Scottish Cross Party Group on Medicinal Cannabis

27th April 2022 (virtual)

Convener: Pauline McNeil MSP, Rona McKay MSP

Deputy Convener: Oliver Mundell, MSP

https://www.parliament.scot/get-involved/cross-party-groups/current-and-previous-cross-party-groups/2021/medicinal-cannabis

THEME: Education around Cannabis Based Medicine

Apologies:

1. Councillor Monique McAdams
2. Gillian Flood – member of PLEA

Present:

Members of Parliament

3. Pauline McNeill (MSP)
4. Beatrice Wishart (MSP)
5. Oliver Mundell (MSP)
6. Rona Mackay (MSP)
7. Collette Stevenson (MSP)
8. Ronnie Cowan (MP)

Scottish Government/Parliament/Local Councillors/Police Scotland

9. Councillor Ben Lawrie – Spokesperson for the Drugs Emergency, Scottish Lib Dems
10. Kate Spence –Scottish Parliament
11. Alison Strath – Chief Pharmaceutical Officer
12. Acting Assistant Chief for Lothian Constable Emma Pond – Police Scotland

Patients and public

13. Simon Erridge
14. Olsson Fabian
15. David Johnstone
16. Marc Landers

Clinics/Industry

17. Kirsty M - CanCard
18. Kyle Esplin– Holistic Highland Hemp, Chair of the Scottish Hemp Association
19. Elisabetta Faenza – LeafCann
20. Harry Thurston Smith – Jazz Pharmaceuticals (owners of G.W. Pharmaceuticals)

Organisations & Academics

21. David Johnston – Scottish sub-group Patient Led Engagement and Access (PLEA)
22. Kayleigh Ross – Scottish sub-group Patient Led Engagement and Access (PLEA)
23. Lucy Troup – University of the West of Scotland, The Scottish Cannabis Consortium
24. Dr Anna Ross – The University of Edinburgh, The Scottish Cannabis Consortium
25. Linda Hendry – Community campaigner/Legalise Cannabis Scotland
26. Lisa Quarrell – The Scottish Cannabis Consortium
27. Fiona Gilbertson – Recovering Justice

Journalists

28. Sarah Sinclair – Cannabis Health News
29. Beata Ciesluk

Speakers

- Professor Roger Pertwee – The University of Aberdeen
- Rayyan Zahar – Imperial College London & Drug Science
- Dr Lucy Troup – The University of the West of Scotland and Sapphire Medical Clinic

Agenda

ACTIONs

- MSPs have a chat offline to see whether it would be good to meet with the ACC so there is a universal approach to the policing of medical cannabis.
- Alison Strath and the Medicines team will be developing guidance on what is needed to provide evidence of legal prescription.

Standing Items

- NHS Funding of Cannabis-Based Medicines
    - Coles Campaign for Bedrolite to be available through NHS funding, or other government funding:
        - Motion has been submitted by MSP Collette Stevenson in the Scottish Parliament.
        - Debate due on **1st June 2022**.
        - Link to recording: https://www.scottishparliament.tv/meeting/members-business-s6m-03233-collette-stevenson-access-to-cannabis-based-products-for-medicinal-use-june-1-2022

    - Setting up a Scottish Government compassionate scheme to fill the gap between Scottish Government funding and NHS prescription
        - no further movement on this
- Policing of Cannabis-Based Medicines
    - A further patient has been charged with cannabis possession despite producing a prescription. Case is now at the Procurator Fiscal's Office.
    - Police Scotland have included ACC Emma Bond and will make it a priority to ensure that all Police Scotland officers are aware of the medical cannabis prescription policy.
    - ACC Emma Bond to clarify what evidence is needed
        - Digital or paper copy of prescription + valid proof of ID matching the prescription, or
        - Digital or paper copy of prescription + valid proof and ID matching the prescription AND the cannabis must be in its original packing.

Matters arising from previous minutes

Engagement with Health Directorate:

- Letter to the Chief Medical Officer requesting his attendance had been sent, and response was he would not attend, and did not give dates that would work for his department.

