

**Submission
No 108**

**INQUIRY INTO USE OF CANNABIS FOR MEDICAL
PURPOSES**

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Emeritus Professor**

25 February 2013

The Honourable Sarah Mitchell
Chair
New South Wales Legislative Assembly General Purposes Standing Committee No.4
Parliament House
Sydney NSW 2000

Dear Ms Mitchell,

Re: Inquiry into the use of cannabis for medical purposes

I am aware that the date for submissions has closed but I hope, never-the-less, that the Committee will be interested to receive the attached submission.

However, I wanted to provide evidence to the Committee of the lived experience of people from disadvantaged communities and backgrounds who struggle to manage their lives in the presence of unremitting pain and who use cannabis.

The content of the submission comes from my clinical experience in a regional/rural community drug and alcohol service, a regional public hospital and a free clinic for homeless people in Sydney. The submission also reflects experience in a drug and alcohol service in the (former) South West Sydney Area Health Service and Liverpool Hospital prior to 2010.

I wish you and the Committee well in your deliberations and I would be pleased to assist the Committee in this task.

Yours sincerely,

Ian W Webster AO

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Submission to the New South Wales Legislative Assembly General Purpose Standing Committee Inquiry into the use of cannabis for medical purposes.

Monday, February 25, 2013

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Cannabis and chronic pain: the poor man's analgesic

This submission is based on the clinical management of patients with continuing chronic pain. It is an attempt to portray the predicaments of these patients and to argue that because of their needs they turn to cannabis for symptom relief.

I am aware of the public health and epidemiological evidence about cannabis; the prevalence rates, its adverse effects and the evidence of the relationship to mental disorder(s) and physical conditions. This submission accepts that others will submit analyses and views of the wider issues not canvassed here.

As Patron of the Alcohol and other Drugs Council of Australia I support the recommendations of that Council's submission.

However, I want to add to the other evidence before the Committee the dimensions of the lived experience of people from disadvantaged communities and backgrounds who struggle to manage their lives in the presence of unremitting pain.

Purpose:

- To highlight for the Committee that, in clinical practice, it is common to encounter patients with unremitting pain who use cannabis to deal with pain, its sequelae and associated health problems.
- To propose that persons, who out of necessity and with some benefit use cannabis, need to be protected by legislation rather than being criminalised by existing law.

Context:

The environments which have generated this submission are public clinics in a regional/rural community drug and alcohol service, a regional public hospital and a free clinic for homeless people in Sydney. The submission also reflects experience in a drug and alcohol service in the (former) South West Sydney Area Health Service and Liverpool Hospital prior to 2010.

Brief case notes:

I have made snapshots of six cases, disguising their identifying characteristics. They are examples of a much greater number of patients who use cannabis in order to deal with their symptoms from medical problems.

The illustrative cases are not included in the submission as there is a remote possibility that individuals could be identified. I am willing to discuss the cases in general terms in confidence with the Committee.

Key points from the cases:

The clinical problems are complex involving – serious physical conditions, unremitting pain and disorders/disturbances in mental health. The International Association for the Study of Pain defines pain as, “ an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in such terms”.¹

The patients come from low socio-economic backgrounds and have no private health insurance and have poor access to specialist services.

The environments are where medical and mental health services are under-resourced; in which access to all level of health care are difficult. For example, relatively few general practitioners ‘bulk bill’ and the practices which do ‘bulk bill’ are overwhelmed. Continuing care of intractable problems is difficult to achieve.

Cannabis is easily available in their local communities.

Commentary:In control, not addicted

Each patient managed their drug use in order to relieve or ameliorate pain and/or the modulation of the distress, anxiety and dysphoria secondary to continuing pain. They were fully aware of the negative aspects of drug use and used cannabis sparingly.

They were seeking assistance to better manage their lives. In these patients the effects of chronic pain on day-to-day functioning and quality of life had features similar to patients diagnosed as suffering from the mental condition - depression. The principal difference being that in pain patients the suffering is attributed to a physical condition although not necessarily caused by a physical condition.

