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Marijuana and Psychosis: An Update on Current Evidence

Angela Janis, MD

The National Survey on Drug Use and Health for 2010 shows cannabis use continues to rise with 17.4 million Americans engaging in regular use, an increase from 14.4 million in 2007. Marijuana use is quite high among adolescents and young adults with 7.4% of adolescents ages 12-17 and 18.5% of young adults ages 18-25 using within the last month. Marijuana is the third most commonly used substance in these age groups behind alcohol and tobacco. This is especially concerning as a growing body of literature implicates cannabis use as a risk factor for psychosis.

In a meta-analysis published in The Lancet in 2007, Moore and colleagues analyzed data from several large cohorts in the United States, the United Kingdom, The Netherlands, Sweden, Germany, and New Zealand. They found that any use of cannabis increased the risk of psychotic illness by 40%. Those who engaged in regular marijuana use had double the risk of psychosis. After controlling for confounding factors, such as other substance abuse, preexisting mental illness, or urban upbringing, the correlation persisted.

The findings of this study were much debated. Some argued that marijuana likely directly caused psychosis while others postulated that psychotic patients may seek marijuana preferentially to a non-psychotic population as a means of self medication. Further studies have attempted to provide clarification of the link.

In 2011, a prospective study by Kuepper assessed a German cohort aged 14-24 over a ten year period. At the start of the study, participants had never experienced psychotic symptoms nor had they used marijuana. They found that subsequent use of marijuana doubled the risk of experiencing psychotic symptoms in the future and continued use of marijuana resulted in a two fold increase in the likelihood of persistent psychotic symptoms. Again, the significance persisted when controlling for variables such as gender, age, other drug use, and socioeconomic status. Interestingly, they found that having psychotic symptoms did not predict later use of marijuana. The authors of this study argued that this design and result more clearly implicated cannabis as a causative factor in psychosis rather than an issue of self treatment.

Recent studies also seem to link marijuana with an earlier age of onset of psychotic symptoms. In 2011, Large and colleagues conducted a meta-analysis of 83 studies which showed that use of cannabis decreased age of onset of psychotic symptoms by an average of 2.7 years. All types of substance use also decreased age at diagnosis by about 2 years, but alcohol use alone did not lead to earlier onset of symptoms. This is a very important finding, as earlier age of onset is known to portend worse long term outcomes.

Also in 2011, Schimmelmann and colleagues looked at age of onset in 625 patients experiencing a first episode of psychosis in Australia. They found that age of onset was not significantly different in those patients meeting criteria for cannabis use disorder compared to patients who did not. However, a significant decrease in age at diagnosis was found if first cannabis use occurred prior to age 14. In that case, age at onset was decreased by approximately 2 years.

Cannabis users with psychotic symptoms do appear to have different characteristics compared to non-using patients with psychosis. A study by Leeson and colleagues in 2011 found that cannabis users tended to have higher premorbid cognitive functioning, with higher IQ, verbal learning, and working memory. Additionally, cannabis users generally had higher premorbid social functioning. The nature of the psychotic symptoms may also be different in cannabis users. Marijuana users have been found to have higher rates of positive symptoms at first break, along with a trend toward lower rates of negative symptoms. In a South African study in 2010, cannabis users also experienced a shorter duration of untreated psychosis prior to engaging in treatment. This is somewhat encouraging, as each of these differences have historically been associated with better treatment outcomes.

The underlying mechanism for the link between cannabis use and psychosis is unclear. THC is known to bind cannabinoid receptors. The cannabinoid 1 receptor, or CB1, found extensively throughout the brain, is a presynaptic receptor which inhibits neurotransmitter release. It is found on neurons which release GABA, glutamate, serotonin, dopamine, and acetylcholine. The highest concentrations of CB1 receptors are found in the striatum, hippocampus, and cerebellum with moderate density in the amygdala, midbrain, and cerebral cortex. The density of CB1 receptors is low in childhood, increases

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during adolescence, and declines in adulthood. The CB1 receptor has previously been implicated in schizophrenia, as post-mortem studies have shown altered distribution in schizophrenic patients.

