

MEDICAL MARIJUANA: WHAT HIV PROVIDERS NEED TO KNOW

Marijuana use is common among individuals living with HIV, and can have serious health consequences: Between 23% and 56% of people living with HIV/AIDS have used marijuana in the previous month,^{1,2} and many of them report that they use it for medical reasons.^{3,4} Though marijuana does provide relief for physical and emotional distress, it can also put users at risk. Research studies show that marijuana use is associated with respiratory illness, cardiovascular complications, problems with learning and memory, mental illness, and misuse of other substances (alcohol, tobacco) that are damaging to health.^{5,6}

Marijuana has some potential medical uses, and many people prefer it to pharmaceutical medications. In spite of its risks, marijuana does have potentially positive medical effects. Research shows that it can reduce nausea, stimulate appetite, relieve pain, control muscle spasms, reduce tics among individuals with Tourette's Syndrome, and help individuals with epilepsy control their convulsions.⁷ Given these benefits, scientists have developed several medications that utilize marijuana's main active ingredient—delta tetrahydrocannabinol (THC)—for therapeutic purposes. Currently, there are two THC based medications—dronabinol (Marinol®) and nabilone (Cesamet®) that are FDA approved to treat nausea and appetite stimulation for people with certain medical conditions. Though these medications work well, many individuals find medical marijuana to be more effective and have fewer unpleasant side effects than THC medications.

Marijuana's legal status is unclear. Even though 18 states and the District of Columbia have approved the medical use of marijuana, the drug is still illegal according to federal law. As a Schedule I drug under the 1970 Controlled Substances Act, marijuana is considered a drug that has no legitimate medical use by the federal authorities. Thus even if people are using marijuana for medical purposes, and are in compliance with state law, they could still be prosecuted for violating current federal drug laws. Though federal enforcement of marijuana laws against individual users is rare, there are still legal risks associated with marijuana possession and use.

Medical marijuana is not regulated by the FDA, so it is unclear what people are ingesting when they use it. The Food and Drug Administration (FDA) is the federal body that tests pharmaceuticals in order to assure that they are effective and safe before allowing them to be used as medications. Medical marijuana has not undergone FDA testing, so there is no guarantee that it is safe or effective. It would be difficult for the FDA to ever test marijuana as a pharmaceutical, since its chemical composition can vary widely depending on how it is grown. Since it is not FDA regulated, people who use medical marijuana can never be sure of what they are ingesting. There are no requirements for medical marijuana to be properly labeled or tested for safety. Consequently, there is no way to be sure of the chemical composition of medical marijuana, and it could be contaminated by mold or fungus.

People living with HIV use medical marijuana for a variety of reasons, but it could be risky for them: People living with HIV often use medical marijuana to cope with HIV symptoms (neuropathy, wasting syndrome),^{2,4,8-10} the stress of being diagnosed with HIV,^{2,4,11} and the side effects of anti-HIV medications.^{2,4} Though many HIV clients get relief from medical marijuana, its use can also endanger their health. Individuals living with HIV are at increased risk for cognitive problems,¹² mental health disorders,¹³ pulmonary disease,¹⁴ and cardiovascular complications;¹⁵ marijuana is associated with increased risk in all of these areas. Consequently, if clients are using medical marijuana, it is important to be sure that it is not endangering their physical or mental health.

What should you do if your clients are using medical marijuana? If clients are using marijuana, your main goal is to assure that their use is not detrimental to their overall well-being. This approach can help ensure that marijuana use does not harm your clients.

Screen for abuse/dependence: The vast majority of marijuana users do not abuse the drug. However, marijuana can be habit forming, so it is important assure that your clients are not at risk for abuse or dependence. Common signs of marijuana abuse/dependence are tolerance and withdrawal symptoms, preoccupations with use, loss of control over use, continued use in spite of adverse consequences, and denial. If clients you identify one or several of these signs, use motivational interviewing techniques to change your clients marijuana use behaviors. In cases that require a higher level of care, you may need to refer clients to specialty substance use disorder treatment.

If clients are not abusing or dependent on marijuana, use the following three-step process.

