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COMMENTS CONCERNING THE PENNSYLVANIA DEPARTMENT OF HEALTH'S RECENT DECISION TO ADD TREATMENT OF OPIOID USE DISORDER (OUD) TO THE LIST OF QUALIFYING CONDITIONS FOR THE STATE'S MEDICAL CANNABIS PROGRAM

We write on behalf of the Pennsylvania Psychiatric Society (PAPS), a district branch of the American Psychiatric Association, representing more than 1,500 physicians who specialize in the treatment of psychiatric conditions in the Commonwealth, including the treatment of addictive disorders. We would like to take this opportunity to provide our comments concerning the Pennsylvania Department of Health's recent decision to add treatment of Opioid Use Disorder (OUD) to the list of qualifying conditions for the state's medical cannabis program.

With the opioid addiction and overdose epidemic significantly impacting the country and Pennsylvania, it is important that patients have access to the clinically proven treatment services that do help people recover. It is also important that they not be given sham treatments or those which might worsen their addiction.

PAPS and American Psychiatric Association (APA) are dedicated to increasing access to and improving the quality of addiction treatment for patients in Pennsylvania and across the country. Ensuring patients have access to all Food and Drug Administration (FDA)-approved medications to treat OUD is a critical part of our efforts to improve the care and treatment of patients with the chronic disease of addiction. However, we are concerned about allowing OUD to be a qualifying medical condition for access to the state's medical cannabis program, specifically, as the Medical Marijuana Advisory Board adopted the following condition: Opioid use disorder for which conventional therapeutic interventions are contraindicated or ineffective, or for which adjunctive therapy is indicated in combination with primary therapeutic interventions.

We have been unable to find any evidence in the scientific literature supporting this use of cannabis. There is some evidence that the use of cannabis can be worsen the course of addiction, however.

Clinical experience in Pennsylvania and elsewhere has found no correlation between cannabis use and remission or recovery from OUD even though cannabis use is common among those in treatment for addiction. Individuals with OUD are at a higher risk for addiction to cannabis given common neurochemical pathways[1,2] and cannabis use by individuals with OUD has been associated with worse treatment outcomes.[3,4] Given these concerns, we recommend the Department reverse the decision to add treatment of opioid use disorder as an approved indication.

Currently, there are three categories of FDA-approved medications available in the US for the treatment of OUD: buprenorphine, methadone, and naltrexone. Each of these medication categories have been proven to be effective for the treatment of opioid addiction, and both clinically and cost-effective in reducing drug use and promoting recovery when used in conjunction with psychosocial services. Cannabis, cannabis-based products, and cannabis delivery devices should be held to the same standards as other prescribed medications and should be subject to the FDA approval process to ensure their safety and efficacy.[5]

PAPS understands that there are epidemiologic reports suggesting that in states where medical cannabis is available there are lower rates of both opioid prescribing and opioid overdose deaths. It is important to note that these studies have yet to conclude that any reduction in opioid overdose deaths and overall prescribing is a result of medical cannabis availability. It is also important to note that as new data becomes available from states that were involved in these earlier studies, greater access to cannabis has not solved the opioid overdose epidemic in those states. Despite the legalization of recreational cannabis in Colorado, on April 4, 2018, The Denver Post reported “opioid deaths hit an all-time high in Colorado in 2017” according to statistics from the Colorado Department of Health and Environment[6]

While the PAPS supports expanding and easing barriers to research cannabis, states must base their decisions for patients on the conclusive data that exists regarding the effectiveness of current FDA-approved medications to treat opioid use disorder and the risks cannabis presents for this patient population. A recent prospective study of patients enrolled from an emergency department who presented with a nonfatal opioid overdose showed that prescription of buprenorphine or methadone was associated with significant reductions in all-cause and opioid-related mortality.[7] Medical marijuana has never been demonstrated to confer these benefits.

Cannabis has been shown to confer the following risks to patients:

(items 1 through 4, with references, are quoted from the Proposed Model State Law for Cannabis Access, AAAP News, Spring 2019)

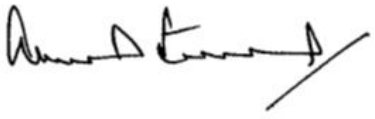
1. Cannabis can be addictive for upwards of 9-17% of users[8,9] and 30-50% of daily users[10,2] especially those who begin use at younger ages (i.e. under age 18)[11].

