Cannabis legislation provides an opportunity to strengthen primary care substance use counseling

Yezarni Wynn MSc Sheryl Spithoff MD MSc CCFP Daniel Z. Buchman PhD MSW RSW

Nonmedical cannabis use was legalized in Canada on October 17, 2018.[1] While the purported political and economic benefits of cannabis legalization have been publicized, as have the social benefits from ending prohibition (eg, reducing the disproportionate criminalization of marginalized groups), the long-term health effects of cannabis legalization remain uncertain. Family physicians are a key group at the forefront of addressing this uncertainty, as their role often involves engaging in initial conversations with their patients about substance use.

At the time of writing, the rates of cannabis use post-legalization remained similar to before legalization in Canada[2] and in other jurisdictions. Indeed, many family physicians counsel their patients routinely about legal and illegal substance use. However, cannabis legalization might provide an opportunity for some individuals to use cannabis for the first time. While some patients might feel more comfortable disclosing their cannabis use in a legalized environment, family physicians face the challenge of respecting a patient's values and preferences while conveying the known evidence about the potential benefits and risks of cannabis use for individual and public health. In this commentary we offer some guidance and argue that cannabis legalization presents an opportunity to strengthen a primary care approach to counseling for cannabis and other psychoactive substances.

Roles and responsibilities of family physicians

First, family physicians have an obligation to act in the best interests of their patients, encompassing not only the health of their patients but also respecting how their patients choose to live their lives. However, "best interests" is a vague concept and can vary depending on who defines *best interests*—the patient, a family member, or the physician—and what kind of interests are being discussed. One physician might support the use of cannabis for an adult patient's psychosocial interests—for example, a patient who reports that his near-daily cannabis use with friends helps him cope with stress. Another physician might actively discourage cannabis use on the basis of a patient's medical interests, with the goal to protect the patient from various adverse effects of daily use (eg, addiction, diminished motivation, and bronchitis if smoked).[3] Physicians can learn what *best interests* means to their patients by exploring what matters most to them. The goal is to consider multiple interests, as well as trade-offs, and how a collaborative approach can help the patient flourish. Physicians can also evaluate if substance use is interfering with the patient's overall functioning, and monitor for a potential substance use disorder.

Second, family physicians have the responsibility to be stewards of information, by applying the best scientific evidence to their clinical practice and ensuring the care they offer is promoting the patient's health and well-being. In the context of cannabis, this includes understanding the perceived benefits of substance use—for example, euphoria and sedation might be pleasurable experiences for some patients. However, the physician should help the patient balance the reported benefits with the potential risks, such as cognitive impairment, short-term confusion, panic, and fatigue, as well as the safety risks to the person and others. Additional discussion of potential risks and benefits can be applied to topics such as cannabis potency, method of consumption, and poly-substance use. Physicians should also discuss the potential risk of psychosis, mood disturbances, and cannabis use disorder (CUD).[4] These might be difficult conversations to have, as some patients might minimize the negative consequences associated with their substance use and exaggerate the perceived benefits. Family physicians can help their patients identify whether the reported benefits of their use are no longer outweighing the harms. Family physicians play a pivotal role in enhancing the capacity of their patients to exercise their autonomy and in empowering them to make informed decisions.

Third, family physicians must be socially accountable and cognizant of how their practice can affect public health. One way to do this is by adopting a prevention and harm reduction approach. Harm reduction is a philosophy and a set of strategies that aim to minimize the risks associated with substance use, rather than requiring abstinence.[5] This patient-centred approach includes understanding the context of substance use (eg, self-medication for trauma, use in hazardous situations). Indeed, many of the harms associated with substance use represent a convergence of factors, including lack of evidence-based treatment access and health policy failures. Risk minimization begins with open dialogue, standardized screening, and destigmatized counseling. On a societal level, physicians can advocate for social justice regarding the long-standing inequities related to drug-related charges against structurally vulnerable

groups. For example, family physicians can advocate for decriminalization of other drugs, as well as cannabis criminal-record expungement, which can include connecting their patients to legal services with a view to applying for a pardon.