1. **Decisional Balance:** Have the client identify the pros and cons of marijuana use. Summarize the pros and cons for the client, and be sure not to add your own opinions of what they say about their marijuana use.
2. **Feedback Sandwich:** First, ask the client permission to give feedback on how marijuana use may be affecting his/her health. Second, give feedback that, while acknowledging the pros and cons clients identified, also incorporates any concerns you may have about marijuana's effects on the client's well-being. Third, ask clients their thoughts on the feedback you provide
3. **Explore Options:** If the first two steps make it clear that reducing marijuana use would benefit the client, explore strategies that the client could use to achieve symptom relief besides marijuana. These could include behavioral interventions, pharmacological interventions, or the use of FDA-approved THC medications.

RESOURCES

- For further information about **marijuana and its impact on health**, you can visit the **National Institute on Drug Abuse** website at www.nida.gov.
- For further information about **medical marijuana**, you can visit **ProCon.org's** medical marijuana website at <http://medicalmarijuana.procon.org/>.
- For further information about **servicing HIV clients**, you can visit the **AIDS Education Training Center National Resource Center** at <http://www.aids-ed.org/>.

REFERENCES

1. Bonn-Miller, et al. (2012). Cannabis use and HIV antiretroviral therapy adherence and HIV-related symptoms. *Journal of Behavioral Medicine* (epub ahead of print).
2. Prentiss, D., et al. (2004). Patterns of marijuana use among patients with HIV/AIDS followed in a public health care setting *Journal of AIDS*, 35,3-45.
3. Fogarty, A., et al. (2007). Marijuana as therapy for people living with HIV/AIDS: social and health aspects. *AIDS Care*, 19(2), 295-301.
4. Furler, M.D., et al. (2004). Medicinal and recreational marijuana use by patients infected with HIV. *AIDS Patient Care and STDs*, 18, 215-228.
5. National Institute on Drug Abuse (2012). *Drug Facts: Marijuana*. PDF available at: http://www.drugabuse.gov/sites/default/files/marijuana_0.pdf.
6. National Institute on Drug Abuse (2012). *Research Report Series: Marijuana Abuse*. PDF available at: <http://www.drugabuse.gov/sites/default/files/rrmarijuana.pdf>.
7. Ben Amar, M. (2006). Cannabinoids in medicine: a review of their therapeutic potential. *Journal of Ethnopharmacology*, 105, 1-25.
8. Abrams, D.I., et al. (2007). Cannabis in painful HIV-associated sensory neuropathy: a randomized placebo-controlled trial. *Neurology*, 68, 515-521.
9. Nicholas, P.K., et al. (2010). Prevalence, self-care behaviors, and self-care activities for peripheral neuropathy symptoms of HIV/AIDS. *Nursing and Health Sciences*, 12, 119-126.
10. Sidney, S. (2001). Marijuana Use in HIV-Positive and AIDS Patients: Results of an Anonymous Mail Survey. *Journal of Cannabis Therapeutics*, 1, 35-41.
11. Corless, I.B., et al. (2009). Marijuana effectiveness as an HIV Self-Care Strategy. *Clinical Nursing Research*, 18, 172-193.
12. Cristiani, S.A., et al. (2004). Marijuana use and cognitive function in HIV-infected people. *Journal of Neuropsychiatry and Clinical Neurosciences*, 16, 330-335.
13. Klinkenberg, W.D., & Sacks, S. (2004). Mental disorders and drug abuse in persons living with HIV/AIDS. *AIDS Care*, 16, s22-s42.
14. Crothers, K., et al. (2006). Increased COPD among HIV-positive compared to HIV-negative veterans. *Chest*, 130, 1326-1333.
15. Currier, J.S., et al. (2008). Epidemiological evidence for cardiovascular disease in HIV-infected patients and relationship to highly active antiretroviral therapy. *Circulation*, 118, e29-e35.

This fact sheet was prepared and reviewed by: Howard Padwa, PhD, Christine Grella, PhD, Beth Rutkowski, MPH, and Thomas Freese, PhD – Pacific Southwest Addiction Technology Transfer Center/UCLA Integrated Substance Abuse Programs; and Phil Meyer, LCSW, Maya Talisa Gil-Cantu, MPH, and Tom Donohoe, MBA – Pacific AIDS Education and Training Center/Charles Drew University of Medicine and Science/UCLA Department of Family Medicine.