Complementary aspects of chronic pain and depression:

Listed below are features shared by patients diagnosed with depression and those experiencing unremitting pain:

- Distress – both pain and depression cause distress in a spectrum of severity.

- Duration – these conditions are long-lasting but depression may be of shorter duration. Both can fluctuate and have periods of exacerbation and remissions.
- Thoughts – there can be self deprecation, repetitive/continuing focus on symptoms and thinking of suicide. (Suicide rates are high in chronic pain as well as depression.)
- Burdensomeness – people in chronic pain and those depressed, feel they are a burden on others and on their own lives.
- Mood – in both conditions there is sadness, flat affect, feeling of emptiness and tearfulness.
- Pleasure and joy – people in chronic pain and people who are depressed do not feel 'good' about themselves and rarely feel pleasure and joy.
- Alcohol and substance use – there is a high prevalence of self medication with alcohol and other drugs, notably cannabis, in chronic pain and depression.
- Future orientation – both groups have difficulty in looking forward to future activities and worthwhile life.
- Relationships – with spouse, family members, friends and work colleagues are impaired and, conversely, others have difficulty engaging in an interactive way with persons who are depressed or in pain.
- Behaviour – there is a tendency to withdraw, to cease activities and for normal daily routines to be neglected in both conditions. There are other behavioural aspects, for example, sleep is difficult and disturbed.
- Activities of daily – living activities, as indicated above, can be affected in many ways – late rising from bed, household and other duties set aside or neglected, lack of interest in simple day-to-day activities- reading, gardening, cleaning and so on.
- Attribution – this is where there is a difference but often unclear. A person with depression can present with physical symptoms such as pain; pain in this case is usually ill-defined, often vague and changing. In the case of pain as the principal problem it is usually, but not always, located by the patient in a body region or part and for which the patient has a physical explanation. However, while pain may be attributed to a physical injury or condition, there maybe no evidence of damage or injury to and organ or tissue: the pain is real never-the-less.

A major textbook on pain says, *“The link between pain and depression, for example, is almost impossible to sort out in terms of cause and effect. Patients diagnosed with depression often report pain, and dying patients those with chronic pain often report depression.”*ⁱⁱ

Chronic pain is a common and increasing problem:

Pain is one of the commonest reasons for seeking medical care and persisting pain represents about 20% of consultations in general practice.ⁱⁱⁱ

The 2006 the South Australian Health Omnibus Report found 20% of adults reporting chronic pain and in 5% this interfered with daily activity.^{iv} A 2001 survey of NSW residents (17,543) found 17% of males and 20% of females were experiencing chronic pain.^v And an earlier study by the same researchers estimated that pain was the third most expensive area of health care after diabetes and asthma.

It has been estimated in the US that one in four people experience continuing pain interfering with normal daily activities and in two out of five pain prevents work; it is associated with high rates of distress, disability and health service utilization. A

community survey in the US found 28.8% of men and 26.6% of women were in pain at the time of contact.^{vi}

In 2011 the former Chief Medical Officer for England, Professor Sir Liam Donaldson, said that eight million Britons were in chronic pain of more than three months duration. He emphasised the extent of suffering and the high level of unmet need in people suffering from pain.

The problem of pain is likely to increase as the population ages, patients survive injuries and chronic diseases and there are more intensive and invasive surgical and medical treatments.

Self-management:

In the cases I have referred to, their decisions were rational; weighing the benefits and disbenefits of using cannabis being fully aware of its use and the consequences. They also knew, in general terms, the adverse effects of cannabis on mental and physical health.

Each patient tailored their personal use to minimise unpleasant symptoms setting this against being able to function in day-to-day living and the harmful effects of chronic pain on interpersonal relationships, mental and physical health.

Effectively the patients were self-managing a chronic relapsing health problem in much the same way as those with other chronic conditions, such as diabetes and asthma, are encouraged to do.

Confusing concepts:

Unfortunately, in the area of medical practice and science dealing with alcohol and drug problems, the terms used can be confusing and lead to inappropriate attitudes to patients and wrongful 'labeling' of their predicaments.