2. Cannabis can cause transient psychosis (a break from reality, paranoia, etc.) with just a single episode of use.[11] Risk is especially high with edibles, high potency cannabis, or products such as concentrates (i.e. wax, "shatter") – which have in common contents higher in THC:CBD ratios.[11,12]
3. Cannabis can cause and/or worsen psychiatric symptoms, especially for individuals vulnerable to, or experiencing mood, anxiety, trauma-related, or psychotic disorders.[9,2]
4. The developing brain (i.e., persons under age 25) is especially vulnerable to the use of cannabis on cognitive performance and increasing the risk for later development of mood and substance use disorders.[2]
5. There is emerging evidence, based on a large prospective clinical trial, that combining cannabis with opioids leads to worse patient outcomes, with lower self-efficacy in managing pain, and no evidence that cannabis use reduced pain severity or exerted an opioid-sparing effect.[13]

PAPS appreciates the State considering all resources available to help patients with OUD and addiction, but for the safety of Pennsylvania's patients this specific decision should be reversed. We ask the Department to base any decisions regarding the treatment of OUD and addiction on the current scientific and clinical evidence around FDA-approved medications and address ways to further increase access and use of those proven pharmacotherapies along with psychosocial services.

PAPS shares the State of Pennsylvania's goal of increasing access to and improving the quality of OUD and addiction treatment services. While we are opposed to this decision to allow patients to treat their OUD with cannabis through the state medical cannabis program, we are committed to working with the state to ensure Pennsylvania's addiction treatment system is aligned with the standards and best practices of the addiction medicine field. Please do not hesitate to contact PAPS if we can be of service to you. We look forward to working with you.

Sincerely,



M. Ahmad Hameed, MD, DFAPA
President

NB: The content of this petition draws in large part on:

1. **2018 NJSAM/ASAM letter to the NJ Department of Health, Re: Comments on New Jersey State Department of Health Adding Opioid Use Disorder Under "Chronic Pain Related to Musculoskeletal Disorders" to the List of Qualifying Conditions for Medical Cannabis**
2. **Proposed Model State Law for Cannabis Access. AAAP Newsletter, Spring 2019. Drs. Arthur Robin Williams, Kevin Hill, Richard Rosenthal, Hilary S. Connery, Justine Welsh.**
   (inclusive of references 8 through 12 below)

References:

1. Cannabis Use and Risk of Prescription Opioid Use Disorder in the United States, Mark Olfson, et. al.
2. National Academies of Sciences, Engineering, and Medicine. 2017. The health effects of cannabis and cannabinoids: The current state of evidence and recommendations for research. Washington, DC: The National Academies Press. doi: 10.17226/24625.
3. The impact of cannabis use on patients enrolled in opioid agonist therapy in Ontario, Canada, Alexandra M. Franklyn, et. al. 2017
4. The Effect of Marijuana on the Outcome of Methadone Maintenance Treatment (MMT), Thersilla Oberbarnscheidt and Norman S Miller
5. American Society of Addiction Medicine. (2015). Public Policy Statement on Marijuana, Cannabinoids and Legalization. Chevy Chase, MD: American Society of Addiction Medicine. Available at http://www.asam.org/docs/default-source/publicy-policy-statements/marijuana-cannabinoids-and- legalization-9- 21-20156d6e0f9472bc604ca5b7ff000030b21a.pdf?sfvrsn=0.
6. https://www.denverpost.com/2018/04/04/colorado-drug-overdoses-opioid-deaths-hit-high/
7. Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association with Mortality: A Cohort Study. Ann Intern Med. 2018;169:137–145. doi: 10.7326/M17-3107
8. Williams AR, Hill KP. Cannabis and the Current State of Treatment for Cannabis Use Disorder. FOCUS: The Journal of Lifelong Learning in Psychiatry. 2019.
9. Halah MP, Zochniak MP, Barr MS, George TP. Review of Cannabis and Psychiatric Disorders. Curr Addict Rep. 2016;3(4):450-462.
10. Hasin DS, Saha TD, Kerridge BT, et al. Prevalence of marijuana use disorders in the United States between 2001-2002 and 2012-2013. JAMA Psych. 2015;72(12):1235-1242.
11. Volkow ND, Baler RD, Compton WM, Weiss SR. Adverse health effects of marijuana use. N Engl J Med. 2014;370(23):2219-2227.
12. Compton M (editor). Cannabis and Mental Health, American Psychiatric Publishing Inc. 2016.
13. Effect of cannabis use in people with chronic non-cancer pain prescribed opioids: findings from a 4-year prospective cohort study. Gabrielle Campbell, et. al. 2018 Lancet