Medical marijuana and psychiatric conditions

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Even though about 30% of medical marijuana patients in California use it for depression and other psychiatric conditions, no other state has approved the use of cannabis for depression.

Of the thirteen states that have medical marijuana laws, all but California require a state board to approve the use of cannabis for conditions not on the short-list explicitly written into each state's law, except Vermont and Maine which have no provision for adding conditions. This short list is fairly standard and is composed exclusively of physical complaints: cachexia, cancer, nausea, glaucoma, pain, seizures (epilepsy), and spasms (Chron's disease, multiple sclerosis).

Psychiatric conditions never make the short list.

Michigan, Nevada, New Mexico, Oregon, and Rhode Island allow the use of cannabis for Alzheimer's rage. New Mexico allows the use of cannabis for Post Traumatic Stress Disorder (PTSD). Evidently, Rhode Island has one legal autistic medical cannabis patient. Washington's state board has denied approval of cannabis for anxiety and depression.

Colorado, Oregon, and Rhode Island provide numbers on their web sites of the relative or absolute number of people using cannabis for various conditions. Glaucoma is 1% in Colorado and 2% in Oregon and Rhode Island. Cachexia is 2% in Colorado and 3% in Oregon. Cancer is 3% in Colorado, 4% in Oregon, and 12% in Rhode Island. Seizure is 4% in Colorado and 3% in Oregon. HIV/AIDS is 2% in Colorado, 2% in Oregon, and 13% in Rhode Island. All of these are short-list conditions.

The case for the use of cannabis for psychiatric conditions

Dr. Tod Mikuriya was probably the foremost proponent of cannabis for psychiatric conditions, though he was hardly alone. Dr. Jay Cavanaugh PhD (California board of pharmacy 1980-90), Dr. Lester Grinspoon (Associate Professor of Psychiatry emeritus, Harvard Medical School), Dr. Phillip Leveque, Dr. Frank Lucido, Dr. David Bearman, Dr. Philip A. Denney, Dr. Robert Sterner, and many others have risked their careers to take a stand for the use of cannabis for psychiatric conditions.

Dr. Mikuriya puts the psychotherapeutic use of cannabis first in his discussion of the Medical Uses of Cannabis: *"Cannabis appears to be effective both adjunctively and alone in bipolar disorders (296.6) by decreasing affectual overreactivity., In schizoaffective disorder (295.70), dysthymic disorder (300.4), and major depression (296.3) cannabis appears to lessen feelings of alienation and blocking of ideation. In any disorder cannabis' sedative properties help with problems of insomnia (307.42).*

"Posttraumatic stress disorders (309.81) are particularly helped by cannabis which afford control of symptoms more effectively than other psychotherapeutic agents because of the absence of incapacitating or debilitating side effects. The modulation of mood response prevents or significantly decreases the symptoms of anxiety attacks, mood swings, and insomnia."

Dr. Mikuriya states that cannabis is particularly effective for PTSD because it modulates emotional responsivity and restores sleep, relieving insomnia (307.42) and ameliorating nightmares and other sleep dysfunctions (307.47). He states further that PTSD is worsened by alcohol, stimulants, and Selective Serotonin Re-uptake Inhibitors (SSRIs).

The United States Department of Veterans Affairs recommends SSRIs for PTSD.

Dr. Mikuriya reported April 2000 that a survey of 3,000 patients in California from 1993-2000 revealed about 27% used it primarily for psychiatric conditions. The breakdown by category was as follows:

analgesic immunomoduolator	1,316
antispasmodic/anticonvulsant	680
appetite stimulant	31
harm-reduction/substitute	126
psychotherapeutic	847

Of those 847 using cannabis as a psychotherapeutic, 44% (369) used it as an anti-depressant while 56% (478) used it as an anxiolytic. Of the 847, 36% used it for depression, 31% for PTSD, 17% for anxiety, and 8% for bi-polar condition. From the total pool of 3,000 medical marijuana patients this works out to: 10% for depression, 9% for PTSD, 5% for anxiety, 2% for bi-polar, and 2% for other psychiatric conditions.

