Clinical Guidance for the Use of Medicinal Cannabinoids in the Management of Chronic Non-Cancer Pain in Veterans

Contents

Glossary of terms

Term	Definition
Adverse effects	Any unfavourable or harmful medical outcome occurring during or after using an intervention
Biopsychosocial framework/approach	A clinical approach to managing chronic pain and guiding treatment decisions that integrates biological, psychological, and social factors
Cannabis Hyperemesis Syndrome	A condition characterised by recurrent cycles of severe nausea, vomiting, and abdominal pain in long-term cannabinoid users
Cannabis Use Disorder	A problematic pattern of cannabis use causing clinically significant impairment or distress, as defined by DSM-5
Category 1: CBD medicinal cannabis product (CBD ≥98%)	Schedule 4 Prescription Only medicines as per the Poisons Standard. Cannabidiol comprises 98% or more of the total cannabinoid content of the medicine. Any cannabinoids, other than cannabidiol, in the medicine are only those naturally found in cannabis and comprise 2% or less of the total cannabinoid content of the medicine.
Category 2: CBD-dominant medicinal cannabis product (CBD ≥60% and <98)	Schedule 8 Controlled Drugs as per the Poisons Standard. Cannabidiol derived from cannabis comprises 60% or more and less than 98% of the total cannabinoid content of the medicine. Other cannabinoids (including tetrahydrocannabinol) derived from cannabis comprise the remaining cannabinoid content of the medicine.
Category 3: Balanced medicinal cannabis product (CBD ≥40% and <60)	Schedule 8 Controlled Drugs as per the Poisons Standard. Cannabidiol derived from cannabis comprises 40% or more and less than 60% of the total cannabinoid content of the medicine. Other cannabinoids (including tetrahydrocannabinol) derived from cannabis comprise the remaining cannabinoid content of the medicine.
Category 4: THC/other cannabinoid dominant medicinal cannabis product (CBD ≥2% and <40%)	Schedule 8 Controlled Drugs as per the Poisons Standard. Other cannabinoids (including tetrahydrocannabinol) derived from cannabis comprise 60% or more and 98% or less of the total cannabinoid content of the medicine. Cannabidiol derived from cannabis comprises 2% or more and less than 40% of the total cannabinoid content of the medicine.
Category 5: THC/other cannabinoid medicinal cannabis product (CBD <2%)	Schedule 8 Controlled Drugs as per the Poisons Standard. Cannabinoids, other than cannabidiol, in the medicine are only those naturally found in cannabis and comprise more than 98% of the total cannabinoid content of the medicine. Cannabidiol comprises less than 2% of the total cannabinoid content of the medicine.
Chronic non-cancer pain	Pain lasting 3 months or longer, including (but not limited to) the following conditions and diagnoses: neuropathic pain, neuralgia, arthritis, fibromyalgia, multiple sclerosis, Crohn's disease, and spinal cord injury

Clinical benefit	Meaningful improvement in patient-centred outcomes such as pain severity, pain interference, function, sleep, or quality of life
Minimum effective dose	The lowest dose that provides adequate therapeutic effect with the fewest side effects
Psychotic symptoms	Symptoms including hallucinations, delusions, paranoia, or disorganised thinking; requires immediate clinical intervention
Substance use	The use of selected substances, including alcohol, tobacco products, illicit drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body with possible dependence and other detrimental effects
Tapering	Gradually decreasing the dose of a medication over time
Titration	Gradually increasing the dose of a medication over time until the desired result is achieved without significant side effects

Abbreviations and Acronyms

Acronym	Term
BPI	Brief Pain Inventory
CBD	Cannabidiol
CNS	Central Nervous System
CNCP	Chronic Non-Cancer Pain
CUD	Cannabis Use Disorder
CUDIT-R	Cannabis Use Disorder Identification Test – Revised
EQ-5D	EuroQoL 5 Dimensions Questionnaire
GAD-7	Generalised Anxiety Disorder-7
OTC	Over-the-counter medications
PCL-5	PTSD Checklist for DSM-5
PHQ-9	Patient Health Questionnaire-9
PTSD	Post-Traumatic Stress Disorder
SF-12	12-Item Short Form Health Survey
THC	Delta-9-tetrahydrocannabinol
VAPAC	Veterans' Affairs Pharmaceutical Advisory Centre

Summary of clinical recommendations

Assessment	
1.1 Indications for consideration of Medicinal Cannabinoids as a treatment	Medicinal cannabinoids could be trialled when veterans with chronic non-cancer pain have persistent moderate–severe pain-related functional impairment and have trialled evidence-based non-pharmacological and pharmacological options matched to the pain characteristics without long-term benefit.
1.2 Contraindications, precautions and populations requiring caution	Do not initiate medicinal cannabinoids in veterans with: • Known hypersensitivity to cannabinoids • Severe or unstable cardiovascular disease • Active psychotic disorder • Pregnancy, breastfeeding or those planning pregnancy • Active untreated substance dependence (excl. nicotine). Use caution and implement enhanced monitoring in • Young adults (<25 years) • Personal history (active or past) or first-degree family history of a mental health disorder • Past history or first-degree family history of psychotic disorders • Active (treated) or past personal history of substance dependence (seek specialist consultation) • Severe hepatic or renal impairment • Older adults at increased risk of falls • Patients taking concomitant medications with potential interactions (see evidence report for further information)
1.3 Baseline pain and physical function assessment	Before initiating medicinal cannabinoids, clinicians should document baseline pain severity and functional status using validated instruments such as the BPI, quality of life measures (e.g., SF-12, EQ-5D), and sleep quality assessments.
1.4 Mental health and psychosocial assessment	Before initiating medicinal cannabinoids, clinicians should screen for mental health symptoms using validated tools appropriate to primary care and the veteran, such as K10 or DASS21, and disorder-specific tools including GAD7 for anxiety, PHQ9 for depression, and PCPTSD5 or PCL5 when PTSD is suspected. Clinicians should document any personal or family history of psychotic, mood, or other psychiatric conditions. Consider contraindications and precautions, see Rec 1.2.

1.5 Substance use and risk assessment	Clinicians should assess current and past cannabis use, alcohol use, and other substance use history. Screen for risk of Cannabis Use Disorder (CUD) using validated tools such as CUDIT-R at baseline and during monitoring. Discuss the 1 in 4 risk of developing CUD among persons prescribed medicinal cannabinoids, noting that individual risk is higher in the presence of risk factors. Risk counselling should be prioritised and documented accordingly.
1.6 Medical and medication review	Clinicians should conduct a comprehensive review of current medical conditions (cardiovascular, hepatic, renal, psychiatric), all current medications (including prescribed, OTC, and supplements), and prior cannabinoid use. Pay particular attention to medications with narrow therapeutic indices (e.g. warfarin, clobazam, tacrolimus) and CNS depressants.
Initiation	
2.1 Selection of formulations	Clinicians should select cannabinoid formulations according to each veteran's pain characteristics, comorbidities, and risk factors. Clinicians are encouraged to begin with CBD dominant and low dose THC products with slower absorption, to minimise the risk of side effects. Titrate THC cautiously depending on clinical response and only if the veteran's psychiatric and medical risk profile permits.
2.2 Route of administration	Consider the veteran's risk profile and the characteristics of their pain condition when selecting the route of administration. Clinicians should prioritise lower-risk routes of administration (e.g., oral, oromucosal) over inhalation wherever clinically appropriate. Clinicians should also counsel veterans on safe storage of edible formulations (e.g., gummies), as these may pose a risk of accidental ingestion by children or pets. While inhaled routes of administration carry increased respiratory risk and should not be routinely recommended, inhaling products (vapourising, vaping) may be considered in limited clinical circumstances where the benefit-risk profile is favourable. Any decision to support or sanction vaporisation should be explicitly justified in the clinical record, accompanied by informed consent regarding respiratory risks, and subject to regular review. Where tolerability issues - such as taste, texture, or gastrointestinal effects of oral formulations may compromise adherence, clinicians should proactively address these through practical strategies (e.g., administration with food, flavour masking, formulation alternatives) to support sustained use and reduce the likelihood of veterans transitioning to higher-risk routes, particularly inhalation. Smoking should not be used due to associated health risks.
2.3 Dosing and titration strategy	Clinicians should use a cautious, structured dosing and titration strategy when prescribing medicinal cannabinoids, following a "start low, go slow" approach. Treatment should begin with a low dose and be increased gradually based on tolerability, clinical response, and veteran-specific factors. Product CBD/THC concentration, dosing (including total daily combined dose in grams) and duration of effect for each product should be clearly specified so that veterans can be assisted in understanding their daily consumption in a consistent and clear

	manner. The goal is to identify the minimum effective dose that achieves treatment objectives while avoiding adverse effects.
2.4 Veteran education, consent and care team communication	Before commencing medicinal cannabinoids, clinicians should implement a structured pre-treatment discussion and informed consent process that clearly outlines treatment objectives, alternative options (e.g. behaviour, lifestyle and biopsychosocial approaches), dosing and titration plans, potential risks(including cannabis use disorder and cannabis withdrawal syndrome) and adverse effects, impacts on ability to drive, drug–drug interactions, monitoring requirements, and criteria for discontinuation. Clinicians should advise veterans when the medicinal cannabinoid products they are prescribing are unapproved therapeutic goods that have not been assessed by the Therapeutic Goods Administration (TGA) for safety or effectiveness, and the associated risks. Clinicians should also communicate initiation of medicinal cannabinoids with the veteran's broader treating team (e.g. GP and relevant specialists), including documentation in shared records such as My Health Record where appropriate, to support coordinated care and monitoring. Clinicians should remind veterans that it is illegal to drive in an impaired state, regardless of whether cannabinoids have been prescribed. Refer veterans to their local state or territory's driving guidance or department for further details. Clinicians should explain that some adverse events, particularly psychiatric changes, may not be recognised by the veteran themselves. Veterans are encouraged to inform a trusted adult such as a family member, carer or close friend about potential warning signs and ask them to report any changes in behaviour. Clinicians should also discuss and document the veteran's current views, prior experiences, and beliefs about cannabinoids and pain, as these can influence how people perceive both benefits and side effects. Use of a written consent form to document veteran understanding of treatment, and the risks associated with longer-term use, and support shared decision-making, is encouraged.
2.5 Psychological support and treatment	Clinicians are encouraged to consider referral to evidence-based psychological treatment for veterans being considered for medicinal cannabinoids for chronic non-cancer pain. Psychological interventions could be incorporated into the veteran's overall pain management plan and can include cognitive behavioural therapy, pain-focused coping skills training, sleep interventions, and trauma-informed care, delivered by appropriately qualified mental health professionals. This support may be offered at treatment initiation and revisited over the course of care as needed.