Policing of cannabis:

- Counsellor Ben Lawrie had asked if there would be any session on educating the police as it was an important aspect due to the harm being done to patients being arrested for possession of legal cannabis prescriptions – see further discussion below on more about policing, and we have now added this as a standing item on the agenda.

Presentations:

Professor Robert Pertwee of Aberdeen University

Roger Pertwee MA, D.Phil. DSc. (Oxford) is an Emeritus Professor at the University of Aberdeen. He is also an Honorary Fellow of the British Pharmacological Society (BPS), has served as President (twice) of the International Cannabinoid Research Society (ICRS) and as Chairman of the International Association for Cannabinoid Medicines (IACM), and is on the IACM (and ICRS) Board of Directors.

Prof. Pertwee's research has focused mainly on the pharmacology and therapeutic potential of cannabinoids. His research achievements include the joint discovery of delta-9-tetrahydrocannabivarin in cannabis, and of endocannabinoids, the discovery of a CB_1 receptor allosteric site, and significant contributions to the pharmacological characterization of phytocannabinoids and notable synthetic cannabinoids.

Professor Pertwee gave us an overview of the historical uses of cannabis, making a strong point that as a medicine it has been used for thousands of years, and was

prescribed as a painkiller up until 1974. No real reason why it was stopped being prescribed except the prohibitive Misuse of Drugs Act that discouraged prescribing.

It has been used in religious ceremonies, socially and recreationally, as a medicine. Ailments that is was commonly used for included. Importantly a source of 'phytocannabinoids', a very important for regulation of the body:

- Swelling, bruises, pain (local application)
- Toothache, headache, pain from minor surgery
- Arthritis, rheumatic, menstrual and labour pain
- Anti-emesis, appetite stimulant
- Insomnia, fever
- Bronchitis, asthma, coughs
- Symptoms of dysentery and cholera (diarrhoea)

Source: Mechoulam R. (1986) in: Mechoulam R. (ed). Cannabinoids as Therapeutic Agents, pp.1-19/ CRC Press.

Cannabis is a unique source of phytocannabinoids – very important for body regulation.

Approved therapeutic uses of cannabinoids since 1986

- Synthetic TCH 'drobinol' (brand name Marinol©)
- Synthetic analogue of THC 'Nabilone'
- Cannabis in alcohol – THC and cannabidiol
- Epiodylex
- Sativex – return of non-synthetic cannabis since mid-1970s.
- Cannabidoil oil drops – Wee Hemp Company (legal but not approved)

Complexity when dealing with medicine where some of it is legal, and others bit of it are not.

RG discussed how he used tincture of cannabis in his research up until the mid 1970's until it was removed from the formulary. He speculates it was to do with fears over recreational use.

Sativex – anecdotal evidence surrounding the use of cannabis to treat epilepsy resulted in a change in the law which showed the efficacy. RG told a story about how when Claire Hodges came out about using cannabis to treat her multiple sclerosis, it resulted in a group of scientists (including Professor Pertwee) to develop an Anecdotal Evidence (ACT) trial. It involved contacting patients in this country who took cannabis for MS, and they published a paper on the effectiveness. They found that cannabis appeared to be effective for:

- Spasticity
- Spasms
- Pain
- improved quality of sleep

Prompted the search for clinical trials which was supported by the British Medical Association. There followed a series of reports that Professor Pertwee was involved in on the topic of cannabis and MS, all recommending more research trials or conducting pre-clinical trials:

- British Medical Association Report – 1997
- House of Lords Select Committee on Science and Technology report – 1997
- Input from the Royal Pharmaceutical Society Working Group and the Medical Research Council - 1998
- British Government written response (in favour) – 1999
- Clinical trials start

Back to front – started with anecdotal, then onto pre-clinical trials, then clinical trials.