There are naturally occurring endocannabinoids which do bind the CB1 receptor and subsequently modulate multiple neurotransmitters, including dopamine. The endogenous cannabinoids are thought to be important in early neuronal development, implicated in processes including proliferation and differentiation of progenitor cells, neuronal migration, axonal guidance, positioning of cortical inter-neurons, and neurite outgrowth. Though their role during adolescence is less well understood, it has been hypothesized that the endocannabinoid system plays an important role in neuronal pruning. This may make adolescence a particularly vulnerable time with respect to the influence of cannabis.

Despite the increasing evidence for the link between marijuana and psychosis, there are still many unanswered questions. Marijuana use is widespread, but psychosis remains relatively rare. Even with increasing rates of cannabis use, rates of schizophrenia have not increased in turn. Therefore, it may be that marijuana interacts with other genetic and environmental factors to cause problems in susceptible populations.

An urban environment has been shown to independently increase risk of psychosis in multiple studies. This risk appears compounded when combined with marijuana use. Another study by Kuepper and colleagues, utilizing data from their German cohort, found a more significant effect of cannabis on incident psychosis in individuals from an urban environment compared to those in rural setting.

Trauma has also been an independent risk factor for development of psychosis. Again, trauma may interact additively with cannabis use. Harley and colleagues examined the risk for psychosis in marijuana use, trauma history, and a combination of both. They found that cannabis increased risk of psychosis by 90% and a history of trauma increased risk by 160%. However, the combination of trauma and cannabis use increased the risk by about 20 fold. Though this study was quite small, it does underscore the importance of the interplay between multiple risk factors.

Genetic variants have also been linked with susceptibility to cannabis psychosis. Catechol-O-methytransferase (or COMT) is an enzyme involved in metabolism of synaptic dopamine. Polymorphisms in this gene exist, and individuals with a Valine/Valine genotype at codon 158 appear particularly sensitive to cannabis use. Caspi and colleagues followed a birth cohort in New Zealand and observed the effect of marijuana on psychosis rates. They found that only those with the Valine/Valine variant had increased rates of psychosis with cannabis use, but the increased risk was quite large. However, this effect was only observed if first use of marijuana was prior to age 18, again suggesting that the effect is limited to adolescence.

Continued use of marijuana is important as well. Psychotic patients who continue to use cannabis have poorer treatment adherence and higher rates of treatment drop out. This effect is independent of age, race, socioeconomic status, gender, or medication type. Patients with continued cannabis use are also at risk for increased frequency of relapse and rehospitalization. Therefore, patients with psychotic symptoms should be advised to avoid use of marijuana.

In conclusion, there is growing evidence for a link between cannabis use and the emergence and persistence of psychotic symptoms. Though the connection remains unclear, more support is accumulating for a direct effect of marijuana in the causation of psychosis. However, other genetic and environmental factors play a large role in determining an individual's susceptibility. The correlation appears most robust when cannabis use starts in adolescence. Given the current evidence, adolescents should be strongly encouraged to avoid all cannabis use and should be educated on its potential hazards. This is particularly true in those with significant risk factors, including a family history of psychosis. Nevertheless, more research is needed to clearly elucidate the risk associated with marijuana use.

Executive Director's Message

Sara Finger, WPA Executive Director

Hello and Happy Fall!

Now that the relaxing summer months are behind us and the hustle and bustle of fall has begun, I want to encourage you all to take care of yourselves. Being a psychiatrist means giving so much of yourself, your day, and your life to so many in need. Not only do you directly provide essential care but many of you are also very involved in organized medicine and leadership roles that further exhaust your time and energy.

You all make incredible contributions to your patients, colleagues and your community, but you can't forget to recognize this contribution and to take care of YOU.

I personally would like to thank you and remind you of how incredibly valued you are. As your Executive Director, I can't tell you how proud I am to work for such a dedicated and involved group of health care professionals. You're called upon not only to treat your patients but to advocate for them as well. It can be an extremely demanding job, but your work has never been more relevant or needed than in today's stressful environments.

As the mother of a 20 month old, maybe it's the maternal side of me speaking, but as someone truly invested in our association, we're only effective if we ourselves are healthy – mentally, physically and spiritually. So please be sure to take care of you so you can continue to take care of so many in need. Please remember how much your contribution to advancing mental health through leadership in education, service, and advocacy is appreciated.