Monitoring outcomes and adverse events	
3.1 Clinical outcomes to monitor	Clinicians should monitor treatment effectiveness using the same validated instruments collected at baseline aligned with the veteran's individual goals (established at initiation – see Rec 2.4). Reassess pain severity and pain interference using the Brief Pain Inventory (BPI) and review functional status and quality of life using tools such as the SF-12 or EQ-5D. Sleep quality should be monitored using a consistent sleep assessment tool. Mental health symptoms should be re-evaluated when clinically indicated using the GAD-7, PHQ-9, or PCL-5, particularly if psychiatric adverse effects are suspected. Substance use risk should be monitored every 3 months using the CUDIT-R or ASSIST in veterans at risk of Cannabis Use Disorder. Clinicians should monitor changes in attention, memory, and cognitive functioning, using brief cognitive screening tools such as the GPCOG if changes in daily functioning are noted. A clinically meaningful response should be determined in the context of the veteran's baseline status and mutually agreed goals and may include a pre-specified minimum clinically important difference (MCID) where an applicable tool supports this. Veteran-reported experience and perceived benefit should be explicitly incorporated into outcome assessment alongside clinician-rated measures. Outcome data should be reviewed at structured intervals - with the veteran as an active participant in that review - to inform explicit continuation, dose adjustment, or discontinuation decisions.
3.2 Monitoring frequency	Use a risk stratified approach for initial review. Reassess high risk veterans i.e. those with relative contraindications or precautions (see recommendation 1.2), or those who are cannabis-naïve, within 2 weeks and other veterans within one month. After the initial review, ongoing monitoring should occur at intervals determined by clinical response, emerging adverse effects, and the need for dose titration, with more frequent contact during periods of dose adjustment or if new symptoms arise
3.3 Side effects and adverse events	Clinicians should routinely monitor for adverse effects in the following domains when prescribing medicinal cannabinoids: • Central nervous system: monitor for dizziness, fatigue, impaired attention, euphoria, balance disturbance and falls • Psychiatric symptoms: monitor for anxiety, mood changes, paranoia, and psychosis, particularly in veterans receiving higher THC formulations or those with pre-existing mental health conditions. • Gastrointestinal effects: monitor for nausea, vomiting, diarrhoea, and appetite or weight change. • Cardiovascular effects: monitor heart rate, blood pressure (including orthostatic symptoms), and any new cardiac symptoms, especially in older adults or those with cardiovascular disease. • Respiratory symptoms: monitor for cough, wheeze, sputum production, or bronchitis in veterans who use inhaled products. • Drug interactions: review existing and any newly prescribed medications.

3.4 Long term harm	Clinicians should also routinely monitor for the following long term harms in veterans using medicinal cannabinoids: • Pulmonary: chronic cough, sputum production, wheeze, and other bronchitis-like symptoms in veterans who use inhaled products. • Cardiovascular: new or worsening tachycardia, palpitations, chest pain, syncope, or other symptoms suggestive of cardiovascular instability, especially in individuals with pre-existing cardiovascular disease. • Cognitive: memory impairment, confusion and attention problems. • Psychosis: emerging psychotic symptoms, including paranoid / suspicious ideations, hallucinations, delusions, or disorganised thinking, especially in veterans using THC containing products or with a personal/family history of psychosis. Veterans and carers should be advised to seek urgent medical attention if any suggestion of psychotic symptoms develops. • Cannabis induced hyperemesis syndrome: recurrent nausea, vomiting, or abdominal pain in long-term users, particularly when symptoms are cyclical or relieved by hot bathing.
3.5 Management of adverse effects	Provide veterans with clear guidance on common and serious adverse effects and encourage prompt reporting of new or worsening symptoms. Clinicians should routinely document and report suspected adverse events to regulatory bodies to strengthen safety monitoring. Treatment goals, dosing, and tolerability should be reviewed regularly (within 2 weeks for high-risk veterans and within 4 weeks for other veterans), with dose adjustment or deprescribing considered when harms outweigh benefits
3.6 Hazardous, harmful or dependent use	Use a structured and proactive approach to assessing and monitoring the risk of hazardous, harmful or dependent use and withdrawal in veterans prescribed medicinal cannabinoids. Screen all veterans for Cannabis Use Disorder (CUD) at baseline and periodically during treatment using a validated tool such as the CUDIT-R. Increase monitoring frequency for veterans with known risk factors, including a history of substance use disorder, mental health conditions, or escalating cannabinoid use. If signs of hazardous, harmful or dependent use emerge, reassess the indication for treatment, consider dose reduction or discontinuation, and take an active role in facilitating access to appropriate evidence-based psychological support and treatment.
Deprescribing	
4.1 Indications for discontinuation	Discontinue medicinal cannabinoids when treatment is not providing meaningful clinical benefit after an adequate trial (usually 8 – 12 weeks after initiation depending on titration) or when safety concerns emerge. Discontinuation or dose reduction should also be considered where the veteran's symptoms have stabilised and they have been successfully transitioned onto other, more evidence-based treatments. Discontinue treatment if adverse effects persist despite dose adjustment, or if the veteran develops symptoms consistent with cannabis use disorder, particularly escalating use of higher potency THC products.

	Immediate cessation is required if the veteran develops psychotic symptoms such as paranoia or hallucinations, cardiac or pulmonary issues or persistent vomiting (cannabis induced hyperemesis). In all cases of suspected acute psychosis, arrange mental health assessment and initiate evidence-based acute management.
4.2 Approach to cessation	Use a gradual, structured taper when discontinuing medicinal cannabinoids. Reduce THC doses slowly in small increments, such as around 10% of total dose every one to two weeks, with regular review to adjust the taper according to symptoms, goals, and clinical need. Switching from flower to oral products, using lower mg per ml products to enable smaller dose reductions, or transitioning to lower potency THC products may help minimise withdrawal severity and support dose reductions. Provide clear education about expected withdrawal symptoms and timeframes. Support cessation with practical coping strategies, including sleep and anxiety management techniques, pain self-management approaches, and psychological support and treatment when needed as well as when to seek assistance. Ensure alternative pain management options are in place before and during the taper, and review symptoms regularly to adjust the plan.
4.3 Management of withdrawal symptoms	Cannabis withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features that occurs upon cessation or reduction of use of cannabis in individuals who have developed cannabis dependence or have used cannabis for a prolonged period or in large amounts. Presenting features of cannabis withdrawal may include: irritability, anger or aggressive behaviour, shakiness, insomnia, restlessness, anxiety, depressed or dysphoric mood, decreased appetite and weight loss, headache, sweating or chills, abdominal cramps and muscle aches. Use structured, supportive interventions to prevent or manage withdrawal symptoms when reducing or discontinuing medicinal cannabinoids. Provide psychoeducation on the expected course of withdrawal, including onset, peak, and duration of symptoms. Encourage sleep hygiene, hydration, nutrition, physical activity, and coping strategies for cravings and anxiety. Consider short-term symptomatic medications for distressing symptoms such as insomnia, anxiety, nausea, or headaches, used cautiously and for no longer than 7 days. Assess for other substance use or comorbid conditions that may mimic or worsen withdrawal and use withdrawal scales when needed to gauge severity and functional impact. Most veterans can complete withdrawal in a community or outpatient setting but consider inpatient withdrawal support for individuals with significant mental or physical health concerns or polysubstance withdrawal risk.

Context and Background

Requests to the Veterans' Affairs Pharmaceutical Advisory Centre (VAPAC) for funding of cannabinoids for medicinal purposes have rapidly increased in recent years, with approximately 95% of prescriptions for the treatment of chronic pain. This trend reflects growing interest among clinicians and veterans in cannabinoids as a therapeutic option for chronic non-cancer pain (CNCP).

Veterans can present with complex health needs that require tailored clinical approaches. These factors increase the complexity of prescribing decisions, particularly given the potential for use of multiple medications, comorbidities, and functional limitations. Prescribing cannabinoids in this context requires careful consideration of efficacy, safety, and psychosocial risks. This guidance provides recommendations informed by current evidence and expert clinical input to support the management of veterans with CNCP.

Current clinical guidance documents for Australian prescribers of cannabinoids are becoming outdated due to the rapid expansion of research. Furthermore, there are no domestic or international clinical guidelines specifically designed to support prescribers treating veterans with cannabinoids for CNCP. This gap creates uncertainty for clinicians and risks inconsistent care for veterans.

Guidance purpose, aims and expected outcomes

The purpose of this evidence-based guidance is to integrate available evidence with multidisciplinary expertise and consumer preferences to provide healthcare providers, veterans and the families of veterans, pharmacists, the DVA, and advisory boards with transparent guidance on the use of medicinal cannabinoids for the management of CNCP in Australian veterans. It also seeks to support healthcare providers in decision-making regarding initiation, monitoring, and discontinuation of cannabinoid therapy; improve prescribing practices; and address knowledge gaps and reduce variability in care for veterans.

- The guidance aims to ensure that all considerations for the use of medicinal cannabinoids to manage CNCP among veterans are:
- Informed: by the best available evidence synthesised via systematic review and with explicit consideration of benefits and harms.

