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Medical Cannabis
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Thank you Chairman McIlhinney, Chairman Ferlo and distinguished members of the Law and Justice Committee. I appreciate the opportunity to testify today.

My name is David Bender. I serve as the Chief Strategic Officer of Compass Mark, a non-profit organization located in Lancaster County which has received national recognition for its work in preventing addiction.

Over 25 years ago, I was in the midst of a highly successful career in financial management when I witnessed the lives of many people close to me being destroyed by substance abuse and addiction. I chose to leave that career, give all of my money to a treatment and prevention organization and devote my time to bringing about better methods of prevention and intervention.

So, coming from someone who has dedicated his life and his resources to preventing the many harms caused by addictive chemicals, it may surprise you that I support Senator Folmer's efforts to permit the use of medical cannabis. Does this mean I'm blind to the risks? No. Does it mean that I see the approach as harmless and without potential collateral damage? No. There are risks we need to address.

I've been to enough House and Senate hearings on various topics to know a couple of things. One is that brevity and clarity are in short supply. I'll try to deliver both. Another is that testifiers tend to choose a side and then choose data supportive of that side. They pretend there is only one truth and that they own it. I hope with this issue we can leave behind the world of pretend. There are truths on all sides of this matter, and we need to calmly assess each one and come to rational – not perfect – decisions.

In brief, here are the issues and realities we ought to discuss. I believe these items are supported by both clinical data and experience. They reflect ONE truth, not THE truth. I'll simply provide bullet points with comments, and we can discuss further in Q&A.

- Yes, despite what some will claim, marijuana is addictive. Yes, there are characteristic withdrawal symptoms. Yes, those symptoms are clinically significant; and yes, the symptoms include cravings that can lead to relapse. The symptoms are mild for most users – similar to tobacco withdrawal – and include impairments such as sleep deprivation, angry outbursts, loss of appetite, irritability and nightmares. They begin about 24 hours after ending use, peak after 3 or 4 days, and subside in 1 to 3 weeks. DSM-V, the diagnostic and statistical manual for diagnosing mental disorders, identifies 11 criteria for the diagnosis of Cannabis Use Disorder, most of which focus on the loss of control of use or the continued use despite harmful

consequences. Two or three symptoms indicate a mild disorder; six or more is severe. So yes, the disorder is definable, observable and quantifiable. It is real.

- Downplaying the risks of cannabis use and overselling its benefits are not helpful to the implementation of medical cannabis practices. This past week, Chicago filed suit against five pharmaceutical companies, alleging they contributed to the nation's prescription drug abuse epidemic by misrepresenting the benefits and concealing the risks of addiction. Last month, two other municipalities filed suit against the same companies for the same reason. Rather than denying the existence of risk, let's assess it against benefit and, if the trade-off is acceptable, seek to contain the risk.
- Two of the greatest risks of medical cannabis are 1) the diversion of it to unintended use and 2) the lowering of the perception of harm of the substance (i.e. the increased belief that if doctors prescribe it for children, it must be completely harmless). The first risk can be addressed in part procedurally, but let's keep in mind that prescription drugs have been broadly diverted to unintended use despite increased regulation. It is clear that the authors of this bill are serious about instituting strict controls to limit diversion, but fallout will still occur and we need to be prepared for it.

  The second risk has been defined as the earliest precursor to increased public use of a substance if not addressed. It is harder to contain than the first item and requires increased attention and resources devoted to prevention and education. Pennsylvania woefully underfunds current prevention efforts and will need to redirect its strategies by focusing less on a criminal justice approach and more on a public health model.
- If the items listed above lead to greater levels of harmful use and addiction, Pennsylvania does not currently have the capacity to respond. As is the case across the nation, only one in ten individuals who need treatment, receive it. New Jersey recently documented 41,000 adults and 9,400 adolescents who requested treatment but were turned away. PA has a similar situation. In my county, treatment dollars that previously made it through the year, now run out three months into it.