Sara

How to Improve Patient Care and Stay Board-Certified

Wisconsin Psychiatric Association Career Development Conference October 22, 2011

Background

The American Board of Psychiatry and Neurology has markedly changed the process of maintenance of certification (MOC). New requirements include self-assessment activities and performance improvement (PI) activities, in addition to more traditional requirements for CME and cognitive examination. Many psychiatrists are ill prepared for the new MOC requirements. They especially lack the training and experience in quality improvement necessary to conduct PI activities. Furthermore, many state medical boards are considering adopting a similar model for maintenance of licensure. In Wisconsin, an additional regulatory change has implications for the care of medical professionals by psychiatrists. Thus, Wisconsin psychiatrists face a number of new regulatory requirements in order to be able to continue practicing psychiatry. We hope to offer our audience a better understanding and appreciation of these changes, as well as tools to help them meet regulatory requirements, including use of electronic medical records.

Goals and Objectives

The goal of this event is for Wisconsin psychiatrists to become familiar with new MOC and licensure requirements. This will be accomplished with a combination of didactics and interactive sessions (panel discussions).

By the end of this conference, participants will:

1. Appreciate the elements of new maintenance of certification (MOC) requirements for psychiatrists. (Ronis)
2. Identify projects suitable for the new Performance in Practice requirements. (Ronis)
3. Identify the resources available to assist psychiatrists in meeting the requirements for self-assessment and performance improvement projects. (Ronis)
4. Describe the principles of performance improvement in clinical practice. (Mejicano)
5. List examples of performance improvement CME projects that have been implemented in other clinical settings. (Mejicano)
6. Anticipate the links between performance improvement, maintenance of certification and maintenance of licensure. (Mejicano)

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7. Appreciate the common professional and disciplinary issues that the Medical Examining Board (MEB) encounters. (Musser)
8. Describe reporting requirements related to the treatment of impaired physicians. (Musser)
9. Describe the advantages of using rating scales in psychiatric practice, including their relevance to ABPN Maintenance of Certification requirements. (Halverson)
10. List outcome measures that can be used to monitor the quality of psychiatric practice. (Halverson)
11. Develop a plan to collect and track outcomes in your psychiatric practice. (Halverson)
12. Describe the use of electronic health records (EHR) in quality improvement projects. (Plovnick)
13. Name financial incentives associated with the use of EHR. (Plovnick)
14. Appreciate regulatory issues associated with the use of EHR. (Plovnick)

Schedule

8:00 a.m.	Breakfast & Registration
8:30 a.m.	Welcome, Introductions & Background (Walaszek)
8:45 a.m.	Introduction to Maintenance of Certification (Ronis)
9:45 a.m.	Break
10:00 a.m.	Introduction to Performance Improvement CME (Mejicano)
11:00 a.m.	Panel Discussion with Ronis & Mejicano
11:30 a.m.	Break
11:45 a.m.	Working Lunch: An Update from the Wisconsin Medical Examining Board (Musser)
12:45 p.m.	Break
1:15 p.m.	Using Outcome Measures for Performance Improvement in Psychiatry (Halverson)
2:15 p.m.	The Electronic Health Record as a Means to Improving Quality (Plovnick)
3:15 p.m.	Panel Discussion with Halverson & Plovnick
3:45 p.m.	Closing & Next Steps (Walaszek)

2012 Annual Meeting

SUICIDE: Science, Assessment, and Prevention

The 2012 annual meeting is fast approaching with the dates of the conference being March 2 and 3, 2012. This meeting will be covering the topic of suicide. Suicide is the most tragic consequence of mental illness and is applicable to all providers that work in any area of mental health. We are fortunate to have put together a great group of locally and nationally known providers to discuss the critical components of suicide.

Dr. Jan Fawcett will be talking about the DSM and suicide, as well as Risk Factors. Dr. Ned Kalin will be discussing the neurobiology of suicide. A subgroup discussion will occur with Drs. Art Walaszek, Stephanie Eken, and Jon Lehrman discussing geriatric patients, child and adolescent patients/bullying, and veteran affairs patients respectively. Drs. Ron Diamond and Jon Berlin will be discussing management of acute suicidal ideation, while Drs. Joseph Layde and Ken Robbins will be discussing liability and suicide. Lastly, Dr. Shawn Shea will be performing a half-day presentation and workshop on the assessment of suicidal ideation.