- Patient-centred: supporting shared decision-making and respect for veteran preferences and values.
- Practical and implementable: designed for real-world clinical settings and adaptable to diverse service models.
- Equitable and stigma-aware: promoting inclusiveness and reducing barriers to care for veterans.

It is important to note that the current evidence base is still small and remains limited by variability in study quality and design, outcome reporting, and dosing approaches. There is a lack of high-quality evidence in populations with complex comorbidities, including veterans, as well as limited long-term safety data, which introduces uncertainty regarding the generalisability and magnitude of observed effects. As a result, recommendations should be applied with clinical judgement, taking into account individual veteran context, preferences, and risk profiles.

Clinical population

The target clinical population for this guidance is veterans who have CNCP.

Clinical question:

"What is the best practice for initiation, monitoring and deprescribing of medicinal cannabis when treating veterans with chronic pain?"

What the guidance does not address

This document does not attempt to provide general guidance for providing medicinal cannabis treatment outside of this clinical context.

Informed by evidence current at: March 2026

Prescribing regulations

The regulatory framework for prescribing medicinal cannabinoids in Australia was established following the 2016 amendments to the *Narcotic Drugs Act 1967* which enabled controlled clinical access to cannabinoid-based products for therapeutic use (The Royal Australian College of General Practitioners, 2025). Only 2 medicinal cannabinoid products are registered on the Australian Register of Therapeutic Goods:

- **Sativex (nabiximols):** indicated for moderate to severe spasticity associated with multiple sclerosis. Sativex is available from selected pharmacies and is reported to cost between $700 and $800 for a 6‑8-week supply (Multiple Sclerosis Australia, 2026).
- **Epidyolex (cannabidiol):** indicated as adjunctive therapy for seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients aged 2 years and older. In 2021, Epidyolex was listed on the Pharmaceutical Benefits Scheme (PBS). For patients who meet the PBS eligibility criteria for these conditions, the out-of-pocket cost is capped at approximately $25 per prescription, compared with $1,535.64 without PBS subsidy or Medicare/concession support (Pharmaceutical Benefits Scheme, 2026).

All other medicinal cannabinoid products are unapproved and must be accessed through the Australian Therapeutic Goods Administration authorisation pathways (Therapeutic Goods Administration, 2025). While the types of products and clinical indications are not restricted in legislation, access is influenced by how each product is scheduled under the Poisons Standard, with scheduling and regulatory requirements varying across states and territories.

Prescribing regulations are subject to change. With the most up to date information on access pathways available through the Therapeutic Goods Administration website: https://www.tga.gov.au/products/unapproved-therapeutic-goods/medicinal-cannabis/access-pathways

Professional responsibilities

Clinicians prescribing medicinal cannabinoids should possess demonstrated competency in cannabinoid pharmacology and relevant clinical guidelines and engage in ongoing professional development in this field. Prescribers hold primary responsibility for safe and accountable prescribing. This encompasses:

- **Competency and credentialing:** Maintaining current knowledge of cannabinoid therapeutics, regulatory requirements, and emerging evidence prior to and throughout prescribing practice.
- **Conflict of interest disclosure:** Declare any actual or potential financial conflicts of interest, including relationships with medicinal cannabis companies or products or suppliers/pharmacies/pharmacists, and the nature of any employment, representation, or sponsorship.
- **Evidence-based non-pharmacological care:** Clinicians should support ongoing engagement with appropriate interventions such as exercise and physical rehabilitation, psychological therapies (e.g. CBT and ACT), self-management strategies, and multidisciplinary pain management, both prior to initiation and throughout treatment where clinically appropriate.
- **Risk identification:** Systematically screening for contraindications and applying heightened caution with higher-risk subpopulations (e.g. history of psychosis, pregnant or breastfeeding and active or historical substance use disorders), with clinical rationale documented.
- **Polypharmacy management:** Conducting a medication review at initiation and each clinical review - with pharmacist input where indicated - to identify and mitigate clinically significant drug interactions.
- **Real-time prescription monitoring (RTPM):** Reviewing relevant real-time prescription monitoring systems in accordance with jurisdictional requirements before initiating medicinal cannabinoids and at ongoing clinical reviews where indicated. RTPM can support identification of multiple prescribers, overlapping high-risk medicines, potential misuse or diversion, and emerging patterns of dependence.
- **Prescribing and care coordination:** Clinicians should communicate initiation of medicinal cannabinoids with the veteran's broader treating team (e.g. GP and relevant specialists), including documentation in shared records

such as My Health Record where appropriate, to support coordinated care and monitoring.

- **Informed consent:** Obtaining and documenting consent covering: the evidence base for the indication; known risks and adverse effects; legal and regulatory conditions; driving and occupational restrictions; and the veteran's right to decline or cease treatment at any time.
- **Unapproved products:** Where prescribing an unapproved medicinal cannabis product via the Special Access Scheme, document the clinical justification and ensure veterans are informed of the unapproved status, associated uncertainties, risks, and prescriber responsibility for monitoring and adverse events.
- **Shared decision-making:** Engaging veterans as active partners in goal setting, treatment planning, and ongoing review, with veteran-reported outcomes and preferences documented.
- **Monitoring:** Establishing measurable treatment goals at initiation and conducting structured reviews at defined intervals to assess therapeutic benefit, functional outcomes, and emerging harms, including dependence or misuse.
- **Adverse event reporting:** Reporting adverse events in accordance with applicable regulatory obligations and contributing to ongoing pharmacovigilance.
- **Documentation:** Maintaining comprehensive records of prescribing rationale, treatment goals, consent, clinical reviews, and any changes to the treatment plan.
- **Discontinuation:** Clinicians should recognise that meaningful clinical benefit from medicinal cannabinoids is not guaranteed. Where treatment goals are not achieved within a defined period, or where harms outweigh benefits, structured dose reduction or cessation should be initiated, with tapering and follow-up documented.

Prescribing medicinal cannabinoids involves distinct clinical, legal, and ethical responsibilities due to it being an unapproved product, variability in products, limited and evolving evidence, known psychoactive risks, and complex regulatory requirements. Clear articulation of prescriber responsibilities supports safe, consistent, and accountable practice.

Clinical guidance

Recommendations in this guidance are informed by the accompanying Evidence Report. Appendix 1 cites key references; readers seeking further details should refer to the Evidence Report.

1. Assessment

1.1 Indications for consideration of medicinal cannabinoids

Recommendation

Medicinal cannabinoids could be trialled when veterans with chronic non-cancer pain have persistent moderate–severe pain-related functional impairment and have trialled evidence-based non-pharmacological and pharmacological options matched to the pain characteristics, without long-term benefit.

Justification

Evidence to support the efficacy, effectiveness, and safety of medicinal cannabinoids for chronic non-cancer pain is limited, including a lack of robust evidence specific to individual pain conditions. Evidence of benefit appears most consistent for neuropathic pain, including some MS-related pain conditions, with limited and inconsistent evidence across other chronic pain conditions. There is insufficient evidence comparing cannabinoids with other evidence-based treatments for chronic pain, as most studies use a placebo comparator. In light of potential risks, cannabinoids should be considered only after other non-pharmacological and pharmacological treatments have been trialled and the individual continues to experience significant symptoms and functional impairment. Note, medicinal cannabinoids are not a well supported primary strategy for opioid cessation or tapering in the management of chronic non-cancer pain; clinicians should refer to established opioid deprescribing pathways and guidance.

1.2 Contraindications, precautions and populations requiring caution

Recommendation

Do not initiate medicinal cannabinoids in veterans with:

- Known hypersensitivity to cannabinoids
- Severe or unstable cardiovascular disease
- Active psychotic disorder
- Pregnancy, breastfeeding, or those planning pregnancy
- Active untreated substance dependence (excl. nicotine)

Use caution and implement enhanced monitoring in:

- Young adults (<25 years)
- Personal history (active or past) or first-degree family history of a mental health disorder
- Past history or first-degree family history of psychotic disorders
- Active (treated) or past personal history of substance dependence (seek specialist consultation)
- Severe hepatic or renal impairment
- Older adults at increased risk of falls
- Veterans taking concomitant medications with potential interactions (see evidence report for further details)

Justification

These contraindications are consistently identified across international guidelines based on evidence of elevated risk of serious adverse events. Absolute contraindications reflect conditions where the risk of harm clearly outweighs any potential benefit. Relative contraindications require an individualised risk-benefit assessment and closer monitoring.

1.3 Baseline pain and function assessment

Recommendation

Before initiating medicinal cannabinoids, clinicians should document baseline pain severity and functional status using validated instruments such as the Brief Pain Inventory (BPI), quality of life measures (e.g., SF-12, EQ-5D), and sleep quality assessments.

Justification

Baseline assessments enable objective evaluation of treatment effectiveness during follow-up and help detect any deterioration during treatment. Without pre-treatment baselines, it is impossible to determine whether cannabinoids are providing meaningful clinical benefit or causing harm.

1.4 Mental health and psychosocial assessment

Recommendation

Before initiating medicinal cannabinoids, clinicians should screen for mental health symptoms using validated tools appropriate to primary care and the veteran, such as K10 or DASS21, and disorder-specific tools including GAD7 for anxiety, PHQ9 for depression, and PCPTSD5 or PCL5 when PTSD is suspected. Clinicians should document any personal or family history of psychotic, mood, or other psychiatric conditions. Consider contraindications and precautions, see Rec 1.2.

Justification

Cannabinoids can have adverse effects on mood and cognition. Veterans with CNCP have a high prevalence of mental health comorbidities, elevating their risk profile. Baseline mental health status is essential for determining treatment risk, monitoring treatment response, and detecting psychiatric adverse effects, particularly given the established association between cannabinoids and risk of developing psychosis.

1.5 Substance use and risk assessment

Recommendation

Clinicians should assess current and past cannabis use, alcohol use, and other substance use history. Screen for risk of Cannabis Use Disorder (CUD) using validated tools such as CUDIT-R at baseline and during monitoring. Discuss that evidence shows approximately 1 in 4 risk of developing CUD among persons prescribed medicinal cannabinoids, noting that individual risk is higher in the presence of risk factors. Risk counselling should be prioritised and documented accordingly.

