Emeritus Professor Ian W Webster AO

Wednesday, 30 May 2018

Mr Tim Watling
Committee Secretary
Senate Legal and Constitutional Affairs
Parliament House
Canberra ACT 2601

Dear Mr Watling,

Thank you for the opportunity to make a submission concerning the Criminal Code and Other Legislation Amendment (Removing Commonwealth Restrictions on Cannabis) Bill 2018. A Bill for an Act to remove Commonwealth restrictions on cannabis, and related purposes.

I strongly support this Bill.

My support arises out of my experience as a physician providing primary health care and specialist services (including addiction management) in outer metropolitan areas of Sydney, in a regional/rural setting and to homeless persons in metropolitan Sydney.

My concerns about the current criminal sanctions applied to cannabis use are:

1. That already impaired persons are further disadvantaged by the risk of being criminalised when they use cannabis to manage their life problems[1], and,

2. That in attempting to treat the complex medical problems of patients using cannabis and other substances, primary health care providers (general practitioners) are at risk of jeopardising their professional standing (see footnote).[2]

I have no comments to make on **Schedules 1, 2 and 3** of the Bill.

Schedule 4 – Amendments to the Defence Force Discipline Act 1982.

The Schedule refers to 'dealing in or possession of prohibited drugs'. It is unclear whether this includes cannabis as defined earlier in the Bill.

I assume the Defence Force has recommended these amendments and is satisfied with them. Nevertheless, there is the question of equity in the response and treatment of cannabis use and/or dependence/addiction of a service person. Alcohol and drug misuse are ubiquitous in the armed services especially amongst those who have been subject to physical and psychological trauma and it is imperative that these personnel have access to the best treatments and support services available.

Schedule 5 - Amendments to the Narcotic Drugs Act 1967

I have no comment to make about the proposed amendments.

[1] See the attached submission to the New South Wales Legislative Assembly Inquiry into the Use of Cannabis for Medical Purposes, 2013 for my rationale.
[2] Webster IW Managing legal and medical complexities in caring for people with drug and alcohol problems: a call for change, *Medical Journal of Australia* 2016; 204(4):141-142.

However, in the context of the oversight of the manufacture and distribution of cannabis in Australia it would be prudent for the Australian Government to establish an independent authority with enforceable powers as set out in the Amendments to the Narcotic Drugs Act 1967. There is a significant risk, as has happened in the manufacture, supply, distribution and promotion of tobacco and alcohol, of untrammelled commercialisation and promotion of cannabis use beyond that which is beneficial in the Australian population.

In amplifying my concerns:

1. That already impaired persons are further disadvantaged by the risk of being criminalised when they use cannabis to manage their life problems, and,

2. That in attempting to treat the complex medical problems of patients using cannabis, primary health care providers (general practitioners) Are at risk of jeopardising their professional standing (see footnote).[3]

I have included below my submission to the New South Wales Legislative Assembly Inquiry into the Use of Cannabis for Medical Purposes in 2013.

The submission details the negative impact of existing cannabis legislation on patients seeking treatment. It includes brief descriptions of some patients using cannabis for relief of their symptoms and distress.

My second concern, about the difficulties experienced by medical practitioners, is described in an article in the Medical Journal of Australia in 2016. That paper accompanies this submission as a separate PDF document.

"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
Ian W Webster, Emeritus Professor of Public Health and Community Medicine, the University of New South Wales

(Minor editorial changes have been made.)

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.

[3] Webster IW Managing legal and medical complexities in caring for people with drug and alcohol problems: a call for change, *Medical Journal of Australia* 2016; 204(4):141-142.

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.

Snapshots of cases

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

Case A: 53 year old male, an armed service veteran.

Survived a parachute accident in his early 20's in which others died.
Suffering post-traumatic stress disorder with alcohol and substance abuse in the past and a current heavy smoker.
Medical problems included a heart attack and stroke.
Spends $300 per week on marihuana to deal with muscle spasticity, insomnia, anxiety and depression.

Case B: Severely incapacitated and socially marginalised 38 year old male.

Severe multiple sclerosis with unremitting neuropathic pain, spasticity and mobility restricted to the use of wheelchair.
Affairs managed by the Public Guardian.
Marihuana assists with control of pain, muscle spasms and sleep.
Unsatisfactory and frequent interactions with medical and social support systems.
Multiple medications for multiple sclerosis, pain and mental health problems.

Case C: Male aged 47 with severe neck injury.

Treated by spinal surgery - discectomy and insertion of prosthetic disc.
Permanent post-operative complications.
Continuing severe pain and neurological damage.

Pain medications – opioids, anticonvulsants and antidepressants.
Uses marijuana to control pain but it mainly helped cope with pain.

Case D: Female aged 57.

Mouth cancer treated by radical surgery with secondary complications and depression.
Severe facial and head pain.
Intolerant to opioid analgesics.
Uses marijuana for sleep and to cope.
Requested a letter of explanation should she be apprehended by the police.

Case E: Male aged 46

Multiple fractures following a road accident, "de-gloving" injury of scalp, loss of muscle and other tissue in the legs.
Continuing severe pain, physical and neurological impairments.
Depression from other personal events.
Long-term opioid analgesic treatment with problems in control; plus other medications.
Marihuana to supplement pain management, coping and help with sleep.
Apprehended by the police for possession of cannabis

Case D: Single mother aged 36.

Severe car accident with post-traumatic stress disorder and complex regional pain syndrome.
Socially marginalised and dependent on others for support.
On psychiatric medications.
Uses marihuana for pain relief and to reduce anxiety.

Key points from the listed 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".[i]

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 levels 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 in these environments.

Cannabis is readily available in the local communities.

Commentary:

In control, not addicted

Each patient managed their drug use in order to relieve or ameliorate pain and/or the modulate 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 (see IASP definition above).

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 may be 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 was 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 'labelling' 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 on abrupt cessation.

The other process, which is behavioural and sociological, involves changes in behaviour and a *compulsive drive* for continued and accelerating drug use expressed in high levels of drug-seeking behaviour. 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, multiple sclerosis, 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 – 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] There needs to be 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 marihuana is readily available in most Australian communities. Given that the population problems of chronic pain will increase and, to this time, 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.

Again, thank you for the opportunity to make this submission.

Yours sincerely,

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[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.

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[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.

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Separate attachment in PDF format: Webster IW Managing legal and medical complexities in caring for people with drug and alcohol problems: a call for change, *Medical Journal of Australia* 2016; 204(4):141-142.