  This is both a money and capacity issue. The number of substance abuse counselors needed to deal with the influx of patients who will now be covered by the Affordable Care Act is projected to increase 27% in five years. The pathway to fill those positions is blocked primarily by inadequate compensation. A patient care worker at a treatment center typically earns $3,000 less per year than an assistant manager at Burger King. Priorities need to change.
- Prior to 1982, Pennsylvania had two mandatory sentences, one for Murder 1 and one for Murder 2. By 1988, we had 23, most related to drug offenses. The state prison population which had remained consistent at approximately 7,000 individuals throughout four decades surged to its present level of 52,000. A corrections budget of $140 million rose to its current $2 billion per year. Further incarceration of individuals involved in diverting medical marijuana to unintended use will exacerbate the fiscal and moral problems of this ineffective approach. Again, proponents of medical marijuana must also be proponents of a changed strategy for addressing possible fallout by shifting focus from a solely criminal justice approach to one emphasizing treatment and prevention.

So why would I iterate these risks yet support the proposal? Doesn't it contradict the testimony I gave here nearly a year ago regarding HB 690's privatization of the liquor stores? Why would I be opposed to HB 690's expansion of access to alcohol but be in favor of a bill that could potentially increase unintended access to marijuana?

First, HB690 was the most financially irresponsible bill I've ever read, and I've read a lot. Second, its primary stated purpose was to make liquor cheaper and more convenient. Its passage through the House was cited by the majority leader as an historic moment. My qualifying bar for an historic moment is apparently higher than his. Discovery of the polio vaccine; the fall of the Berlin Wall; the Normandy invasion; the births and deaths of Gandhi, Martin Luther King, Mother Theresa, Jesus and the Buddha would make my list. How small is the world of someone who puts cheap vodka in that list? I said then that if the purpose of the bill was something grander and nobler – that if it somehow led to a cure for cancer or brought peace to the Middle East - I'd see the sacrifice of additional lives to addiction worth the greater outcome. But all it offered was cheap vodka.

This bill promises something worthy of the risks, and the risks can be moderated through changes in strategies and budget priorities. I'm not here to speak to the efficacy or potential that lies in the treatments that have been or will be extracted from cannabis. The medical community has already spoken of the need to lift the barriers and allow further clinical use and testing. I'm here to speak for the protection of those who can and do become addicted to cannabis.

For the "benefit" of cheap vodka, I would never risk any of those lives. But I have to ask myself how that compares to the real benefit of moving a child from hundreds of seizures a day to several a week. Do we have the right to sacrifice that child for the sake of the greater good of the Commonwealth....to protect its larger population from possible addiction? It may be acceptable to answer in the affirmative. As difficult as it would be to face that child and his or her parents and deny the treatment, I could be that tough. I could be that tough if there were no alternatives. But there are. There are alternatives if we make the decision to roll back mandatory sentencing, reduce the prison population, increase prevention and treatment capacity and adopt a public health approach to addiction.

The treatment system would be overwhelmed if marijuana were legalized today. But that day may very well be coming. The silver lining to medical cannabis is that it buys us time. It tests the risks, allows us to begin the shift from prisons to treatment and helps us build programs of prevention that are built on greater knowledge of how cannabis heals and how it harms.

What I work for and hope for is the day when laws regarding mind-altering drugs will be a non-issue. I work for the day when people don't care whether a substance is legal or not. They simply choose not to muddle their minds. That day arrived for me a long time ago, but it hasn't arrived for much of the population. I would never even think of using a drug like propofol to alter my mind, but I'd be grateful for its existence if I suffered major burns or a severe head injury. I understand the difference between its medical uses and its unintended uses. Because others do not, or because others may abuse it is not a reason to ban its medical use. I suggest that we apply the same thinking to cannabis, but as we do, let's get serious about how we deal with the societal side effects of all mind-altering medicines.

Thank you for your time, and I'd be happy to answer any of your questions.