Justification

Approximately 22-25% of medicinal cannabis users meet criteria for CUD. Veterans with CNCP face particularly elevated risk of developing CUD. Other risk factors may include frequency of usage, age, sex and prior and mental and substance use disorders, however the certainty of this evidence is low. Prior hazardous, harmful, or dependent substance use is a relative contraindication to medicinal cannabis requiring caution and close monitoring. Early identification enables appropriate risk management and monitoring intensity.

1.6 Medical and Medication Review

Recommendation

Clinicians should conduct a comprehensive review of current medical conditions (cardiovascular, hepatic, renal, psychiatric), all current medications (including prescribed, OTC, and supplements), and prior cannabinoid use. Pay particular attention to medications with narrow therapeutic indices (e.g. warfarin, clobazam, tacrolimus) and CNS depressants.

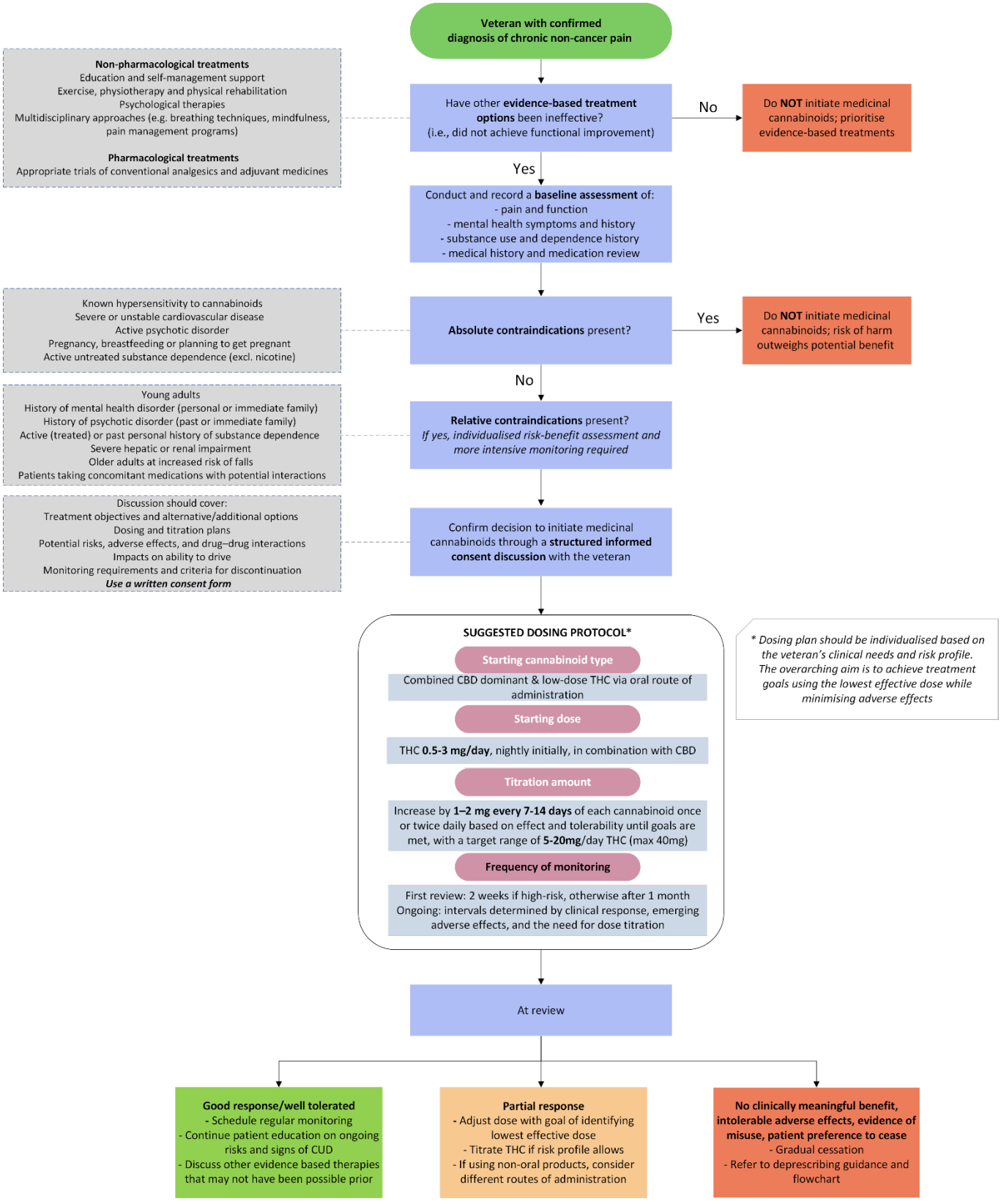
Justification

Cannabinoids can interact with many commonly prescribed medications through CYP450 enzyme effects, potentially causing serious adverse events. Concurrent CNS depressant use should be avoided. Dose adjustments of concomitant medications may be required when cannabinoids are added.

Example assessment and approach

The following dosing protocol provides a suggested framework for initiation and titration of medicinal cannabinoids. Selection of approach, starting dose, and titration schedule should be individualised based on the veteran’s clinical needs and risk profile. The overarching aim is to achieve treatment goals using the lowest effective dose while minimising adverse effects.

Flowchart 1. Clinical Assessment and Prescribing Protocol



2. Initiation

2.1 Selection of medicinal cannabinoid formulations

Recommendation

Clinicians should select cannabinoid formulations according to each veteran's pain characteristics, comorbidities, and risk factors. Clinicians are encouraged to begin with CBD-dominant and low dose THC products with slower absorption, to minimise the risk of side effects. Titrate THC cautiously, depending on clinical response and only if the veteran's psychiatric and medical risk profile permits.

Justification

Medicinal cannabinoids contain 2 main active components: THC, which is psychoactive, and CBD, which is not. Weak evidence indicates that THC contributes to analgesic effects in chronic pain. Evidence for CBD alone shows limited therapeutic benefit but is supported by expert clinical guidance as potentially improving overall function. Because THC carries psychoactive effects and associated risks, formulation selection should be individualised through careful assessment of each veteran's risk–benefit profile. Expert clinical guidance recommends commencing treatment with the lowest feasible THC dose. This approach aims to identify any therapeutic benefit while minimising exposure to psychoactive effects and reducing the likelihood of adverse outcomes**.**

2.2 Route of administration

Recommendation

Consider the veteran's risk profile and the characteristics of their pain condition when selecting the route of administration. Clinicians should prioritise lower-risk routes of administration (e.g., oral, oromucosal) over inhalation wherever clinically appropriate. Clinicians should also counsel veterans on safe storage of edible formulations (e.g., gummies), as these may pose a risk of accidental ingestion by children or pets. While inhaled routes of administration carry increased respiratory risk and should not be routinely recommended, inhaling products (vapourising, vaping) may be considered in limited clinical circumstances where the benefit-risk profile is favourable. Any decision to support or sanction vaporisation should be

explicitly justified in the clinical record, accompanied by informed consent regarding respiratory risks, and subject to regular review.

Where tolerability issues - such as taste, texture, or gastrointestinal effects of oral formulations, may compromise adherence, clinicians should proactively address these through practical strategies (e.g., administration with food, flavour masking, formulation alternatives) to support sustained use and reduce the likelihood of veterans transitioning to higher-risk routes, particularly inhalation. Smoking should not be used due to associated health risks.

Justification

Medicinal cannabinoids can be administered via several routes, including oral, inhalation, sublingual, and topical, each with different characteristics. When selecting a route, clinicians should consider the required dose and expected onset of action. A stepwise approach that prioritises lower-risk routes supports safer prescribing while allowing treatment to be tailored to clinical need.

Oral and oromucosal formulations are generally preferred because they provide a consistent longer-lasting effect and lower respiratory risk compared with inhaled products. However, in limited circumstances where rapid onset is clinically necessary and the anticipated benefits outweigh risks, inhalation may be considered following explicit informed consent, clear documentation of clinical rationale, and regular review.

Smoking is not recommended in any circumstances due to the associated health risks.

2.3 Dosing and titration strategy

Recommendation

Clinicians should use a cautious, structured dosing and titration strategy when prescribing medicinal cannabinoids, following a “start low, go slow” approach. Treatment should begin with a low dose and be increased gradually based on tolerability, clinical response, and veteran-specific factors. Product CBD/THC concentration, dosing (including total daily combined dose in grams) and duration of effect for each product should be clearly specified so that veterans can be assisted in understanding their daily consumption in a consistent and clear

manner. The goal is to identify the minimum effective dose that achieves treatment objectives while avoiding adverse effects (see Flowchart 1 for suggested dosing plan).

Justification

A “start low, go slow” approach is the fundamental principle for initiating medicinal cannabinoids. Dosing and tolerability vary widely between individuals, and a conservative titration strategy helps minimise adverse effects while allowing clinicians to identify the lowest dose that provides meaningful benefit. This approach is consistently endorsed across international guidelines.

Clinicians may adjust the pace of titration based on veteran characteristics and treatment response. Regular monitoring during titration is essential to ensure safety and to reassess the benefit-risk balance as doses increase.

2.4 Veteran education, consent, and care team communication

Recommendation

Before commencing medicinal cannabinoids, clinicians should implement a structured pre-treatment discussion and informed consent process that clearly outlines treatment objectives, alternative options (e.g. behaviour, lifestyle and biopsychosocial approaches), dosing and titration plans, potential risks (including cannabis use disorder and cannabis withdrawal syndrome) and adverse effects, impacts on ability to drive, drug–drug interactions, monitoring requirements, and criteria for discontinuation.

Clinicians should advise veterans when the medicinal cannabinoid products they are prescribing are unapproved therapeutic goods that have not been assessed by the Therapeutic Goods Administration (TGA) for safety or effectiveness, and the associated risks.

