Commentary on Ware and St Arnaud-Trempe (2010): Nabilone abuse in Canada? Nature provides an effective prevention program

Ware and St Arnaud-Trempe investigated indicators of nabilone abuse in Canada and concluded that ‘the prevalence of current abuse...is low...isolated and rare’ [1]. We purport that there was probably very little reason for concern regarding such abuse to begin with. Nabilone is a synthetic cannabinoid available by prescription primarily for the treatment of chemotherapy side effects. Its existence and concerns regarding possible abuse cannot, of course, be discussed adequately without consideration of the wider contexts and dynamics of medical usages of cannabis as well as the landscape of current non-medical cannabis use control in general.

Nabilone is a pharmaceutical product where the ingenuity of pharmaceutical engineering has attempted to mimic the observed and fairly well-documented therapeutic effects of natural (i.e. mainly smoked) cannabis, including its anti-emetic effects [2,3]. These attempts have occurred in the wider context of staunchly persistent political resistance on crucial (mainly federal) political levels in both Canada and the United States, as well as in the medical arena, to formally sanctioning or universally allowing for medical use of natural cannabis products. A decade ago, however, the Canadian federal government established the then Medical Marijuana Access Program (MMAP—now the Medical Marijuana Access Division; MMAD), through which individuals with confirmed severe and applicable medical conditions may obtain government-grown marijuana medical use or obtain marijuana from sanctioned providers [4,5]. Importantly, the MMAP was not created proactively, yet came about as a remedial consequence of a constitutional challenge to Canada’s drug control law—the Controlled Drugs and Substances Act (CDSA), defining any form of cannabis use (possession) as illegal and stipulating criminal punishment—in higher courts and its alleged discrimination against ill people relying on cannabis for symptom relief [6,7]. As it stands, the MMAP is reportedly accessed and utilized only by fewer than 2000 approved individuals, partly because of its onerous bureaucratic procedures and restrictive rules [6,7]. Then, there are the dozens of ‘Cannabis Compassion Clubs’ in cities across Canada, providing thousands of individuals with medically certified health problems—and in practice sheltered from law enforcement—with reliable and quality-regulated cannabis products [6].

Outside these different ‘back- (or side-) door’ mechanisms facilitating medical cannabis use, and offering real-life alternatives to potential reasons for nabilone ‘abuse’, in Canada exists the extensively large realm of ‘recreational’ cannabis use. According to the 2003 Canadian Addiction Survey (CAS), one in eight Canadians (> 15 years of age) are active cannabis users, representing one of the highest use rates in the western world, and cannabis is produced and available in ample quantity and high quality in many regions across Canada [8–10]. The extent of cannabis production in the province of British Columbia in 2000 has been estimated to involve some 17 500 grow-operations and represents an economic value of $2 billion, or the equivalent of 2.8% of the province’s gross domestic product (GDP) [11]. Interestingly, surveys have documented that substantial proportions of so-called ‘recreational’ cannabis users in Canada report using cannabis at least occasionally for medical or health reasons [12,13]. Within these numerous alternatives for access to, and possible use of, cannabis there simply ought to be little worry of large-scale abuse of a synthetic pharmaceutical product such as nabilone. The essence of this observation is amplified by the fact that many (medical or other) users find the experienced quality and effects of synthetic cannabinoids to be considerably inferior compared to those of naturally produced and easily available cannabis products [14,15].

As such, the limited prevalence of nabilone abuse as reported by Ware & St Arnaud-Trempe appears simply as mainly a function of user preference, demand and supply—and herein lies an important policy implication of this case study—with the cannabinoid product of greatest preference being produced amply (by nature) and easily available to those who seek to use it [16]. This situation is not likely to change in Canada unless access to natural cannabis products is made extensively more difficult (unlikely), or pharmaceutical engineering emerges with a synthetic cannabinoid product which is distinctly better or preferred among natural cannabis users in the near future (equally unlikely). Important analogies relevant for understanding comparable demand dynamics and policy implications are currently unfolding in other areas of psychoactive substance use, specifically opioids. For several decades heroin, the potent opiate analgesic produced illegally from opium as the raw material, was the undisputedly reigning ‘queen’ of narcotic street drugs [17]. With the arrival of highly potent (semi-)synthetic pharmaceutically produced prescription opioid analgesic formulations such as fentanyl or oxycodone—diverted most commonly from medical sources—the preferences of many street opioid...
drug users have shifted from heroin to medical prescription opioid products [18,19]. It is not clear at this point which side of these epidemiological developments’ needs is more significant from public health or policy perspectives: the reduction of heroin use or the increase of prescription opioid use among Canadian street drug users.

Although most policy makers pretend or wish reality was different, the lines between the various dynamics related to ‘medical use’ and ‘abuse’ of psychoactive drugs (including cannabinoid products) are not drawn clearly or reliably, but are in reality messily intertwined. The limited prevalence of nabilone abuse in Canada is one of the (few) positive consequences of these circumstances.

Declaration of interest
None.

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References
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