Important to stress: THC has a unique pharmacological profile which means it differs from other drugs that can active CB1 and 2 receptors – same applies to phytocabbiniods

- THC and CBD work together - Important is that they have opposing effects.
- Different uses for synthetics and whole plant cannabidiol
- Some potential therapeutic benefits including nausea from cancer
- CBD acid is a precursor to cannibidiol, synthetic cannabidiol is more stable.
- CBD has an anti-anxiety effects
- Cannabis has lots of application including potentially anti-inflammatory
- Adverse effects not that important
- Benefit ratio is important and in weighing up adverse effects
- Synthetics could help with the endocanniod system
- Synthetics may be toxic – for example renanodoid, had to be removed because patients who took it became suicidal – some designer drugs that act like THC but are not.

Rona thanks Roger and moved onto the other speakers but

Rayyan Zahhar from Imperial College London

Rayyan Zafar is a Medical Research Council PhD student studying at Imperial College London in the centre for Neuropsychopharmacology under the supervision of Professor David Nutt. His PhD focuses on the application of multi-modal neuroimaging to understand addictions such as gambling and alcoholism. Mr Zafar has a keen interest in psychopharmacology, in particular how addictions could be treated with psychedelics. Additionally, his current research with Drug Science focuses on medical cannabis and its clinical applications, together with Dr Anne Schlag and Prof David Nutt.

Rayyan gave us an overview of some of the work being done at drug science and a brief history

- Legal challenge to NICE by family and said that guidance is restricted – NICE came back and said that there is no recommendations to not prescribe, which

is important for clinicians going forward. Instead they set out the following recommendations:
    - Chemotherapy induced nausea and vomiting – recommended Nabilone
    - Spasticity from Multiple Sclerosis – THC/CB spray (Sativex)
    - Severe treatment resistant Epilepsy – CBD Epidiolex
- Cannabis research largely stopped in the field after the 71 Act, - 400 research projects in 1971 so nowhere near there yet
- Cost is an important barrier to access.
- Last 3 years there is only 3 NHS prescriptions, so House of Lords event, set up by Drug Science in March 2022 was to urge this to be addressed quickly, deadlock has gone on far too long.

Epilepsy and cannabis trial [https://www.drugscience.org.uk/medical-cannabis-for-severe-treatment-resistant-epilepsy-in-children-a-case-series-of-10-patients/]

Drug Science conducting qualitative data to assess the effectiveness of cannabis-based medicines for children with treatment resistant epilepsy. 3 different data sets – important to say this is retrospective analysis, not clinical trials, but collected oral data – difference is that it is not a randomised controlled trial (RCT) and was not in a controlled environment

<u>Data set#1: Qualitative interview Findings</u>

- A reduction in seizures – 84%reduction across cohort (whole plant products not synthetic) – FDA epilepsy results was 50%, and similar in other drugs. Difficult to compare like for like but very significant results.
- **Private prescription in the UK costing around £1700 per month (£20,400 per year)**. Families looking after sick children and are in poverty (losing home, losing jobs because needing to look after children).
- **Same private cannabis in Netherland cost around £7000 per year – reduction in cost result of less red tape.**
- **Black market cannabis for same amount costs around £3000 per year.**
- Therefore an incentive to buy from black market.
- ICU – many children in ICU, costs around 5000 a day, and freedom of information is costs around 34000 for a cannabis treatment for the whole year.