More recently Fred Gardner reported a survey of California doctors revealed 30% of their patients use it for depression and other psychiatric conditions with between 3% and 5% of them using it for PTSD. Dr. Mikuriya reported 8% of his patients used marijuana primarily for PTSD.

Ed Glick attempts to get psychiatric conditions approved in Oregon

In 2000, Oregon's Debilitating Medical Conditions Advisory Panel considered applications to add schizophrenia, schizo-affective disorder, bipolar disorder, anxiety with depression, post traumatic stress disorder, insomnia with anxiety, agitation associated with Alzheimer's disease, and attention deficit disorder to the conditions for which patients in Oregon may use marijuana. The panel rejected all but Alzheimer's rage.

Ed Glick, a nurse of 25 years, was a member of the panel. He says it wasn't long after Oregon passed it's medical marijuana act that he began meeting patients where he worked as an acute care mental health nurse at Good Samaritan Regional Medical Center in Corvallis who were reporting they were self-medicating with cannabis for a variety of mental-health symptoms. He says when he began volunteering at the Compassion Center (a volunteer medical facility that helps assist patients with education, support and registration into the medical marijuana program) he began to see these same patients seeking cannabis recommendations for psychiatric conditions.

He says he began to assist these people by trying to find a physical correlation to their psychiatric symptoms; a physical complaint that would qualify them under Oregon's law so they could use cannabis to treat their psychiatric conditions. In an effort to determine how many of Oregon's legal medical marijuana patients were using cannabis to treat psychiatric symptoms he surveyed 172 charts, of which 95% were registered to use cannabis for pain. Of these, 40% had multiple qualifying conditions that did not include psychiatric conditions.

Ed states 64% of the patients in the survey showed some sort of significant psychiatric benefit: 39% reported insomnia relief, 5% reported PTSD relief, 11% reported anxiety relief, 11% reported depression relief. Additionally, 15% reported they used cannabis to reduce the side-effects of pharmaceuticals and 56% reported they used cannabis to reduce or eliminate pharmaceuticals.

In January of 2006, five years after the panel had refused to approve the use of cannabis for any psychiatric condition other than Alzheimer's rage, Ed petitioned the Oregon Medical Marijuana Program (OMMP) Advisory Committee on Medical Marijuana (ACMM) to revisit the issue of marijuana for depression, anxiety, severe agitation, and post traumatic-stress disorder. He submitted his survey to support his petition. The panel rejected his request with a "summary denial".

A Portland attorney, Lee Berger, offered to sue the Oregon Department of Human Services and a formal request for judicial review was filed in February. Ed announced that Oregon had agreed to revisit the question of cannabis for psychiatric conditions on 8 Apr 2006 at the Fourth National Clinical Conference on Cannabis Therapeutics sponsored by *Patients Out of Time*. Fred Gardner reports that 10 days later Ed was fired from his job at Good Samaritan Regional Medical Center where he had worked for 15 years as an acute care psychiatric nurse.

The petition Ed filed is recorded in the minutes for the January 26, 2009 meeting. Interestingly, these are the only minutes available on the website for Oregon's medical marijuana program. Nothing more about this has been found, except that the next meeting of the Advisory Committee is scheduled for 14 Sep 2009, 10:00am-2:30pm, Portland State Office Building, 800 NE Oregon Street, Conference Room 1E, Portland, Oregon.

Pharmaceuticals, as prescribed, are the 4th leading cause of death in America.

In 1998 *The Journal of The American Medical Association* published a study which announced that pharmaceuticals, as prescribed, were the fourth leading cause of death in America. Every year prescription drugs kill more Americans than died in the entire Viet Nam war.

Keep in mind, when it comes to the damage done, deaths are just the tip of the iceberg. It is estimated that each year pharmaceuticals, as prescribed, have injured 1.5 million Americans to the point that they required hospitalization. According to the *Journal of The American Medical Association*, each year 2.2 million Americans suffer serious reactions and permanent disability from pharmaceuticals taken as prescribed. We're not talking about overdose here, accidental or otherwise.