Clinicians should also communicate initiation of medicinal cannabinoids with the veteran’s broader treating team (e.g. GP and relevant specialists), including documentation in shared records such as My Health Record where appropriate, to support coordinated care and monitoring.

Clinicians should remind veterans that it is illegal to drive in an impaired state, regardless of whether cannabinoids have been prescribed. Refer veterans to their local state or territory's driving guidance or department for further details.

Clinicians should explain that some adverse events, particularly psychiatric changes, may not be recognised by the veteran themselves. Veterans are encouraged to inform a trusted adult such as a family member, carer or close friend about potential warning signs and ask them to report any changes in behaviour.

Clinicians should also discuss and document the veteran's current views, prior experiences, and beliefs about cannabinoids and pain, as these can influence how people perceive both benefits and side effects. Use of a written consent form to document veteran understanding of treatment, and the risks associated with longer-term use, and support shared decision-making, is encouraged.

Justification

A structured pre-treatment education and consent process ensures that veterans: understand the intended goals of therapy; recognise that cannabinoids are not first-line treatments; and appreciate the uncertainties and limitations of the evidence base and potential adverse events. Clear discussion of treatment objectives, available alternatives, dosing and titration plans, potential risks (including cognitive effects, mood changes, impaired driving, and possible dependence), and relevant drug–drug interactions help set realistic expectations and reduces the likelihood of treatment failure or harm. Given the absence of universally established thresholds for meaningful clinical response, clinicians should, in collaboration with the veteran, ensure treatment goals are individualised and select appropriate validated outcome measures at initiation.

Documenting these elements promotes shared decision-making, encourages adherence to monitoring requirements, and provides a clear framework for discontinuation if treatment goals are not met or harms emerge.

Further information

A prescribing medicinal cannabinoid products checklist can be found at the end of this document (Appendix 2).

Information on prescribing pathways can be accessed here: https://www.tga.gov.au/resources/explore-topic/medicinal-cannabis-hub/medicinal-cannabis-information-patients/accessing-medicinal-cannabis-patient

2.5 Psychological support and treatment

Recommendation

Clinicians are encouraged to consider referral to evidence-based psychological treatment for veterans being considered for medicinal cannabinoids for chronic non-cancer pain. Psychological interventions could be incorporated into the veteran's overall pain management plan and can include cognitive behavioural therapy, pain-focused coping skills training, sleep interventions, and trauma-informed care, delivered by appropriately qualified mental health professionals. This support may be offered at treatment initiation and revisited over the course of care as needed.

Justification

Psychological interventions are an established component of evidence-based multidisciplinary care for chronic noncancer pain. Approaches such as cognitive behavioural therapy, pain-focused coping skills training, sleep interventions, and trauma-informed care have been shown to improve function, reduce pain interference, and support long-term self-management.

Integrating psychological support alongside medicinal cannabinoids helps address the cognitive, behavioural, and emotional contributors to pain, clarifies treatment expectations, and reduces reliance on pharmacological strategies alone. Ensuring that this support is provided by appropriately qualified mental health professionals also promotes safety and consistency. Offering psychological interventions at treatment initiation and revisiting them throughout treatment aligns with best practice chronic pain management and supports veterans to develop sustainable coping strategies as treatment progresses.

3. Monitoring outcomes and adverse effects

3.1 Clinical outcomes to monitor

Recommendation

Clinicians should monitor treatment effectiveness using the same validated instruments collected at baseline, aligned with the veteran's individual goals (established at initiation – see Rec 2.4). Reassess pain severity and pain interference using the Brief Pain Inventory (BPI) and review functional status and quality of life using tools such as the SF-12 or EQ-5D. Sleep quality should be monitored using a consistent sleep assessment tool. Mental health symptoms should be re-evaluated when clinically indicated using the GAD-7, PHQ-9, or PCL-5, particularly if psychiatric adverse effects are suspected. Substance use risk should be monitored every 3 months using the CUDIT-R or ASSIST in veterans at risk of Cannabis Use Disorder. Clinicians should monitor changes in attention, memory, and cognitive functioning, using brief cognitive screening tools such as the GPCOG if changes in daily functioning are noted.

A clinically meaningful response should be determined in the context of the veteran's baseline status and mutually agreed goals, and may include a pre-specified minimum clinically important difference (MCID) where an applicable tool supports this. Veteran-reported experience and perceived benefit should be explicitly incorporated into outcome assessment alongside clinician-rated measures. Outcome data should be reviewed at structured intervals - with the veteran as an active participant in that review - to inform explicit continuation, dose adjustment, or discontinuation decisions.

Justification

Monitoring outcomes with validated instruments ensures that decisions about continuation or adjustment of cannabinoid therapy are based on reliable and clinically meaningful indicators of change. Given the absence of universally established response thresholds for medicinal cannabinoids, defining individualised treatment goals at initiation and interpreting change in relation to baseline status, veteran priorities, and agreed clinical targets supports transparent, patient-centred decision-making. Pain intensity alone is insufficient to determine

benefit, given the modest effect sizes observed in cannabinoid studies. Functional improvement, sleep quality, and overall wellbeing offer a more comprehensive picture of treatment response. Reassessment of mental health and substance use risk supports early detection of emerging psychiatric symptoms or problematic cannabis use, ensuring that treatment remains safe and aligned with veteran goals.

3.2 Frequency of monitoring

Recommendation

Use a risk stratified approach for initial review. Reassess high risk veterans i.e. those with relative contraindications or precautions (see recommendation 1.2), or those who are cannabis naïve, within 2 weeks and other veterans within one month. After the initial review, ongoing monitoring should occur at intervals determined by clinical response, emerging adverse effects, and the need for dose titration, with more frequent contact during periods of dose adjustment or if new symptoms arise.

Table 1: Risk-stratified timing for initial clinical review after initiation of medicinal cannabinoids

Veteran group	First review	Rationale
High risk veterans (relative contraindications or precautions, see Rec 1.2)	Within 2 weeks	Early detection of adverse effects and psychosis risk; closer supervision needed
Cannabis-naïve veterans	Within 2 weeks	Higher sensitivity and uncertainty in response
All others	Within 4 weeks	Balance safety with feasibility

Justification

A risk stratified monitoring schedule balances veteran safety with practical clinical workload. Incorporating clinical response and dose adjustment needs ensures that monitoring remains dynamic rather than fixed. Early follow up is essential during titration to identify adverse effects, optimise dosing, and confirm that treatment goals are being met. Once veterans achieve stable benefit without harms, monitoring intervals may be extended.

As the evidence base is limited by short trial durations, ongoing monitoring is essential to detect longer term harms or diminishing benefit. Veteran recorded data on use patterns, adverse effects, and symptom change improves the accuracy of clinical assessment and supports shared decision-making regarding continuation, adjustment, or cessation of therapy.

3.3 Side effects and adverse events

Recommendation

Clinicians should routinely monitor for adverse effects in the following domains when prescribing medicinal cannabinoids:

- Central nervous system: monitor for dizziness, fatigue, impaired attention, euphoria, balance disturbance, and falls
- Psychiatric symptoms: monitor for anxiety, mood changes, paranoia, and psychosis, particularly in veterans receiving higher THC formulations or those with pre-existing mental health conditions.
- Gastrointestinal effects: monitor for nausea, vomiting, diarrhoea, and appetite or weight change.
- Cardiovascular effects: monitor heart rate, blood pressure (including orthostatic symptoms), and any new cardiac symptoms, especially in older adults or those with cardiovascular disease.
- Respiratory symptoms: monitor for cough, wheeze, sputum production, or bronchitis in veterans who use inhaled products.
- Drug interactions: review existing and any newly prescribed medications.

Justification

Given the heterogeneity of patient responses and uncertainty in the full spectrum of harms, this guidance adopts a precautionary approach to monitoring across a broad range of potential adverse effects.

Randomised trial and observational data demonstrate consistent increases in central nervous system, gastrointestinal, psychiatric, and cardiovascular symptoms with cannabinoids compared with placebo, particularly for THC containing products, supporting routine monitoring in these domains. However, most trials are short in duration and unable to detect rare, cumulative, or delayed adverse

effects. Adverse events are frequently under reported or inconsistently classified, and trial populations typically exclude higher-risk groups such as older adults, those with significant cardiovascular or psychiatric comorbidity, and people taking multiple medications.

Individual sensitivity also varies, with prior exposure, comorbidities, concomitant medicines, and THC:CBD ratios influencing both the likelihood and severity of adverse effects.

3.4 Long-term harm

Recommendation

Clinicians should also routinely monitor for the following long-term harms in veterans using medicinal cannabinoids:

- Pulmonary: chronic cough, sputum production, wheeze, and other bronchitis-like symptoms in veterans who use inhaled products.
- Cardiovascular: new or worsening tachycardia, palpitations, chest pain, syncope, or other symptoms suggestive of cardiovascular instability, especially in individuals with pre-existing cardiovascular disease.
- Cognitive: memory impairment, confusion, and attention problems.
- Psychosis: emerging psychotic symptoms, including paranoid / suspicious ideations, hallucinations, delusions, or disorganised thinking, especially in veterans using THC containing products or with a personal/family history of psychosis. Veterans and carers should be advised to seek urgent medical attention if any suggestion of psychotic symptoms develops
- Cannabis induced hyperemesis syndrome: recurrent nausea, vomiting, or abdominal pain in long term users, particularly when symptoms are cyclical or relieved by hot bathing.

Justification

Evidence on long term harms derives primarily from observational studies rather than randomised clinical trials. These studies consistently identify potential risks in pulmonary, cardiovascular, psychiatric, and gastrointestinal domains, though causality is often uncertain due to confounding, reliance on self-report, and lack of dose or route specificity.

A precautionary approach is warranted given this uncertainty and the potential for harms to emerge gradually over time. Monitoring across these domains supports early detection, risk mitigation, and informed shared decision making in the context of incomplete long-term evidence.