Our goal is to provide a specific focus on suicide given the impact that it has on the patient, family, and providers. We will be specifically focusing on assessment, as this continues to be of critical importance. This conference will address a multitude of facets and will benefit all providers who work with suicidal patients. We look forward to seeing you on March 2nd and 3rd.

The Charles E. Kubly Foundation has generously provided a grant to the WPA to offset the costs of bringing Shawn Christopher Shea, MD to the Annual Meeting next spring. Dr. Shea is nationally renowned for his interviewing strategy for uncovering suicidal ideation and intent, the Chronological Assessment of Suicide Events (the CASE Approach). Dr. Shea regularly speaks at national conferences and academic medical centers and is a consultant to the military on suicide prevention. Dr. Shea is the author of six books and numerous articles including, *The Practical Art of Suicide Assessment* and *Psychiatric Interviewing: the Art of Understanding*.

American Psychiatric Association Bestows Highest Award to Rogers Medical Director

Dr. Kambiz Pahlavan awarded distinguished life fellowship

Milwaukee - Kambiz Pahlavan, MD, FAPA, FAACAP, has been bestowed the American Psychiatric Association's highest award at its annual meeting. The award is given to those individuals who have made outstanding contributions in the field of psychiatry.

"As a clinician, educator, researcher and administrator, Dr. Pahlavan has long been recognized for his leadership and dedication," said David L. Moulthrop, PhD, president and CEO of Rogers Behavioral Health System. "This award represents the appreciation and respect shown by his accomplished colleagues."

Dr. Pahlavan is the medical director of Rogers Memorial Hospital-Milwaukee and is also the director of the Rogers Center for Research and Training. He has worked at Rogers for more than a decade and has been a member of the American Psychiatric Association (APA) for nearly 30 years.

He has also been recognized for his contributions toward the quality partnerships Rogers has established with the Medical College of Wisconsin and Children's Hospital of Wisconsin.

He has twice been awarded the APA's Nancy C.A. Roeske Certificate of Excellence in Medical Student Teaching, receiving this honor in 1999 and 2008.

Dr. Pahlavan has served on the Ethnic and Cultural Issues Committee of the American Academy of Child and Adolescent Psychiatry (AACAP), the Work Group on Diversity and Culture of the AACAP and the Inpatient and Continuum of Care Committee of the AACAP, and many other local and national committees.

As director of the Rogers Center for Research and Training, Dr. Pahlavan oversees the research studies conducted within the Rogers Behavioral Health System. He has been an investigator or co-investigator in more than 90 studies, in areas including ADHD, affective disorders, psychotic disorders and suicide.

Members in the News

Clarence Chou, MD, was recently elected president-elect of the American Medical Association Foundation Board of Directors. Doctor Chou has served in numerous leadership roles at the local, state and national levels. He is a past president of the Wisconsin Medical Society and has served on the boards of the Planning Council for Health and Human Services in Southeastern Wisconsin and the National Alliance on Mental Illness of Greater Milwaukee.

Doctor Chou, who is board-certified in general psychiatry and child and adolescent psychiatry, is a full-time psychiatrist at the Psychiatric Crisis Service of Milwaukee County and is also an associate clinical professor in the Department of Psychiatry and Behavioral Health at the Medical College of Wisconsin.

Claudia Reardon, MD, was elected chair of the AMA Women Physicians Congress Governing Council during the 2011 AMA Annual Meeting. Doctor Reardon is a member of the AMA Young Physicians Section (YPS) Assembly.

A member of the Wisconsin Medical Society's Council on Legislation and alternate delegate to the AMA, Dr. Reardon represented the Resident/Fellow Section on the Society's Board of Directors from 2008 to 2010 and served on the Dane County Medical Society Board of Directors from 2009 to 2010. She is a psychiatrist with UW Health in Madison and serves on the faculty at the University of Wisconsin School of Medicine and Public Health.

On the opening day of the AMA Annual Meeting, Jerry Halverson, MD, gave a brief presentation and served on a panel discussion. Doctor Halverson participated on the panel "Leadership in Health Care Change: If Not Physicians, Then Who?" The panel discussion followed a keynote presentation by Alice Gosfield, JD, which encouraged physicians to serve in a leadership capacity regardless of their practice setting and further the delivery of quality and value of patient care. Doctor Halverson is the medical director of adult services at Rogers Memorial Hospital in Oconomowoc and serves as District 2 representative on the Wisconsin Medical Society's Board of Directors and is chair of the Society's Council on Legislation.