Fourth, family physicians should seek to reduce stigma around substance use and addiction. Even though cannabis is legal, people who use cannabis—particularly people who use daily or near daily—will likely remain stigmatized, especially youth and those from structurally vulnerable populations. There is still considerable stigma attached to people who smoke tobacco or have an alcohol use disorder, despite tobacco and alcohol being legal substances. Some family physicians might discourage substance use even when patients are not experiencing harm and report benefits. This might lead to stigmatization of substance use in clinical practice, and the patient might be apprehensive to disclose any other information related to substance use, other stigmatized behaviour patterns, or their health. We encourage family physicians to engage in thoughtful and respectful dialogue with their patients, in order to convey their professional expertise while also preventing patients from feeling invalidated. We believe patients should feel safe and comfortable disclosing information about their substance use, such as frequency, route of consumption, and the effect of substance use on their life, including perceived benefits. In order to keep this line of communication open, physicians must create a destigmatized climate of trust for disclosure and collect information while being self-reflective about assumptions. One such approach is explicitly asking about psychoactive substance use in routine history taking, similar to smoking and alcohol use. This might help reduce the stigmatization of people who use substances, and the topic becomes part of a normalized set of questions that patients can expect.

Finally, because family physicians often have longstanding relationships with their patients, they have an obligation to follow their patients through the continuum of care, including when substance use disorders arise. Most people use cannabis without developing a CUD; however, about 9% of those who try cannabis will develop a CUD.[3] The rates are much higher for people who start using cannabis as adolescents and much lower when people start after the age of 25.[6,7] Risk factors for CUD include depression, anxiety, and posttraumatic stress disorder.[8] If CUD is diagnosed, the family physician should not hesitate to treat it. This involves sharing his or her concerns with the patient, motivating the patient toward change, and conveying treatment options with the goal of formulating a patient-centred management plan. As such, family physicians should be familiar with pharmacologic treatment options for withdrawal symptoms (eg, antidepressants, cannabinoid agonists for CUD) and psychotherapy for sustained management (eg, cognitive-behavioral therapy).[9] The patient might benefit from a multidisciplinary approach with other health care providers such as psychiatrists, counselors, social workers, or other practitioners who specialize in the care of people who use drugs. For patients who are structurally vulnerable, primary care interventions into poverty might provide additional benefits.

Tools

Practical tools have been developed for physicians to screen for and counsel on cannabis use. One tool is the Cannabis Abuse Screening Test (CAST), a questionnaire that screens for problematic cannabis smoking in the past 12 months; this test is an effective tool, particularly among youth, with high sensitivity and specificity of 93% and 81%, respectively, in cannabis users who are low alcohol consumers.[10] Additionally, the *Lower-Risk Cannabis Use Guidelines* handout[11] is a useful patient education tool. This concise evidence-based guideline provides recommendations, such as delaying the age of initial use, navigating the choice between cannabis products and methods of consumption, frequency and intensity of use, and combined risks of cannabis use and other types of behaviour (eg, impaired driving).[11] After educating patients, physicians can help patients address problematic cannabis use through motivational interviewing. In a literature review of 39 studies on substance use–related motivational interviewing, 67% reported a statistically significant reduction of substance use.[12] We suggest this is done through providing information, answering questions, and helping the patient explore his or her own values. Family physicians can use these suggestions as elementary steps toward developing routine practice in line with current evidence. If patients have severe CUD, or are unable to make changes, physicians should help patients access additional resources such as an addiction counselor, an addiction physician, or support groups. If a patient has a concurrent disorder (eg, CUD and posttraumatic stress disorder), the physician should refer him or her to the appropriate resources. If a physician believes that a patient is at risk of driving while under the influence of cannabis, he or she has a duty to inform the provincial ministry of transportation.[13]

Conclusion

Some family physicians might be uncertain how to appropriately counsel patients about substance use and negotiate their ethical and professional responsibilities. However, these challenges are not new and a number of lessons are transferable from other clinical scenarios, such as routine counseling and management of tobacco and alcohol use. As the primary point of contact for many patients, as well as participants in patients' long-term health and well-being, family physicians must remain adaptable in their approach. They can meet their obligations to individuals and society by being vigilant

with screening and addressing identifiable problems before they become worse, and by being a nonjudgmental, compassionate, listener patients can trust.