3.5 Management of adverse effects

Recommendation

Provide veterans with clear guidance on common and serious adverse effects, and encourage prompt reporting of new or worsening symptoms. Clinicians should routinely document and report suspected adverse events to regulatory bodies to strengthen safety monitoring. Treatment goals, dosing, and tolerability should be reviewed regularly (within 2 weeks for high-risk veterans and within 4 weeks for other veterans), with dose adjustment or deprescribing considered when harms outweigh benefits.

Justification

Regular reassessment of benefits and harms ensures that treatment remains aligned with veteran goals and allows timely dose modification or deprescribing when risks begin to outweigh therapeutic benefit.

Evidence from pharmacovigilance systems in Canada and Australia shows that adverse events related to medicinal cannabinoids are frequently under-reported, limiting the ability of these systems to detect emerging risks. Encouraging both clinicians and veterans to report suspected adverse events improves the quality of safety data and regulatory oversight.

Further information

Information on how to report an adverse event to the TGA can be accessed here: https://www.tga.gov.au/safety/report-problem/report-adverse-event-or-safety-problem/reporting-adverse-events-health-professionals

3.6 Hazardous, harmful, or dependent use

Recommendation

Use a structured and proactive approach to assessing and monitoring the risk of hazardous, harmful, or dependent use and withdrawal in veterans prescribed medicinal cannabinoids. Screen all veterans for Cannabis Use Disorder (CUD) at baseline and periodically during treatment using a validated tool such as the CUDIT-R.

Increase monitoring frequency for veterans with known risk factors, including a history of substance use disorder, mental health conditions, or escalating cannabinoid use.

If signs of hazardous, harmful, or dependent use emerge, reassess the indication for treatment, consider dose reduction or discontinuation, and take an active role in facilitating access to appropriate evidence-based psychological support and treatment.

Justification

A consistent and proactive approach to monitoring helps clinicians identify early signs of hazardous, harmful, or dependent use before they become entrenched. Using a validated tool such as the CUDIT R provides a simple, structured way to detect concerning patterns of use. Screening is especially important for veterans with known vulnerabilities, such as past substance use, untreated mental health conditions, or difficulty adhering to treatment plans, because these groups are more likely to develop problematic use.

When hazardous, harmful, or dependent use is suspected, reassessing the original treatment goals helps determine whether cannabinoids remain appropriate. Consider dose reduction or discontinuation and referral to specialist addiction services where indicated. Evidence supports psychological therapies, particularly cognitive behavioural therapy, and motivational enhancement therapy, as effective treatments for CUD. These approaches can be offered alongside dose reduction or discontinuation and ongoing management of chronic pain symptomatology.

4. Deprescribing

4.1 Indications for discontinuation

Recommendation

Discontinue medicinal cannabinoids when treatment is not providing meaningful clinical benefit after an adequate trial (usually 8 – 12 weeks after initiation depending on titration) or when safety concerns emerge. Discontinuation or dose reduction should also be considered where the veteran's symptoms have stabilised and they have been successfully transitioned onto other, more evidence-based treatments. Discontinue treatment if adverse effects persist despite dose adjustment, or if the veteran develops symptoms consistent with cannabis use disorder, particularly escalating use of higher potency THC products. Immediate cessation is required if the veteran develops psychotic symptoms such as paranoia or hallucinations, cardiac or pulmonary issues or persistent vomiting (cannabis induced hyperemesis). In all cases of suspected acute psychosis, arrange mental health assessment and initiate evidence-based acute management.

Justification

Clear discontinuation criteria ensure that medicinal cannabinoids are used safely and only when they provide sustained benefit. Evidence shows that many veterans do not experience clinically meaningful improvements in pain or function, and continuing therapy without benefit exposes them to unnecessary risks. Persistent adverse effects indicate poor tolerability and warrant reassessment of product formulation, dosage or route of administration or cessation. Psychotic symptoms represent a serious safety concern and require immediate discontinuation. The emergence of cannabis use disorder or escalating THC use indicates that treatment is no longer being used in a controlled, therapeutic manner and may be associated with an increased risk of harm. Applying structured discontinuation criteria supports safe prescribing, prevents prolonged exposure to ineffective treatment, and ensures that veterans transition to alternative evidence-based options when appropriate.

4.2 Approach to cessation

Recommendation

Use a gradual, structured taper when discontinuing medicinal cannabinoids. Reduce THC doses slowly in small increments, such as around 10% of total dose every one to two weeks, with regular review to adjust the taper according to symptoms, goals, and clinical need. Switching from flower to oral products, using lower mg per ml products to enable smaller dose reductions, or transitioning to lower potency THC products may help minimise withdrawal severity and support dose reductions. Provide clear education about expected withdrawal symptoms and timeframes.

Support cessation with practical coping strategies, including sleep and anxiety management techniques, pain self-management approaches, and psychological support and treatment when needed as well as when to seek assistance. Ensure alternative pain management options are in place before and during the taper, and review symptoms regularly to adjust the plan.

Justification

A structured taper reduces the likelihood and severity of withdrawal symptoms such as irritability, sleep disturbance, anxiety, and rebound pain. Evidence and international guidelines consistently recommend gradual dose reduction when discontinuing cannabinoids, particularly for veterans using higher potency THC doses or long-term therapy. Switching to lower-THC and longer acting formulations such as oral formulations may further ease withdrawal by reducing abrupt changes in cannabinoid exposure.

Providing education and supportive strategies improves patient confidence and reduces distress during cessation, while psychological support is beneficial for individuals with dependence or difficulty reducing use. Ensuring alternative pain management approaches are in place maintains continuity of care and reduces the risk of symptom recurrence. Although high-quality trials on cessation strategies are limited, expert consensus and observational evidence strongly support a gradual, supported taper to optimise safety and minimise adverse outcomes.

4.3 Management of withdrawal symptoms

Recommendation

Cannabis withdrawal is a clinically significant cluster of symptoms, behaviours and/or physiological features that occurs upon cessation or reduction of use of cannabis in individuals who have developed cannabis dependence or have used cannabis for a prolonged period or in large amounts. Presenting features of cannabis withdrawal may include: irritability, anger or aggressive behaviour, shakiness, insomnia, restlessness, anxiety, depressed or dysphoric mood, decreased appetite and weight loss, headache, sweating or chills, abdominal cramps and muscle aches (World Health Organization (WHO), 2018).

Use structured, supportive interventions to prevent or manage withdrawal symptoms when reducing or discontinuing medicinal cannabinoids. Provide psychoeducation on the expected course of withdrawal, including onset, peak, and duration of symptoms. Encourage sleep hygiene, hydration, nutrition, physical activity, and coping strategies for cravings and anxiety. Consider short-term symptomatic medications for distressing symptoms such as insomnia, anxiety, nausea, or headaches, used cautiously and for no longer than 7 days. Assess for other substance use or comorbid conditions that may mimic or worsen withdrawal and use withdrawal scales when needed to gauge severity and functional impact.

Most veterans can complete withdrawal in a community or outpatient setting, but consider inpatient withdrawal support for individuals with significant mental or physical health concerns or polysubstance withdrawal risk.

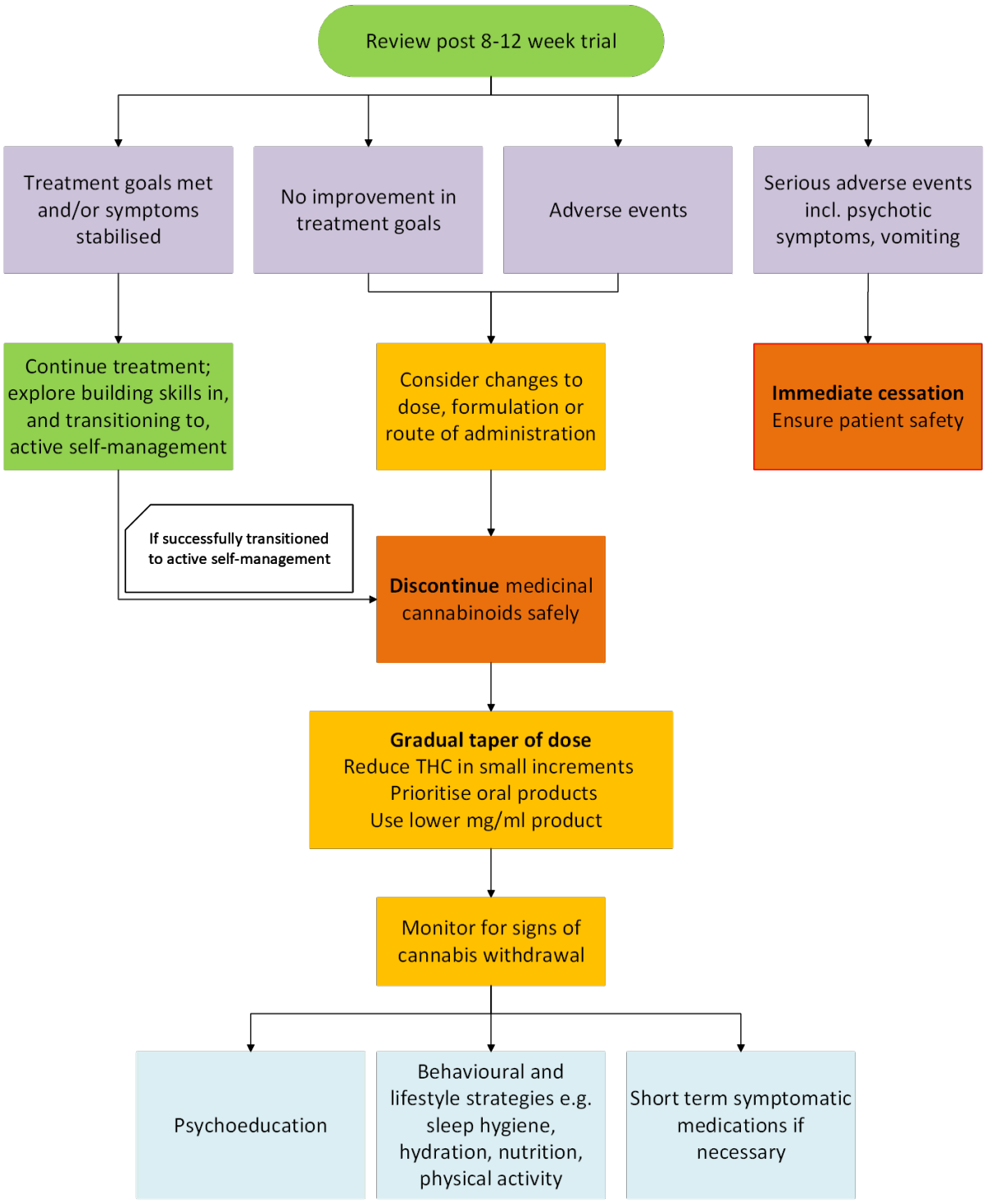
Justification

Cannabis withdrawal is a well-defined clinical condition recognised in the ICD-11 and occurs in a substantial proportion of regular or dependent users when reducing cannabis intake.

