

March 8, 2017

Mr. Chair and Members of the Committee,

Thank you for the opportunity to share my concerns regarding SB 17-017. I represent myself, and in doing so, draw from extensive behavioral health and research related professional experiences as:

- The President of the Colorado Society of Addiction Medicine
- Distinguished Fellow of the American Psychiatric Association, Fellow of the American Society of Addiction Medicine, Member of the American College of Psychiatry
- The Medical Director of CeDAR, a 78 bed residential and outpatient treatment center for individuals with addiction and co-occurring behavioral health disorders
- An Associate Professor at the University of Colorado School of Medicine
- The Addiction Medicine Fellowship Program Director
- I spent the first half of my career involved in drug development for schizophrenia through the Denver VAMC
- I now spend my time in direct patient care of individuals with co-occurring trauma and addiction, advocating for improved behavioral health care (access, medication coverage and therapy coverage), and educating the next generation of addiction specialists and primary care physicians in addiction.

In a perverse way, I am here today to try to put myself out of a job by reducing the number of individuals who develop addiction.

I would also like to share that I have personal reasons to be here:

- I am the daughter and granddaughter of veterans and care for them deeply
- I know first-hand through my own experiences, as well as those of my close family members and friends, what it is to deal with chronic pain, whether physical or emotional, within our current medical system
- I am the mother of a 10 year old son and 12 year old daughter, both of whom more naturally associate the smell of a skunk with the idea that someone is smoking weed rather than the possibility of the animal being present nearby. Last year one of their friends was expelled for selling weed. 5<sup>th</sup> grade.

I want to stress to all those here today that I do not wish to invalidate the pain, frustration, and often poor outcomes that occur despite our best medical treatments for stress and trauma. I don't refute that cannaboids are promising therapeutics. I don't refute that there have been great costs to the inappropriate

prescribing of other medications, namely our current opioid epidemic, and what I think are other controlled substance epidemics coming down upon us, namely benzodiazepines and stimulants. I appreciate that to wait years to adopt medical marijuana for PTSD is at the risk of lost lives, but I fear that there are many lives also at risk with premature adoption of cannabis on large scale. There will be collateral damage.

Thus, I oppose SB17-017 as it is currently written. Please consider:

Lack of regulation of this treatment process and product is life-threatening

- Cannabis is not non-toxic. Intoxication is life threatening. Ask the kid who dabs medical hash oil and passes out, or the kid who jumps off a balcony, or the father who shoots his wife. How many homicides, suicides and motor vehicle accidents are associated with cannabis use? Stroke, intractable vomiting? We have little idea what the long term risks are within other organ systems. We do know that in addition to the risks above, there is risk of worsened behavioral health outcomes and increased rate of addiction.
- Whether prescribed on or off-label, FDA approved medications have quality control and have had to go through a process of study to understand the side effect profile so that a practitioner can work with a patient to make a truly informed decision based on risks and benefits. With the exception of DEA scheduled medications, other pharmacotherapies for stress and trauma are not dependence forming. When used off-label, which is not ideal, it is done so with at least some positive evidence base and excellent understanding of side effects.
- Did you know that the dose used in the oft quoted Sisley PTSD Cannabis study is 2 gummy bear legs?
- Did you know that THC levels (harmful) have risen from 0.2% in the 1960's to 11% in 2011 and 36% in 2015 while the amount of cannabidiol (protective) has been fairly consistent?
- Did you know that life-threatening and other behavioral risks are dose dependent and potency dependent?

A second point of opposition is related to the risk of decreasing child, adolescent and adult perception of risk with cannabis use if "stress" is adopted as an indication for medical marijuana. This is associated with increased risk of recreational use by individuals. Presence in the home increases risk of diversion. These factors increase the risks of intoxication, dependence, and development of other behavioral health disorders in individuals without stress disorders.

A third point is my concern that the relative ease and accessibility of cannabis over medical treatment for stress disorders will prevent individuals from seeking more appropriate care for their disorders, delaying treatment and exposing them to the risks discussed previously.

Finally, I fear that commercial enterprises, much in the lines of the tobacco industry, will exploit a vulnerable population and broken health care system to improve profits. Given the risks of cannabis exposure on developing brains, the high risks and unclear benefits of cannabis in behavioral health disorders, and the highly addictive nature of this substance, please do not pass this bill as written.


I beg you to consider ways to reduce the risk of the collateral damage that comes with the increasing use of cannabis products. Possibilities include:

- Restricting use to individuals over 21
- Quality control of prescribed product
- Creating a treatment guideline that insures treatment resistance to evidence based therapies prior to medical marijuana use and proper dosing strategies
- Creating a registry of all providers and patients to track potential benefits and side effects
- Insure that all MM prescribers abide by the Colorado Medical Practice Act and have a bona fide relationship with their patients
- Mandate that all prescribers are trained in addiction assessment and treatment.

I also strongly urge you to consider a model similar to compassionate use exemptions for experimental drugs, the x-waiver system for prescribing buprenorphine products, The Clozapine REMS mitigation strategy or adopt the protocol that Sisley et al are using for their study that has been approved by safety experts.

Thank you for your time and commitment to the people of Colorado. I would be honored to answer any other questions you may have now or in the future.

Sincerely,



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