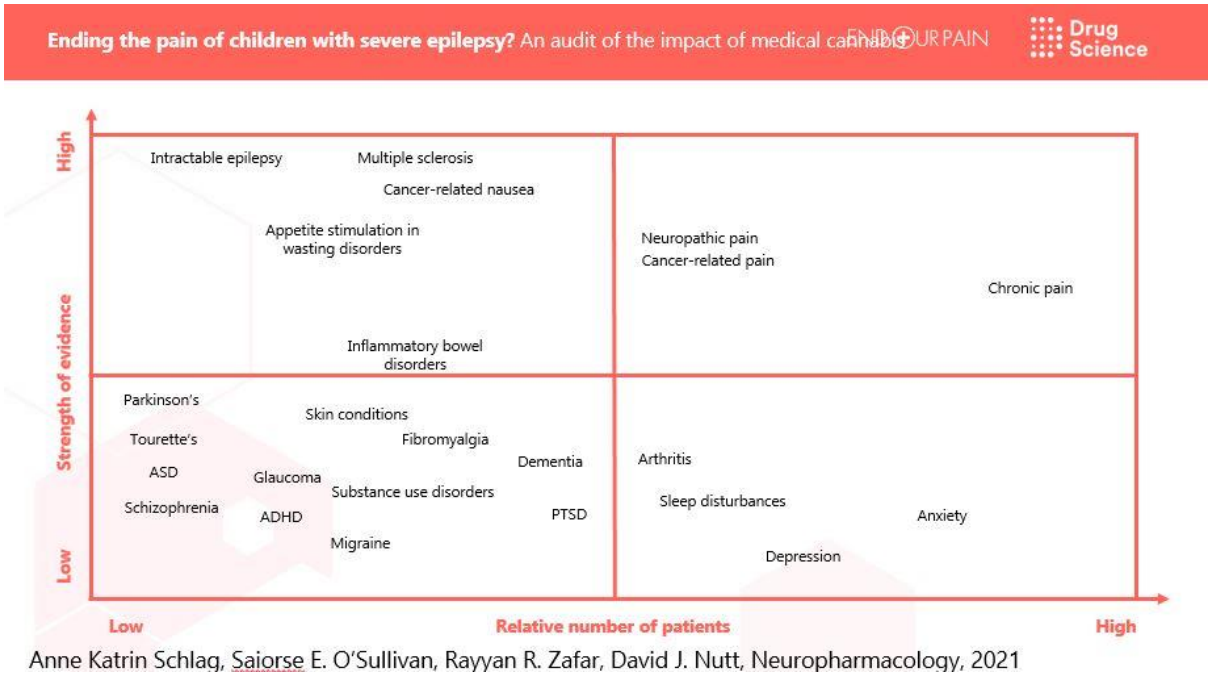
If we can drive the cost down of prescription, then we can widen access

Dataset#2: Data registry

- prescription of medical cannabis – recruited 2400 patients across a range of conditions –discuss
- Characterises many using 2 products and flowers with an average age range of 39 years old
- Perhaps vs an RCT conflict between what is feasible in clinical trial, and what is the real-world use. Very hard to translate clinical trial data into real world.
- Cannabis use improved in the 3 month period, overall well-being measure, and lokat the effect size, and here we see an effect size 2x greater at least that anti-depressants.

Dataset#3: triangulated analysis using clinical case studies, data registry and Delphi technique.

- Clinical case studies and data registry, and pulled together with clinical data
- Used a Delphi technique
- Chronic pain: there is a medium to high level of evidence with a lot of potential patients
- Box shows the level of evidence – all conditions have some evidence supporting the use of cannabis to treat, but some conditions have a higher amount of supporting evidence.



Anne Katrin Schlag, Saiorse E. O'Sullivan, Rayyan R. Zafar, David J. Nutt, Neuropharmacology, 2021

The question is: how can we get more evidence in the lower 2 boxes, and build evidence base of those conditions?

Difficult to get large pharmaceutical companies to have an interest to fund trials, plus real world evidence.

<u>Key issues to overcome</u>

Resistance: myths surrounding cannabis resulting from lack of engagement with the actual evidence. For example: thalidomide was given to children in the 1960's, and Chris Whitty is scared of that. BUT – moral panic. No evidence to support that opinion yet it continues to be a major barrier to increasing prescribing.

Institutional Guidelines: British Paediatric Neurological Society (BPNA) state there no is evidence of efficacy of whole plant: but simply ignoring the evidence from around the world, plus UK evidence published in peer reviewed journal.

Therefore, it's not just about lack of evidence, institutional barriers too.

Randomised Controlled Trials (RCT's) – Sir Michael Rawlins: RCT's are not the apex of treatment trains. RCT's are expensive, unethical because of placebo: withholding treatment can result in death, plus does not work for co-morbidities and therefore they are not eligible for clinical trials. For example, CBD they looked at 2 very rare forms of epilepsy, but most patients have undisclosed conditions, no way to patent whole plant product because of so many compounds therefore no incentive to research because not possible to patent.