Evidence and clinical guidelines consistently recommend psychoeducation and behavioural strategies as first-line interventions, as these help patients understand the normal course of withdrawal and reduce anxiety about symptom fluctuations. No medications are specifically approved for CWS, but short-term symptomatic treatments can reduce discomfort when used cautiously. NSW Health advises

limiting these medications to brief use only. For further information see the Evidence Report for examples of symptomatic medications.

Flowchart 2. Clinical Deprescribing of Medicinal Cannabinoids



Development of this guidance

This guidance was developed utilising the expertise of a three-tier structure that allows for multidisciplinary review. The intent is to ensure transparent processes, clear roles, and documented decisions across all stages of development.

- **Research Team**: Lead the methods and project management, conducted evidence review and synthesis, drafted the guidance, and managed consultation.
- **Guideline Development Group (GDG)**: A multidisciplinary external group of clinicians, researchers, and consumers representatives that provided expert advice throughout development, identified priority issues for consideration, reviewed evidence and draft recommendations, and participated in consultation processes.
- **Independent Review Committee (IRC)**: Provided independent review at key decision making points and endorsement for finalisation and publication.

Research Team

This project was led by the National Drug and Alcohol Research Centre (NDARC), UNSW Sydney, and drew on strong, ongoing partnerships with Key Personnel from other institutions including the University of Queensland and Monash University.

Table 2: Research Team Members

Key Personnel	Role
Louisa Degenhardt	Professor, NDARC Director of Research, UNSW
Chrianna Bharat	Post-doctoral Research Fellow, NDARC, UNSW
Michael Farrell	Professor, NDARC Director, UNSW
Gabrielle Campbell	Senior Research Fellow, UQ
Suzanne Nielsen	Professor, Monash Uni
Wayne Hall	Emeritus Professor, UQ
Jennifer Martin	Professor, University of Newcastle
James Manley	Prescribing Clinician, ACT
Zoe Pollock	Research Officer, NDARC, UNSW
Xintong Huang	Research Assistant, NDARC, UNSW
Nicole Leong	Project Officer, NDARC, UNSW

Guideline Development Group

A Guideline Development Group (GDG) was established to ensure that this clinical guidance is evidence-based, practical, and reflects both clinical expertise and the lived experience of cannabinoid use.

The GDG brought together a balanced mix of clinical experts, researchers, and community representatives. Members were selected for their expertise in chronic pain, veteran health, addiction medicine, military psychiatry, and the therapeutic use of cannabinoids, as well as their ability to represent consumer perspectives. See table 2, below for details on members.

Table 3: Guideline Development Group Members

Name	Position/ expertise	Affiliation
Robert Ali AO	Emeritus Professor (Addiction); Physician (Public Health)	University of Adelaide
Ainslie Cahill AM	Community representative (Chronic pain)	UNSW Sydney Health Systems Review Theme Executive Committee
Nicola Fear	Professor (Military psychiatry) Co-Director	King's College London Forces in Mind Trust Research Centre King's Centre for Military Health Research
Ian R Gardner	Physician (Veterans' health)	Chair, Services and Clinical Governance Committee, RSL Queensland
Bridin Murnion	Clinician (Pain, Addiction) Conjoint Associate Professor	Pain Management and Research Institute, Northern Sydney LHD Medicine and Health, UNSW Sydney
Lara Shallard	Community representative (lived experience of using cannabinoids for chronic pain)	N/A
Hester Wilson	Chief Addiction Medicine Specialist General Practitioner	Chair of RACGP Addiction Special Interest Group

Independent Review Committee

An Independent Review Committee (IRC), convened by the Department of Veteran's Affairs reviewed project plans and guidance materials, provided independent feedback, and were responsible for the final endorsement of the Clinical Guidelines.

Table 4: Independent Review Committee Members

Name	Role	Expertise
Associate Professor Dr Vicki Kotsirilos AM	Chair	Clinician General Practitioner and medicinal cannabis prescriber
Associate Professor Michael Vagg	Member	Clinician Pain and Rehabilitation Medicine specialist
Mr Scott Jeffrey JP	Member	Consumer Representative
Dr Maxwell Qu	Member	Clinician Consultant Psychiatrist and Addiction Medicine Specialist

Disclosure of conflicts of interest

The Research Team, GDG and IRC Members were asked to disclose all relevant interests (financial and non-financial) upon acceptance into the group so that conflicts of interest could be identified and managed. No major conflicts of interest were identified.

Funding

Funding for this guidance was provided by the Department of Veterans Affairs.

Methods

The development of this clinical guidance was informed by a comprehensive Evidence Report, which includes the full systematic review of primary studies and a narrative synthesis of existing international guidelines.

Developing the recommendations

Recommendations were developed through an iterative process. The Research Team drafted initial guidance based on the findings of the Evidence Report and the synthesis of existing guidelines. The Guideline Development Group (GDG) then reviewed and refined these drafts, considering clinical experience, consumer perspectives, feasibility, acceptability, and relevance to the veteran population. Draft recommendations were subsequently reviewed by the Department of Veterans' Affairs Independent Review Committee (IRC), and revisions were made in response to their feedback.

Clinical questions were structured using the PICO framework (Population, Intervention, Comparator, Outcome), focusing on outcomes most relevant to people with chronic non-cancer pain, including pain interference, functional improvement, sleep, mental health symptoms, adverse effects, and risks such as dependence and psychosis. Where evidence was limited or uncertain, this is noted, and recommendations are based on expert consensus.

Appendix

Appendix 1. Evidence to inform recommendations

eTable 1: Relevant evidence that informs the recommendations drawn from the draft evidence report

Assessment		Page no.
1.1 Indications for consideration of Medicinal Cannabinoids as a treatment	- Section One: "The outcome-related findings derived from the systematic review are summarised below…" - Section Two: Initiation "When to consider starting medicinal cannabinoids"	10, 14-16
1.2 Contraindications and populations requiring caution	- Section Two: Table 1: Absolute and relative contraindications for medicinal cannabinoids	18-19
1.3 Baseline pain and physical function assessment	- Section Two: "Documenting baseline status is essential for detecting any deterioration during treatment, monitoring treatment response and assessing whether benefits outweigh risks" - Section Three: " Accurate assessment of symptom change requires the use of validated instruments"	18 & 29
1.4 Mental health and psychosocial assessment	- Section Two: "Cannabinoids can have adverse effects on mood and cognition" - Section Two, Table 1 - Section Three: "Substantial evidence supports an association between cannabinoids use and psychotic disorders, particularly schizophrenia, with the highest risk among frequent and heavy users"	18-19 & 33
1.4 Substance use and risk assessment	- Section Two: "Research shows that people who use cannabis have a 1 in 4 risk of developing cannabis use disorder (CUD). Veterans with chronic non-cancer pain face a particularly elevated risk" - Section Two, Table 1: Previous substance hazardous, harmful or dependent use is a relative contraindication - Section Three: "A meta-analysis of 10 studies found a pooled prevalence of 25% (95% CI: 18–33%)" for CUD among medicinal cannabis users	17, 19 & 35
1.6 Medical and medication review	- Section Two: "Medicinal cannabinoids can interact with many commonly prescribed medications through the induction or inhibition of Cytochromes P450 family isoenzymes" - Section Two, Table 2: Interactions between cannabinoids and other medications (Antoniou et al., 2020).	20-21

Initiation		
2.1 Selection of formulations	- Section two: "THC is the psychoactive component responsible for the "high" associated with cannabinoid use, while CBD does not produce psychoactive effects" - Section two: "....individualised based on careful assessment of each patient's risk-benefit ratio and their willingness to accept the associated risks"	23
2.2 Route of administration	- Section two: "Medicinal cannabinoids can be administered through several routes, each with different characteristics, including oral ingestion (e.g., tablets, capsules, and oils), inhalation, and others (including sublingual and topical)" - Section two: "Smoking is not recommended "	23-24
2.3 Dosing and titration strategy	- Section two: "The fundamental principle for initiating medicinal cannabinoids is to 'start low and go slow'" - Section two: "safe and effective dosage varies among individuals, and a conservative approach minimizes adverse effects while identifying the minimum effective dose "	24-25
2.4 Veteran education, consent and care team communication	- Section two: "A structured treatment plan and informed consent process are critical for safe, effective and ethical prescribing of medicinal cannabinoids" - Appendix 3: Patient consent forms	26 & 59
2.5 Psychological support and treatment	- Section two: "CNCP should be managed within a biopsychosocial framework" - Section two: "including individually tailored physical exercise programs and behavioural therapies such as cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT) to improve coping, function, and quality of life"	14 - 15
Assessment		
3.1 Clinical outcomes to monitor	- Section three: "Accurate assessment of symptom change requires the use of validated instruments "	29
3.2 Monitoring frequency	- Section three: "Monitoring frequency.... the recommended follow-up frequency depends on 3 key factors: prior cannabinoid use, comorbidities, and the patient's ability to adhere to the treatment plan "	28
3.3 Side effects and adverse events	- Section three: "Evidence from systematic reviews and meta-analyses indicates that non-serious adverse events are common particularly with THC-containing formulations, while serious adverse events are rare" - Table 3: Adverse events associated with cannabinoids	29- 30
3.4 Long term harm	- Section three: "Long-term safety data for medicinal cannabinoids remain limited. Most evidence on chronic adverse effects derives from recreational cannabinoids use, which is not directly comparable due to differences in regulation, dosing and route of administration."	31-34