The phenomena of *dependence* and *addiction* to cannabis result from the interactions of the drug with the neurobiological system and to the expectations the person brings to the use of cannabis. For example, a young person in a peer group, possibly psychologically damaged from childhood trauma, or other vulnerabilities, will bring different expectations of cannabis use than a person (generally older) who is experiencing chronic pain. The person in pain is looking for relief and not for a change in mood or feelings of euphoria.

Dependence:

Dependence is not a simple diagnosis, as for example in diagnosing a physical illness - such as asthma or tuberculosis - but involves biological, behavioural and sociological elements.

Dependence is defined in the DSM IV in the following terms:

Criteria for substance dependence (DSM IV TR) Diagnostic Services Manual, American Psychiatric Association

1. The maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period.
2. Tolerance, as defined by either a need for markedly increased amounts of the substance to achieve intoxication or desired effect or a markedly diminished effect with continued use of the same amount of the substance.
3. Withdrawal, as defined by either the characteristic withdrawal syndrome for the substance or where the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
4. The substance is often taken in larger amounts or over a longer period that was intended.
5. There is a persistent desire or unsuccessful attempt to cut down or control substance use.
6. A great deal of time is spent on activities necessary to obtain the substance or to recover from its effects.
7. Social, occupational or recreational activities are given up or reduced.
8. Substance use is continued despite awareness of recurrent problems associated with use.

Two sides of dependence (and addiction):

There are two processes in train.

One is the adaptation of the neurobiological systems (neurotransmitters, pathways and receptors) to being exposed to a drug over a prolonged period of time. The adaptation leads to person becoming tolerant to continuing and increasing drug levels and when drug exposure stops – the person experiences withdrawal symptoms.

The other process involves changes in behavior and a *compulsive drive* for continued and accelerating drug use expressed in high levels of drug-seeking behavior. It is as if the brain's need for reward and pleasure is running in 'over-drive'. This is commonly known as addictive behaviour.

Cannabis in medical conditions:

Mental illness and psychosis:

It is common experience in clinical practice, supported by research studies, to encounter people with established mental illnesses who use cannabis.

For example, the survey of "People Living with Psychotic Illness" – people in the community – reported in 2012 that 63.2 % of males and 41.7 % of females were dependent on cannabis and almost the same percentages were alcohol dependent – males 58.3 % and females 38.9%.^{vii} Numbers of this kind could be reversed to document the prevalence of mental health problems in people with alcohol and drug use problems.

Unremitting pain:

Many studies show the prevalence of use of cannabis in the management of chronic pain. A study in the US reported that between 6.2 % and 39.0% of patients on prescribed opioids for pain were also on cannabis compared with 5.8% of the general US population.^{viii}

There are studies which have shown that cannabis use in pain patients can lessen the use opiate analgesics.^{ix} Also, it has been shown that cannabis can lessen dependence on other drugs of dependence with fewer adverse effects and less intense withdrawal.^x

A systematic review of double blind randomised studies of cannabis in chronic pain found cannabis was efficacious in the management of chronic pain but this had to set against the incidence of harms in perception, cognitive function and motor function.^{xi}

There are many research reports of cannabis in the relief of neuropathic pain. In a randomized control study of people with post-traumatic and post-surgical neuropathic pain the levels of pain decreased and sleep improved in proportion to the dose levels of cannabis.^{xii}

Other conditions:

Cannabis has been used to manage pain in other conditions such as chronic multiple arthritides, HIV/AIDS and cancer and in the latter instances, to assist with poor appetite and loss of weight. A UK multi-centred study in patients with multiple sclerosis showed that cannabis extract decreased pain, muscle spasticity and insomnia.^{xiii}

Failed service delivery:

There is no doubt that cannabis can cause harm. The Committee will receive many submissions to that effect.

There are two sides to the question of why people, such as those seen in clinical practice, use cannabis.

Beneficial effects on symptoms:

In addition to the personal experiences reported by patients using cannabis there is a large body of literature which indicates that components of cannabis can have beneficial effects on pain and mental distress. I have referred to some of the evidence above. This is an on-going area of research and development around the world.