More recently, *Marijuana ProCon* used the Freedom of Information Act to require the FDA to provide information regarding the adverse event reports of marijuana and 17 FDA-approved drugs. Their survey covers the period from 1997-2005 and consists of physician reports of "adverse events" and includes their designation of the "primary suspect". The 17 pharmaceuticals fell into four categories: anti-emetics, anti-spasmodics, anti-psychotics, and other popular drugs. Of 10,008 deaths counted, 16% (1,593) were designated anti-psychotics (haldol, lithium, neurontin) and 81% (8,101) other (ritalin, wellbutrin, adderall, viagra, vioxx). In 97% (9,694) of deaths suspected to be "adverse events" the "primary suspect" was from these two categories. Marijuana was not a primary suspect for any adverse event.

Keep in mind this survey does not include deaths suspected to be adverse drug reactions from any of the SSRIs or their cousins the SNRIs (Serotonin-norepinephrene reuptake inhibitors). Neither Prozac, Paxil, Zoloft, or Effexor were included.

The pills don't work

In 2003 *BBC News* reported that "Allen Roses, of GlaxoSmithKline, is quoted in a national newspaper as saying more than 90% of drugs only work in 30-50% of people." He said cancer drugs work 25% of the time, Alzheimer's 30%, and many others only 50%.

This past February *The Guardian* reported that Prozac, used by 40 million people, doesn't work say scientists. This is not exactly new news. This fact was first brought to light 14 years ago in an article entitled Talking back to Prozac by Peter and Ginger Briggen published in

Psychology Today on 1 Jul 1994 and echoed by *The Washington Post* on 7 May 2002 in the article Against depression a sugar pill is hard to beat.

The 1994 *Psychology Today* article stated:

Contrary to widespread public belief, the FDA does not conduct any of the studies used for drug approval; they are financed, constructed, and supervised by drug companies using doctors they hire. While it may take a decade for a drug to get through the FDA bureaucracy, the actual controlled scientific studies last--as in the case of Prozac--just four to six weeks. Anecdotal material is collected on longer-term patients, but for Prozac, only 63 patients were followed for more than two years before the drug's approval.

For starters, seriously suicidal patients and hospitalized patients were excluded. Of the included patients, many were allowed to take sedatives and minor tranquilizers to overcome Prozac's stimulant-like side effects, vastly compromising data interpretation.

After weeding out the most badly flawed studies, the FDA found only four that were adequate enough to consider. One of these showed that Prozac was no better than placebo. Three others supposedly showed Prozac to be somewhat superior to the sugar pill, but not as good as older antidepressants. However, due to adverse drug effects and lack of drug effectiveness, the dropout rates in most of these studies was very high.

While the gross number of patients receiving Prozac in all the trials was more than 5,000, the actual number finishing the trials used for approval was very small. When I counted the actual number of patients who completed the four- to six-week trials used for the approval of Prozac, it turned out to be a grand total of 286. It bears restating--only 286 patients finished the four- to six-week trials used to determine Prozac's efficacy.

Because of the high dropout rates and because Prozac was often no better than placebo in many trials, many statistical maneuvers were required to make the studies look positive. In one of the key studies, involving six different sites around the country, results at five sites showed Prozac to have no benefit. One site--representing 25 percent of the patients who finished the trials--was discarded. Then the data from the remaining sites were pooled. This is such a scientifically unacceptable practice that the FDA prohibits drug companies from doing it in the studies used to support advertising claims. Yet the FDA allowed it in this case. Otherwise Prozac could not have been approved.

In 2002 *The Washington Post* reported:

His analysis of 96 antidepressant trials between 1979 and 1996 showed that in 52 percent of them, the effect of the antidepressant could not be distinguished from that of the placebo. Khan said the makers of Prozac had to run five trials to obtain two that were positive, and the makers of Paxil and Zoloft had to run even more. He analyzed trials that were made public in the medical literature, which tend to show positive results, and those that were not.

In February 2008 *The Guardian* reported:

The review breaks new ground because Kirsch and his colleagues have obtained for the first time what they believe is a full set of trial data for four antidepressants.

They requested the full data under freedom of information rules from the Food and Drug Administration, which licenses medicines in the US and requires all data when it makes a decision.