Jake Behrens, MD (3rd from right), poses with APA President John Oldham, MD, and other MITs and ECPs at the recent APA Area 4 meeting in Indianapolis. Doctor Behrens was recently elected Area 4 MIT Deputy Representative to the full APA Assembly. He'll be representing Wisconsin, along with APA Assembly Representative Clarence Chou, MD, at the upcoming APA Assembly meeting in Wash, DC. Doctor Behrens is the current UW Resident (MIT) Representative on WPA's Executive Council.

Jon Berlin, MD was featured in the latest issue of the APA news. Congrats Jon!

http://pn.psychiatryonline.org/content/46/14/12.1.full

The Risks of Legislating Conversations between Doctors and Patients

Marc W. Manseau, MD, MPH; Michael T Compton, MD, MPH; Carol Koplan, MD; Frederick JP Langheim, MD, PhD; Rebecca A Powers, MD, MPH; Ruth Shim, MD, MPH
The Prevention Committee of the Group for the Advancement of Psychiatry

A political battle is playing out in Florida about conversations within doctors' offices, and public health and safety are collateral damage. With Governor Rick Scott's signature, the Privacy of Firearm Owners bill became law in Florida this spring. It subjects doctors to fines and disciplinary action for asking their patients about gun ownership. As originally written, the law would have made asking about guns a felony. However, a compromise with the Florida Medical Association allows doctors to ask about guns in emergency situations, such as when a patient is making explicit threats of suicide or violence. Nevertheless, this new law still threatens a doctor's ability to assess risk of injury and death. It also interferes with physicians' professional responsibilities and places the public's health at risk.

According to a 2007 report from the Centers for Disease Control and Prevention, accidental injuries were the fifth leading cause of death in the United States. Suicide was in eleventh place and homicide in fifteenth place. And in each category, firearms were responsible for large proportions of these deaths. Guns were only second to motor vehicle accidents in causing injury-related deaths. In the case of suicide, about half of deaths involved firearms, and more than two-thirds of homicides involved them.

A larger portion of suicides and homicides among young people are related to firearms, and the rate of lethal injury from guns among children is many times higher in the United States than in other industrialized countries. Most shooting deaths among children occur when guns have been kept loaded and unlocked, and are accessible to them. Further, because suicidal thoughts in young people can lead to impulsive actions during times of emotional crisis, depressed and suicidal youth are much more likely to successfully complete suicide when they have access to a gun.

There is strong evidence that when doctors bring up concerns and provide health education, it can lead to healthier and less risky behavior. For instance, when physicians address smoking and excessive alcohol use, it has been shown to significantly decrease both behaviors. This is why many professional medical societies across a wide range of specialties have released official guidelines about addressing firearm safety. Whatever their personal views on gun rights and ownership, doctors in these groups share a deep concern for their patients' health and safety, and a commitment to practice medicine in an ethical, professional, and scientifically evidence-based manner.

We as physicians bring up highly private, personal matters that affect health every day. Examples include sexual behavior, seat belt use, tobacco use, drug and alcohol use, mental health concerns, and sensitive details of family medical history. The point of this questioning is not to intrusively pry into patients' private lives, harass patients, or attempt to compromise their autonomy. Rather, it is to ensure that diseases can be diagnosed and treated early, health risks can be identified and ameliorated to prevent illness, and vital health education can be delivered in a sensitive and effective manner.

By asking about firearm availability and safety in patients' homes, physicians are not violating privacy, pushing an anti-firearm agenda, or compelling patients to disclose their gun ownership. Instead, physicians are fulfilling professional responsibilities to protect patients' and the public's health by asking about an important risk factor for unintentional or intentional injury. In doing so, physicians are also empowering patients with relevant health and safety education, within the strict confidence of the patient-doctor relationship. Just as patients may choose not to share aspects of their sexual behavior or drug use in a physician's office, they can choose not to disclose information about firearm ownership.