Mr Wynn is an undergraduate medical student at the University of Toronto in Ontario. **Dr Spithoff** is a lecturer in the Department of Family and Community Medicine at the University of Toronto, and a family physician and an addiction physician in the Department of Family and Community Medicine at Women's College Hospital in Toronto. **Dr Buchman** is a bioethicist at the University Health Network, a clinician investigator at the Krembil Research Institute, Assistant Professor in the Dalla Lana School of Public Health at the University of Toronto, and a member of the University of Toronto Joint Centre for Bioethics.

Competing interests
None declared

Correspondence
Dr Daniel Z. Buchman; e-mail **daniel.buchman@utoronto.ca**

References

1. Senate of Canada [website]. *The Cannabis Act in the Senate.* Ottawa, ON: Senate of Canada; 2018. Available from: **https://sencanada.ca/en/sencaplus/news/cannabis-act/**. Accessed 2019 Sep 19.
2. Statistics Canada [website]. *National Cannabis Survey, fourth quarter 2018.* Ottawa, ON: Statistics Canada; 2019. Available from: **www150.statcan.gc.ca/n1/daily-quotidien/190207/dq190207b-eng**.htm. Accessed 2019 Sep 19.
3. Volkow ND, Baler RD, Compton WM, Weiss SRB. Adverse health effects of marijuana use. *N Engl J Med* 2014;370(23):2219-27.
4. Government of Canada [website]. *Health effects of cannabis.* Ottawa, ON: Government of Canada; 2018. Available from: **www.canada.ca/en/health-canada/services/drugs-medication/cannabis/health-effects/effects.html.** Accessed 2019 Sep 19.
5. Logan DE, Marlatt GA. Harm reduction therapy: a practice-friendly review of research. *J Clin Psychol* 2010;66(2):201-14.
6. Government of Canada [website]. *Is cannabis safe to use? Facts for young adults aged 18–25 years. Cannabis resource series.* Ottawa, ON: Government of Canada; 2018. Available from: **www.canada.ca/en/health-canada/services/publications/drugs-health-products/is-cannabis-safe-use-facts-young-adults.html.** Accessed 2019 Sep 19.
7. Chadwick B, Miller ML, Hurd YL. Cannabis use during adolescent development: susceptibility to psychiatric illness. *Front Psychiatry* 2013;4:129.
8. Steinbuchel PH, Wilens TE, Adamson JJ, Sgambati S. Posttraumatic stress disorder and substance use disorder in adolescent bipolar disorder. *Bipolar Disord* 2009;11(2):198-204.
9. Sherman BJ, McRae-Clark AL. Treatment of cannabis use disorder: current science and future outlook. *Pharmacotherapy* 2016;36(5):511-35.
10. Legleye S, Karila L, Beck F, Reynaud M. Validation of the CAST, a general population Cannabis Abuse Screening Test. *J Subst Use* 2009;12(4):233-42.
11. *Canada's lower-risk cannabis use guidelines*. Ottawa, ON: Canadian Research Initiative in Substance Misuse; 2018. Available from: **www.camh.ca/-/media/files/pdfs---reports-and-books---research/canadas-lower-risk-guidelines-cannabis-pdf.pdf**. Accessed 2019 Sep 19.
12. Barnett E, Sussman S, Smith C, Rohrback LA, Spruijt-Metz. Motivational interviewing for adolescent substance use: a review of the literature. *Addict Behav* 2012;37(12):1325-34.
13. *Highway Traffic Act.* R.S.O. 1990, c. H.8.

This article has been peer reviewed. *Can Fam Physician* 2019;65:777-9

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro **de novembre 2019** à la **page e456**.