The pattern they saw from the trial results of fluoxetine (Prozac), paroxetine (Seroxat), venlafaxine (Effexor) and nefazodone (Serzone) was consistent. "Using complete data sets (including unpublished data) and a substantially larger data set of this type than has been previously reported, we find the overall effect of new-generation antidepressant medication is below recommended criteria for clinical significance," they write.

Two more frequently prescribed antidepressants were omitted from the study because scientists were unable to obtain all the data.

Because scientists were unable to obtain all the data?

In the second video above, Fox News reports that over 10% of America is taking Prozac or one of its cousins and that 5% of these will develop manic-psychosis as a result. That works out to 1.5 million maniacs waiting to explode. This same video states that 7 of the past 12 school shooters were either on some kind of SSRI or withdrawing from one.

And this is just the tip of the iceberg. Other effects (they're effects, not "side-effects") of the SSRIs and their cousins the SNRIs include sleepwalking, homicidal/suicidal ideation, sexual dysfunction, akathisia, agitation, tardive dyskinesia, and discontinuation syndrome. It is no accident "going postal" entered the vernacular at the same time Prozac entered the pharmacopeia. Sleepwalking + homicidal ideation = Columbine.

Tardive dyskinesia is a disease caused only by pharmaceuticals. It is not "versible". It is expressed most often as repetitive facial tics, but also twitching in the limbs, fingers, toes, and torso. Protruding tongue is also a symptom. Psychoactive pharmaceuticals were first used in 1954 and by the early 1960s tardive dyskinesia was observed in 30% of psychiatric patients. Those people you see twitching on the street ARE taking their medication. That's how they got that way. And they will probably be that way for the rest of their lives, even if they stop taking the stuff that did it to them.

Discontinuation Syndrome is pharmalord newspeak for "addiction" and is reported at a rate as high as 60% for the SSRIs. People talk about electric shocks (The Zaps) throughout their nervous system when they try to reduce their dose or quit. The "side-effect" has been described as feeling as if someone was pounding a nail into the top of your head.

It's all about money

Last September *Hollywood Today* published an article inspired by the death of Heath Ledger. Among many salient points is found the following:

From 1960 to 1980, prescription drug sales were fairly steady as a percent of the U.S. gross domestic product, but from 1980 to 2000, they tripled. Sales now stand between $200 billion to $300 billion a year.

The top ten drug companies (which included European companies) had profits of nearly 25 percent of sales in 1990.

In 2001, the ten American drug companies in the Fortune 500 list ranked far above all other American industries in average net return, whether as a percentage of sales (18.5 percent), of assets (16.3 percent), or of shareholders' equity (33.2 percent). These are astonishing margins. For comparison, the median net return for all other industries in the Fortune 500 was only 3.3 percent of sales. The most startling fact about 2002 is that the combined profits for the ten drug companies in the Fortune 500 ($35.9 billion) were more than the profits for all the other 490 businesses put together (33.7 billion).

Let me emphasize this again. The combined profits of the ten largest US drug companies reaches 35.9 billion - a sum higher than the combined profits for all other 490 corporations on the Fortune 500 List!

Among the 13 states with some sort of medical marijuana legislation in the works none specify any psychiatric condition other than Alzheimer's agitation, which is specified by 5 states. They are Illinois, Iowa, Missouri, New Hampshire, and North Carolina. Six states have clauses similar to California which provide for a physician to recommend cannabis for any other condition for which it may provide relief without requiring the approval of a state board. These states are Alabama, Delaware, Missouri, New York, North Carolina, and Pennsylvania.

Tennessee requires that the patient be "terminal".

Alabama is the only state that has a law explicitly authorizing the use of cannabis for psychiatric conditions as its "any other" clause contains the phrase "physical or mental health".

For more info:

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Heath Ledger Legacy: Prescription Drugs A Silent Killer - Hollywood Today | 29 Sep 2008
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Oregon in Denial Over Cannabis as an Antidepressant - California Cannabis Research Medical Group
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National Center for Post Traumatic Stress Disorder - United States Department of Veterans Affairs