Making it illegal for physicians to ask about gun ownership and safety needlessly and dangerously intrudes in the patient-doctor relationship. It may mean the difference between a depressed teenager completing suicide rather than receiving help. This is why the Florida chapters of the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians filed a First Amendment suit against the new law. With the recent success of this court challenge (a Federal Judge blocked implementation of the law ruling that it violates first amendment rights – Governor Scott has vowed to appeal) we hope that other states considering similar prohibitions will decide against placing physicians in a moral and ethical bind, interfering with responsible patient care, and compromising public health.

APA Components Convene in Arlington in September

Claudia L. Reardon, MD

You know the summer has ended when the APA Fall Components meeting rolls around. Well…perhaps that's not how all of us demarcate the change of seasons, but nonetheless the Components meeting has come and gone much like the leaves on the trees soon will do.

The APA Components are the Councils and Committees that make up one part of the governance structure of our umbrella organization. The Components met in Arlington, VA (home of the APA National Headquarters) on September 8-10, 2011. I serve on the Council on Communications, while another of our District Branch and WPA Executive Council members, Jerry Halverson, MD, continues his work on the Council on Advocacy and Government Relations.

Each component has a very specific focus area. We gather twice yearly for in-person meetings, which are punctuated by numerous conference calls and emails to conduct our year-round business. For the Council on Communications, here are some of the topics we tackled at the Fall meeting:

- DSM-5 media outreach: Many of you have probably seen the angry attestations by one of the leaders of the former DSM-IV work group regarding the DSM-5 procedures purportedly not being organized and transparent enough. The APA takes great issue with such accusations, asserting that the 5th edition of our diagnostic manual is transparent to unprecedented degrees, and has been a gargantuan undertaking requiring epic proportions of organization. The Council on Communications does not want the APA to passively step back and let such accusations go unchallenged, but also does not want to get into verbal warfare about the issue. A calm, measured approach (as psychiatrists are want to do) will continue to be undertaken.
- APA website redesign: It's just around the corner now! The much-anticipated new rendition of the APA website will be revealed at the end of 2011 or shortly after the New Year. Along with the vast improvements in structure and organization (i.e., no longer will one need to make innumerable mouse clicks to find her page of interest!), the website domain name will change. Out with www.psych.org, as we plan to welcome in www.psychiatry.org.
- Newsletter of the Year awards: This is a topic near and dear to many WPAers, as our District Branch has taken home the bacon in this annual newsletter competition more times than I can count. Changes are underfoot regarding award categories, and surely the WPA will rise to the occasion. The new set of award categories will likely be: overall communication plan; newsletters and e-newsletters; regular message updates; blogs; and websites.
- Psych News: Most of you are probably familiar with this APA newsletter that you receive in the mail once per month. In addition to the old-fashioned way of receiving this content, the APA communications crew has been busy crafting more technologically advanced methods of disseminating Psych News. For example, sign up to receive daily mini-blogs of hot topics within psychiatry by going here: http://pn.psychiatryonline.org/. I find these snippets to be easily digestible quick reads that keep me up to speed on the latest APA/psychiatry happenings on a daily basis.

Dr. Halverson reports the following as prime topics of conversation at his Component meeting of the Council on Advocacy and Government Relations:

- Review of the current state of legislative affairs in Washington, D.C., including the debt ceiling debacle and the "Supercommittee"
- Reaffirmation of the importance of getting the ever-so-flawed sustainable growth rate (SGR) thrown out once and for all
- Discussion of the successes of the year at the state level insofar as scope of practice challenges, as countered by vast state-level challenges to mental health budgets
- Dialogue about how psychiatry can best integrate with medicine, from the level of the Federally Qualified Health Center all the way to the relationship between the private practice psychiatrist and the primary care physician
- Consideration of the "future of psychiatry" with regards to workforce issues, which include changing employment and practice patterns within our specialty. This complex issue also has some relevance for pay for "quality" (however that may be defined), accountable care organizations, and payment bundling.
- Debate on how to protect patient privacy in the age of electronic medical records and "health information exchanges"

Never hesitate to contact Dr. Halverson or me with questions or concerns you would like us to try to address with our national Components, and thank you kindly for the opportunity to serve and represent you.

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UPCOMING EVENTS

November 11-12, 2011
Fall 2011 Psychiatric Update
UW School of Medicine and Public Health and Madison Institute of Medicine, Inc.

March 16-17, 2012
Spring 2012 Psychiatric Update
UW School of Medicine and Public Health and Madison Institute of Medicine, Inc.