Equating the dangers of cannabis and opioid use

CMCR psychiatrists proposed warning for medical cannabis users

"The Medicinal Cannabis Treatment Agreement: Providing Information to Chronic Pain Patients via a Written Document" by Barth Wilsey et al was published in the *Clinical Journal of Pain: December 2015*.

The "Agreement" has 12 "tenets," generally emphasizing the harms associated with cannabis use. Igor Grant, MD, director of the Center for Medical Cannabis Research at UC San Diego, is a co-author. He and Wilsey are colleagues in the medical school's Department of Psychiatry.

The authors state that they "borrow from concepts developed in the prescription of opioids." As if the risks posed by cannabis and opiate use were equivalent! "Regrettably," they add, "the widespread adoption of opioids was undertaken while harmful effects were minimized; obviously, no one wants to repeat this misstep."

The authors are prominent members of a US psychiatric establishment that downplayed the risks of addiction associated with opioids in the 1990s, when the drug companies were pushing opioids. And now, when the drug companies see cannabis as dangerous competition, they pledge not to downplay the risks of cannabis use!

Wilsey et al: "As more individuals gain access to this botanical product through state ballot initiatives and legislative mandate, the pain specialist is likely to be confronted (sic) by patients either seeking such treatment where permitted, or otherwise inquiring about its potential benefits and harms…"

"Although the efficacy of opioid agreements have yet to be proven, they have been endorsed by the Federation of State Medical Boards and utilized in several treatment guidelines for chronic opioid therapy." —Wilsey, et al.

The "Medicinal Cannabis Treatment Agreement" conflates the use of opiods and cannabinoids, endorses urine testing for cannabinoids as well as opioids, and provides a "confrontation" scenario:

"When prescribing opioid therapy, written informed consent via treatment agreements are implemented to minimize abuse liability. These agreements commonly specify that one prescribing physician will provide the opioids, with subsequent follow-up of efficacy, adverse events, and functional status. A corollary to the one physician rule is that controlled substance prescriptions should be filled at the same pharmacy. In addition, random urine drug screens and state prescription drug monitoring reports may be alluded to in the agreement. They are designed to help determine if the patient is taking other substances and to monitor the patient's medication use patterns. A drug screen may provide the first indication that a patient is using cannabis. Subsequently, a confrontation (sic) between the clinician and patient may ensue as to whether or not opioids should be continued concurrently with cannabis. This is probably not an uncommon event; the prevalence of cannabis use among patients prescribed chronic opioid therapy ranges from 6.2% to 39%; compared with 5.8% in the general population."

"The Medicinal Cannabis Treatment Agreement" is substantiated, ostensibly, by 109 citations. We were struck by a reference to a position paper by the Federation of State Medical Boards!

Wilsey et al wrote: "Although the efficacy of opioid agreements have yet to be proven, they have been endorsed by the Federation of State Medical Boards (105) and utilized in several treatment guidelines for chronic opioid therapy."

Here is the reference: "105. Model policy for the use of controlled substances for the treatment of pain. *J Pain Palliat Care Pharmacother. 2005; 19:73–8. [PubMed: 16061467]."*

Got that? In the absence of any studies showing that the "Agreement" pain patients sign when getting a prescription for opioids actually reduces the addiction rate, Wilsey et al cite a "model policy" being pushed by the Pharma-funded Federation of State Medical Boards!

As if you could establish a scientific fact by getting it "endorsed" in a policy statement! Facts require proof!

The authors simply had no basis whatsoever for pushing a demeaning "Treatment Agreement" on doctors who approve cannabis use by patients.

The CMCR "Treatment Agreement" in the *Journal of Clinical Pain* ends with a "Decision Tree" that helps clinicians identify patients with "Cannabis Use Disorder" and steer them to "Expert psychiatric services."

UC San Diego psychiatrist Barth Wilsey, MD

Indications of CUD include a patient "noting deleterious physical, mental or social consequences" or acknowledging use "for purposes other than response to pain levels."

Thus patients who reveal to the doctor that family members disapprove of their cannabis use, or who mention that cannabis improves their mood or their enjoyment of sex, qualify for a CUD diagnosis and "expert psychiatric services."

The Medicinal Cannabis Treatment Agreement: Providing Information to Chronic Pain Patients Through a Written Document