See further:

Why medical cannabis is still out of patients' reach—an essay by David Nutt
BMJ 2019; 365 doi: https://doi.org/10.1136/bmj.l1903 (Published 01 May 2019)Cite this as: *BMJ* 2019;365:1903

Nutt D, Bazire S, Phillips LD*, et al.* **So near yet so far: why won't the UK prescribe medical cannabis?** *BMJ Open* 2020;**10:**e038687. doi: 10.1136/bmjopen-2020-038687

Importantly there is sufficient evidence for prescription of whole-plant products to be supplied via the NHS where clinically appropriate – for example Childhood intractable Epilepsy.

Rona thanked Rayyan

Dr Lucy Troup, Reader in Psychology at the University of the West of Scotland

Dr Lucy Troup CPsychol is currently Reader in Psychology at the University of the West of Scotland. Dr Troupe does research in Clinical and Cognitive Neuroscience and Biological Psychology. The focus of her lab's research centres on the effects of cannabis on emotion processing. As well as traditional academic research, Dr Troupe has extensive relationships with the use of cannabis in Colorado, the first US state to legalize cannabis for recreational use.

Dr Troup has advised policy makers, educational leaders, medical professionals and the cannabis industry. She has published both in academic journals and in many other media outlets including news articles, television and radio. The emphasis of her approach is stressing the importance of developing fact-based scientific support for arguments for and against cannabis exposure.

Dr Troup presented the patient experience data from the cannabis clinic, Sapphire, as well as spoke to evidential requirements from the perspective of the US, where she lived and worked in Colorado during the implementation of a legal cannabis market. What the Sapphire research has tried to do is focus back on the patient perspective of the current state of medical cannabis

Lucy's area is primary brain imaging and current working imperial college and how we can use medical cannabis and understand it.

Cannabis is an incredibly complex compound and important to get the head around the good, the bad and the ugly aspects of cannabis.

Difficult to research because of the way it is used – difficult to separate from the medical and recreational. In the US it is not like that. In the US private doctor provides a prescription but you get the cannabis from commercial market. January this year in Colorado doctors now need to state the level of thc in prescription. Very different model to how it is used over here.

In the US there were only 13 licences for cannabis grow, and cannabis had to be bought by government labs – just very different science. Very difficult to separate recreational and medical because often people are often self-medicating, plus over 21's can grow their own. Self-medication or prescription

Stigma around cannabis

- The UK has a lack of understanding around the lack of education around cannabis, extremes between knowing a lot or knowing nothing.
- Stigma research, started with undergrads exploring the patient experience of stigma
- Lots of medicine are also reactional drugs – why can we accept medicines are recreation but not recreation as medicine?
- Why is it that it is so difficult for Lisa to get an NHS prescription for her son? Every time a child has a seizure they are damaging their brain, therefore the argument that cannabis medicine may have an impact on the developing brain (which has next to no evidence supporting it) is not valid. Not giving cannabis-based medicines is in fact resulting in permanent brain damage.
- A huge amount of perceived stigma from legally prescribed cannabis
- There is an issue around the kinds of specific stigma around the criminal justice system and institutional agencies, but feel concern about discussing it with people who maybe have a negative impact on their lives, for example benefits, job, police
- But patients are happy to discuss with friends and family, but it becomes a problem when they want to think about it outside a close relationship.
- How do we take a sensible approach - we need to understand the patient perspective

Both speakers spoke about the lack of understanding in the medical model of people who should be supporting this, and historically this goes back to the foundations of the DEA and how the narrative of cannabis was put out there and was racist.

If you look at the number of off-label prescribing it is quite interesting because there is a very significant level off this kind of prescribing. BUT importantly not for off-label cannabis.

If we bring recreational and medical together we can overcome the stigma because stigma is based on the idea that using cannabis for pleasure is somehow wrong.

More data on the relationship between recreational and medical use is coming from the current data set, qualitative data on stigma and effectiveness.

Medical model does not really fit.

