Legal/Law enforcement

# WHY DO PEOPLE SEEK HELP FOR THEIR MENTAL HEALTH?

- Symptom relief
- Support
- Because someone asked them to
- Because someone told them to

# WE WANT TO...

- Make people feel better
- Increase functioning
- Prevent negative outcomes (harm reduction)

# POTENTIAL BARRIERS

- Stigma
- Judgmental responses
- Generic approaches/helper biases
- Unrealistic goal setting



SHOWING UP STONED!

# STATE DEPENDENT LEARNING:

- “State-dependent memory or state-dependent learning is the phenomenon through which memory retrieval is most efficient when an individual is in the same state of consciousness as they were when the memory was formed.”

# HOW DO WE ASSESS THE ROLE, EFFECT, AND IMPACT OF CANNABIS?

- First, we ask!
- Recreational, symptom management, or abuse?
- Does this individual have any relevant challenges that may “raise the stakes?”
- Does this individual have access to legal or medical cannabis?

# HARM REDUCTION:

- “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.”

# RESOURCES

- [https://en.wikipedia.org/wiki/State-dependent\\_memory](https://en.wikipedia.org/wiki/State-dependent_memory)
- <http://harmreduction.org>



# CASE STUDIES



# PTSD & VETS

Christina Keelan

# QUESTIONS

- Do you agree on Cooper's prescription for cannabis from his civilian doctor without the VA's consent?
- Do you think veterans should have access to legal medical marijuana as a replacement for pharmaceuticals?
- Do you think there is a conflict of interest between the VA and the DEA, both being federal agencies, in regards to the prescribing of medical marijuana and research?



# LEGAL MEDICAL MARIJUANA

Molly Lyon

# QUESTIONS

- What do you think of Anne and her therapist's agreement about her marijuana use?
- Anne asks her therapist to help her with a budget. Her therapist suggests she include money for marijuana in this budget. Is this appropriate?
- Anne has a good job opportunity, near her house, with good pay. However, she has to take a urine drug test and feels that she can not stop smoking long enough to pass. She is considering turning down the offer because she doesn't want to fail the test.
  - Should her therapist discuss ways in which she might beat the drug test? (The job does not entail use of machinery or other potentially hazardous conditions.)
- What other considerations might Anne's therapist introduce?



# “SELF-PRESCRIBED” MEDICAL MARIJUANA

Elizabeth Elliot

# QUESTIONS

- Tom has attended two therapy sessions and will soon attend his third. What do you think the therapist should talk with Tom about regarding his marijuana use?
- The therapist struggles with understanding how a prescription for marijuana was given without discussion of including talk therapy. Tom reported that the medical doctor did not mention therapy nor asked about his history of talk therapy. He also reported that he has not seen the doctor since the initial prescription was written. What could the therapist do to help Tom manage his symptoms in conjunction with his marijuana use, why? What else should be considered aside from symptom management?
- What do you think should be considered in this case from the perspective of:
  - Medical doctor
  - Tom
  - A therapist who does believe in the use of marijuana as a treatment for mental health
  - A therapist who does not believe in the use of marijuana as a treatment for mental health
- What questions might you have regarding Tom's past? Would you want to further explore the possibility of trauma, why or why not?



THE FUTURE...

# FINAL THOUGHTS

- More current research is needed for long term mental health benefits
- Better relationships/communication between prescribing medical doctors, therapists, and patients
- Understand facts v. myths to make informed decision about legislation

THANK YOU!