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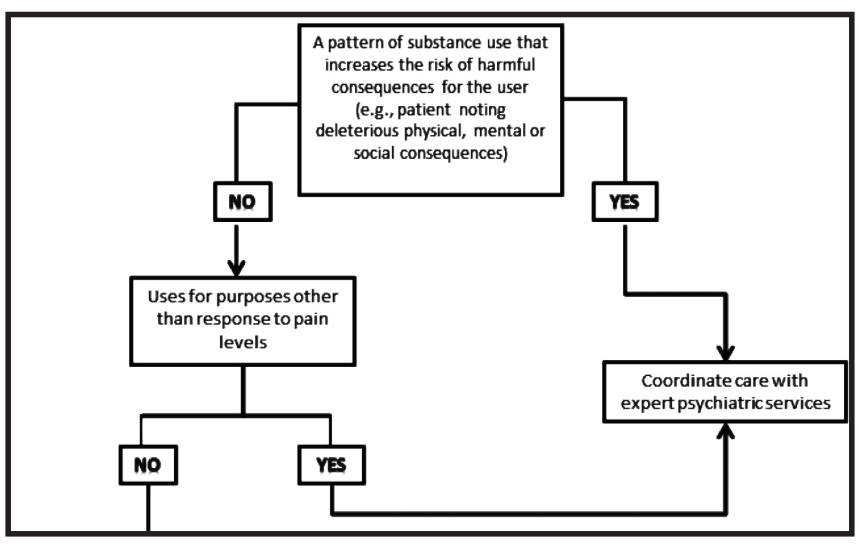
Aim: Pain practitioners would seem to have an obligation to understand and inform their patients on key issues of the evidence base on cannabinoid therapeutics. One way to fulfill this obligation might be to borrow from concepts developed in the prescription of opioids: the use of a written agreement to describe and minimize risks. Regrettably, the widespread adoption of opioids was undertaken while harmful effects were minimized; obviously, no one wants to repeat this misstep.



"Decision Tree" facilitating diagnosis of Cannabis Use Disorder by Wilsey et al.

Deconstructing 'Cannabis Use Disorder'

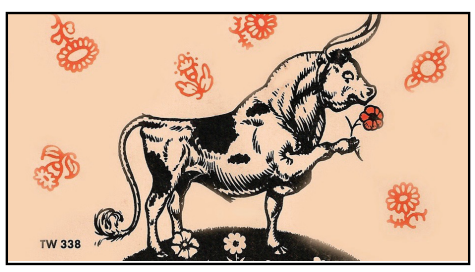
In cities and towns throughout the US there are alienated teenagers and adults living unproductive lives and staying stoned on weed. Excessive cannabis use is a response to their situations and prospects —a symptom of a disordered life, not a disorder in and of itself. So says me, an editor trying to apply accurate terminology.

The Diagnostic and Statistical Manual of the American Psychiatric Association — known as "The Bible" of the profession— says otherwise.

The *DSM* has a double purpose: it endows the field of Psychiatry with a facade of rigor and it facilitates billing.

The *DSM* defines and assigns a number to every ailment of the mind and spirit for which psychotherapists provide treatment, physicians prescråibe medication, and insurance companies reimburse.

The first *DSM*, published in 1952, listed 106 disorders. By increasing the number of disorders and the broadness of the definitions over the years, the *DSM* authors —establishment psychiatrists with drug-company funding— have increased the number of Americans who qualify for prescription drugs (and, fortuitously, for medical marijuana).



"Cannabis Abuse" is one of many conditions defined by the *DSM* under "Substance Related and Addictive Disorders." The other substances said to give rise to "addictive disorders" are alcohol, caffeine, hallucinogens (phencyclicine and others), inhalants, opioids, sedatives (hypnotics or analgesics), stimulants, and tobacco.

DSM-V says, "The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance." Nine such behaviors are listed. They are listed below, with our retro messages in **boldface:**

"Criterion 1: The individual may take the substance in larger amounts or over a longer period than was originally intended."

• If you try marijuana and find that it agrees with you, you may use it more than originally intended. How is that evidence of pathology?

"Criterion 2: The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use."

• If a parent (or boss, counselor, or other authority figure) says marijuana is dangerous and you must stop using it, you may promise to stop. But when you're among friends you're reminded that it's harmless (and even helpful), so you resume. According to the psychiatrists' Bible, that is evidence of *pathology.* But it's actually evidence of *disobedience* to the authority figuresE who pressured you to stop.

"Criterion 3: The individual may spend a great deal of time obtaining the substance."

• That is a direct result of prohibition.

"Criterion 4: Craving is manifested by an intense desire or urge for the drug… more likely when in an environment where the drug previously was obtained or used."

• The craving for cannabinoids is never "intense" compared to the craving for cigarettes or opiates. And it's obvious you'll be craving more when you're around people who are indulging. Duh.

"Criterion 5: Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home."

• This makes sense if the failure to fulfill is due to impairment, but it's often due to punishment.

"Criterion 6: The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance."

• Meaning: if people who disapprove of your cannabis use snub you, it's your fault and evidence of pathology.

"Criterion 7: Important social, occupational, or recreational activities may be given up or reduced because of substance use."

• Who decides that a given extra-curricular is "important?" Not the patient, obviously. Some people are like Ferdinand the Bull, they'd rather smell the flowers than play football.

"Criterion 8: Recurrent substance use in situations in which it is physically hazardous."

• Definitely a sign of stupidity.

"Criterion 9: The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance."

• A drug can exacerbate a problem *and* produce benefit. Say a patient has chronic bronchitis, PTSD, and insomnia. They have a nightmare and wake up in a sweat. They take a few puffs of myrcene-rich marijuana, which can exacerbate bronchitis, but restores equanimity and makes sleep possible. A reasonable choice or evidence of pathology?

These psychiatrists play fast and loose with the language. *—The managing editor*