Lisa Quarrell:

Update form Lisa- everything is doing good – good news is we have a lot of funding. Where we are with SG and NHS, debate is happening but no date (now passed). Looking at getting an ethical second opinion – if we take cannabis out of it then he would be prescribed it. Are they doing what is best for Cole? No.

Question for Rayyan – does NICE cover Scotland

Answer – very difficult to understand the impact of clinical guidance – it is ultimately the consultant's decision, and that is the difficult thing, trying to convince doctors that they have the power. It is unfortunate and more than happy to help.

Kyle Esplin

Roger Pertwee – from your prior 1974 research what was the source of the cannabis? Answer, a British company that produced it was used for pain relief and in fact my wife used to give it to patients as she was a nurse

Cllr Ben Lawrie

Roger Pertwee's presentation but open question. One of the conditions was opioid dependence, curious if CBM has a role to play in reducing heroin use.

Answer

Lucy – research is weak and not promising but interesting because the science shows us it interacts, so more about the quality of research. Anecdotal evidence is that heroin users will use cannabis to withdraw from heroin.

Roger – some pre-clinical evidence for cannibidiol, some evidence that cannabis is opioid sparing and therefore can be given alongside opioid.

Rayyan – data from t21, lots of patients using opioid medication for chronic pain, 44% of patients reduced opioid medications by 50% after taking cannabis products.

Collette Stevens

Put forward a motion for Lisa, problem is they are putting new ones first, so taking a bit longer, and data from tonight would really help in the motion. How can I get the information on that?

Anna Ross (Scottish Cannabis Consortium)

Contacted by a patient who had been arrested and charged with cannabis possession despite being only in possession of 2 grams of cannabis (a minor offence so should not have been charged) and having a valid prescription (evidence of medical cannabis therefore should not have been charged).

Despite Anna and colleagues contacting Police Scotland, and the patient's prescriber forwarding the evidence of prescription to the police in charge, the case was still sent to the procurator fiscal to be prosecuted.

This goes against everything we are being told by Police Scotland: namely they are not interested in policing cannabis, only interested in organised crime and will therefore not pursue medical patients.

We have been informed that medical cannabis is now part of the policy surrounding all prescription drugs.

Although Police Scotland have been *reactive* to the situation, we are very disappointed that they have not been *proactive* in making sure all their officers are aware of the change in policy, and are aware that they are not expected to police medical cannabis. Still appear to be using cannabis as low hanging fruit for policing targets.

Deputy Assistant Chief Constable Emma Bond: Police Scotland response

- Prevention Partnerships and Community portfolio
- It is not in any bodies interested, not least Police Scotland's, to be arresting or detaining medical cannabis users.
- This incident was around the ability to prove eligibility to lawful possession
- Assurance that we will endeavour to not have this again.
- Collectively will ensure that those who are entitled to medical cannabis have the required evidence.

Kirsty from Cancard

Been involved in Police Scotland's stigma training. Had really good feedback from Police Scotland on the issue.

Anna Ross: But the response we got was that it has gone to the procurator fiscal. How do we get the PF to drop the case? The reality is we have a non-crime here that has been processed as if it was a crime. The result – a patient living in fear about the potential repercussions.

IMPORTANT – impact on patients while police bed in the process is not acceptable.

Marc Landers- what do I need to carry in order make sure I am not stopped and charged with possession of cannabis.

Emma Bond Police Scotland answer – not 100% clear what the evidence proof is. However, probably proof of identity plus the online prescription, and not having an amount that is greater than your prescription.

Kayleigh (PLEA) – has been asked for a copy of prescription, cannabis in original container and vapourising devise.

Kirsty – key point of vapourisation is that the devise is a key indicator of medical use. It is illegal for people to smoke medical cannabis with tobacco.

Alison Strath - Valid prescription is what is required as proof. The only thing needed in order to provide evidence of legality. SG are going to do some work with information bodies to get some information out because lack of knowledge and understanding.

Pauline – MSPs have a chat offline to see whether it would be good to meet with the ACC so there is a universal approach to the policing of medical cannabis.

Everyone thanked.