3.5 Management of adverse effects	- Section three: "Reporting adverse events...."	34-35
3.6 Hazardous, harmful or dependent use	- Section three: "The Diagnostic and Statistical Manual of Mental Disorders (5th edition) (DSM-5) defines Cannabis Use Disorder (CUD) as “a problematic pattern of cannabis use leading to clinically significant impairment or distress” - "Section three: While most research focuses on recreational cannabinoid use (Gottschling et al., 2020) emerging evidence indicates that CUD is also common among people using cannabinoids for medical purposes."	35-37
Deprescribing		
4.1 Indications for discontinuation	- Section four: "Clinical guidelines recommend discontinuing medical cannabinoids if...."	38
4.2 Approach to cessation	- Section four: "When treatment goals are unmet or adverse effects occur, patients should work closely with their clinician to develop a safe discontinuation plan " -Section four: "Pair deprescribing with psychoeducation, coping strategies and discussion of alternative treatments"	38- 39
4.3 Management of withdrawal symptoms	- Section four: "....cannabinoids withdrawal syndrome occurred in about 47% of regular or dependent cannabinoids users" - Section four: "Management of CWS...." - Table 4: “Symptomatic medications for the management of CWS”	39-40

Appendix 2. Checklist for prescribing medicinal cannabinoids for chronic non-cancer pain for Veterans

Veteran Name: _____

Date of appointment: _____

This checklist is designed to support shared decision making between veterans and clinicians when considering medicinal cannabinoids for chronic non-cancer pain. It is intended to guide discussion, clarify expectations, document consent, and support safe initiation, monitoring, and discontinuation where appropriate. It should be used in conjunction with the ***"Clinical Guidance for the Use of Medicinal Cannabinoids in the Management of Chronic Non-Cancer Pain in Veterans".***

Section 1: Veteran priorities and goals

Primary pain condition(s) and duration: _____

Impact on daily activities, sleep, work, and mood: _____

_____

Veteran-identified goals for treatment (what would "meaningful improvement" look like for you?):

☐ Reduced pain ☐ Improved function ☐ Better sleep ☐ Improved coping

☐ Improved mood ☐ Reduce other medicines ☐ Other:

_____

_____

Understanding of medicinal cannabinoids. Discuss and document the veterans:

- Previous use or experience with cannabinoids, if any
- Expectations of benefit
- Concerns, fears, or misconceptions
- Cultural or personally related perspectives

_____

_____

Section 2: Veteran eligibility and prior treatment review

☐ Diagnosis of chronic pain confirmed

☐ Adequate trials of evidence-based non-pharmacological and pharmacological treatments with minimal success

Clinical rationale for considering medicinal cannabinoids: _____

_____

To support safe prescribing, coordination of care, and monitoring of interactions or adverse effects, medicinal cannabinoids (and if possible, all medications) should be prescribed by a single nominated clinician, with communication to other treating providers as appropriate.

☐ Agreement that medicinal cannabis will be prescribed by a single nominated clinician

☐ Care coordination with the other prescribers discussed:

_____

_____

Section 3: Baseline assessments

To support safe consideration for prescribing, the following assessments should be completed:

☐ Pain severity and pain interference documented (e.g. BPI). Score: _____

☐ Functional status and quality of life assessed (e.g. SF-12 or EQ-5D). Score: _____

☐ Sleep assessment completed (e.g. PSQI). Score: _____

☐ Mental health screening completed (e.g. K10, DASS21, GAD7, PHQ9 or PCL5) Score: _____

☐ Substance use and CUD risk screening completed (e.g. CUDIT-R). Score: _____

☐ Medical conditions and current medications reviewed

Section 4: Contraindications

Medicinal cannabinoids **will not be started** if any of the following apply:

- Known hypersensitivity to cannabinoids
- Severe or unstable cardiovascular disease
- Active psychotic disorder
- Pregnancy, breastfeeding or planning to get pregnant
- Active untreated substance dependence (excl. nicotine)

Heightened caution and monitoring discussed if applicable, including:

- Young adults (<25 years)
- Personal history (active or past) or first-degree family history of a mental health disorder
- Past history or first-degree family history of psychotic disorder
- Active (treated) or past personal history of substance dependence – seek consultation with specialist
- Severe hepatic or renal impairment
- Older adults at increased risk of falls
- Veterans taking concomitant medications with potential interactions (see evidence report for further details)

☐ No absolute contraindications identified

☐ Relative risks assessed and discussed with the veteran

Product not endorsed by TGA discussed

Any financial COI including of company worked for (not just doctor personally)

If present, risks requiring enhanced monitoring: _____

_____

Section 5: Risks and side effects

☐ Potential adverse effects and safety risks discussed

Possible side effects of medicinal cannabis include:

- Central nervous system: monitor for dizziness, fatigue, impaired attention, euphoria, balance disturbance and falls
- Psychiatric symptoms: monitor for anxiety, mood changes, paranoia, and psychosis, particularly in veterans receiving higher THC formulations or those with pre-existing mental health conditions.
- Gastrointestinal effects: monitor for nausea, vomiting, diarrhoea, and appetite or weight change.
- Cardiovascular effects: monitor heart rate, blood pressure (including orthostatic symptoms), and any new cardiac symptoms, especially in older adults or those with cardiovascular disease.
- Respiratory symptoms: monitor for cough, sputum production, or bronchitis in veterans who use inhaled products.

☐ Risk of developing physiological dependence and cannabis use disorder explained

☐ Action plan for experiencing side effects developed

☐ When to seek urgent medical attention e.g. any psychotic symptoms, cardiac experienced to seek urgent medical care (ED or hospital)

☐ Veteran advised that some adverse effects, including psychotic or behavioural changes, may not be recognised by the veteran themselves.

☐ Veteran encouraged to inform a family member, carer, or trusted person about potential warning signs and to ask them to monitor for changes

Driving

Veterans must be advised that it is illegal to drive while impaired or incapacitated, regardless of whether the substance causing impairment is prescribed.

☐ Veteran advised to refer to their relevant state or territory transport authority website for current driving and medicinal cannabis regulations

Section 6: Treatment plan

☐ TGA categories of medicinal cannabinoids explained to veteran

☐ Start low and go-slow approach explained

☐ Initiation should generally commence with CBD and low dose THC products, with cautious titration of THC where clinically indicated

Proposed product: _____

TGA category of product:

☐ Category 1: CBD medicinal cannabis product (CBD ≥98%)

☐ Category 2: CBD-dominant medicinal cannabis product (CBD ≥60% and <98%)

☐ Category 3: Balanced medicinal cannabis product (CBD ≥40% and <60%)

☐ Category 4: THC/other cannabinoid dominant medicinal cannabis product (CBD ≥2% and <40%)

☐ Category 5: THC/other cannabinoid medicinal cannabis product (CBD <2%)

Rationale for chosen formulation: _____

_____

Route of administration: ☐ Oral ☐ Sublingual ☐ Topical ☐ Inhaled products

☐ If inhaled products selected, explain additional risk

Starting dose: _____

Timeline for titration: _____

☐ Psychological support referral discussed or initiated

☐ Safe storage of products

Section 7: Discontinuation

☐ Criteria for deprescribing of treatment explained:

- Lack of meaningful improvement
- Persistent adverse effects
- Development of problematic or escalating use
- Emergence of psychiatric symptoms

☐ Plan for safe cessation discussed

- Gradual taper planned where appropriate

- Alternative pain management strategies in place during and after cessation
- Veteran informed about possible withdrawal symptoms and when to seek review

Section 8: Follow up and monitoring plan

☐ Expected benefits and limitations of treatment discussed

☐ Monitoring outcomes discussed and decided upon

☐ Clear criteria for dose adjustment and discontinuation explained

Initial review scheduled for (date): _____

☐ Planned ongoing monitoring frequency discussed

☐ Ongoing prescribing to be coordinated through a single clinician, with changes to other medicines communicated and reviewed

Section 9: DVA funding eligibility and process

Eligibility criteria (must be met):
☐ Veteran holds an eligible Veteran Card (Gold/Orange, or White Card for an accepted condition)
☐ Evidence-based standard treatments have been trialled and were ineffective or not tolerated

Medicinal Cannabis Framework 2-tier classification

Use this table to help you identify the appropriate Tier for submitting your client's application.

Criteria	Tier 1	Tier 2
Number of products	The eligible DVA client is receiving a maximum of 2 products at any one time.	The eligible DVA client is receiving up to 3 products at any one time.
Total dosage	The eligible DVA client is receiving 40 mg or less of Tetrahydrocannabinol (THC) in any product or products per day.	The eligible DVA client is receiving a total of more than 40 mg per day of THC across all products.

Product and prescribing constraints:

☐ Tier 1 vs Tier 2 requirements explained to veteran
☐ Veteran informed that only certain products are funded (e.g. oral capsules/liquids or approved vaporised dried herb; edibles such as gummies are not funded)
☐ Dose and product selection aligned with DVA limits

Process and patient information:

☐ Veteran informed of approval process, including need for authority prescription
☐ Veteran advised on concessional access via RPBS
☐ Further information provided to veteran on DVA website

https://www.dva.gov.au/providers/information-for-gps-other-primary-care-providers/medicines/medicinal-cannabis-information-for-providers

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