Inability to access effective medical care:

Current health services are inadequate to meet the needs of all the people who experience chronic pain and its sequelae. Access to specialised pain clinics is a remote possibility for all those affected by persistent pain. But the pain problem is ubiquitous – affecting 20% and more of the population many of whom are significantly disabled – that specialised pain centres will never be answer to this ubiquitous problem.

The solution lies in creating regional networks of services capable of dealing with these health/medical problems in the environments where people live and work and strengthening the capacity of primary health care (general practitioners and others) to provide treatment, support and follow-up of these patients. A recent Australian study of access to pain clinics showed the median time from referral to being seen in a public clinic was 150 days.^{xiv} It requires a new way of planning pain services and drug and alcohol services to be delivered in the environments in which people live and work.

Summary

The problem of unremitting pain is ubiquitous and cannabis in the form of marijuana is readily available in most Australian communities. Given that the population problems of chronic pain will increase (see above) and, to this point, chronic pain is an intractable problem it is inevitable that a proportion of patients, for their own reasons, will turn to cannabis use as a way of ameliorating their suffering.

Whatever recommendations the Committee might make, the least that should happen is that persons using cannabis to deal with persistent pain should be protected within the legislation from being dealt with by the criminal justice system.

Appendix:

Snapshots of cases

Cases to be discussed in confidence with the Committee if the Committee agrees.

ⁱ www.iasp-pain.org/AM/Template.cfm accessed 24th February 2013.

ⁱⁱ Bushnell MC and Mayer EM Eds. Functional Pain Syndromes: Presentation and Pathophysiology. Page XVI International Association for the Study of Pain, 111 Queen Anne Avenue, Suite 501, Seattle, WA 98109-4955 USW.

ⁱⁱⁱ Semple TJ and Hogg MH. Waiting in pain: innovative approaches can give more Australians access to pain management. *Medical Journal of Australia*, 2012; 196(6): 372-373.

^{iv} Curnow DC, Agar M, Plummer J, *et al* Chronic pain in South Australia – population levels that interfere extremely with activities of daily living. *Aust NZJ Public Health*, 2010; 34: 232-239.

^v Blyth FM, March LM, Brnabic AJM, Jorm LR, Williamson M and Cousins M. Chronic pain in Australia. *Pain*, 2001; 8: 127-134.

^{vi} Krueger AB and Stone AA Assessment of pain: a community-based diary survey in the USA,

^{vii} *People living with psychotic illness: Report on the second national survey*. Department of Health and Ageing, Commonwealth of Australia, 2011.

^{viii} Reisfield GM, Watan AD and Jamieson RN. The prevalence and significance of cannabis use in patients prescribed chronic opioid therapy: a review of the extant literature. *Pain Medicine* 2009, Vol. 10(8) pp.1434-1441.

^{ix} Cannabis and chronic pain, *J Psychoactive Drugs* Vol 44(2) 2012pp. 125-133.

^x Reiman A, Cannabis as a substitute for alcohol and other drugs. *Harm Reduction Journal*, 2009, Vol.6, p. 35

^{xi} Martin-Sanchez E, Furukawa TA, Taylor J and Martin JL. Systematic review and meta-analysis of cannabis treatment for chronic pain. *Pain Medicine*, 2009, Vol.10(8) pp.1353-1568.

^{xii} Ware MA, Wang T, Shapiro S, Robinson A, Ducruat Huynh T, Gamsa A, Bennett GJ and Collet JP. Smoked cannabis for chronic neuropathic pain: a randomised control trial. *CMAJ* 2010 Vol.182 (14) pp. E 694-701.

^{xiii} Zapiceck JP, Hobart JC, Slade A, Barnes D and Mattison PG. *J.Neurosurg Psychiatry*, 2012 Vol.83(11), pp. 1125-35.

^{xiv} Hogg MN, Gibson S, Helou A, DeGabriele J and Farrell MJ. Waiting in pain: a systematic investigation into the provision of persistent pain services in Australia. *Medical Journal of Australia*, 2012; 196: 386-390.