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SENATE JOURNAL
CLERK NO. 9
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SB 336

Fwd: PTSD -- SENATE BILL NO. 336

Thu, Feb 17, 2011 at 12:18 AM

TayIn Lang <tayInlang@gmail.com>
To: Montanaconnect@gmail.com

----- Forwarded message -----

From: "Michael Krawitz" <miguet@infonline.net>
Date: Feb 16, 2011 9:19 PM
Subject: PTSD -- SENATE BILL NO. 336
To: "Representative David Wanzenried" <daveew@gmail.com>

Dear Representative Wanzenried,
Thank you so much for presenting this bill, SENATE BILL NO. 336, to add PTSD as a qualifying condition in Montana's medical marijuana program.

Our organization is in contact with veterans from many states that report good results with cannabis as a treatment for the symptoms of post traumatic stress. Access to cannabis for this medical condition can and does save lives.

You might not be aware of recent changes in VA policy that recognize medical marijuana and defer to state laws but this new policy makes it clear that your bill is absolutely necessary to provide Montana's veterans access to this important treatment option as well as giving the VA itself the ability to understand this treatment and study it's effectiveness. The VA can do nothing towards that end without this bill becoming law.

New VA medical marijuana policy:

http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2276

Good luck! Please let me know if we may be of any assistance,
Michael

Michael Krawitz
Executive Director, Veterans For Medical Cannabis Access
<http://www.veteransformedicalmarijuana.org/>
3551 Flatwoods Road, Elliston, Virginia, USA -- 540-365-2141

EVIDENCE:

1}

Israel reference Article:
<http://realneo.us/va-difficult-position-300000-brain-damaged-veterans-may-need-illegal-marijuana>

From Medical Marijuana for PTSD, November, 2009, in PsychCentral:

A new study carried out by Dr. Irit Akirav and research student Eti Ganon-Elazar, working at the Learning and Memory Lab in the University of Haifa's Department of Psychology, suggests the use of cannabinoids may help in the treatment of post-traumatic stress disorder patients. According to Dr. Akirav, the results of this study show that cannabinoids can play an important role in stress-related disorders. "The results of our research should encourage psychiatric investigation into the use of cannabinoids in post-traumatic stress patients," she concludes.

2}

Cesemet study:

<http://onlinelibrary.wiley.com/doi/10.1111/j.1755-5949.2008.00071.x/full>

3}

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<http://science.iowamedicalmarijuana.org/Home.aspx/Psych>

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Psychiatric

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Michael Krawitz

Executive Director, Veterans For Medical Cannabis Access

<http://www.veteransformedicallmarijuana.org/>

3551 Flatwoods Road, Elliston, Virginia, USA -- 540-365-2141

Evidence:

<http://www.cmcrc.ucsd.edu/geninfo/research.htm>

http://www.cmcrc.ucsd.edu/CMCR_REPORT_FEB17.pdf

Since we received the results of these studies [only last year] the Veterans Health Administration has accepted these proof and have issued the following VA system wide directives and clarifications:

<http://www.veteransformedicalmarijuana.org/files/Undersecretary-Jun6.pdf>

http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2276

###

The Use of a Synthetic Cannabinoid in the Management of Treatment-Resistant Nightmares in Posttraumatic Stress Disorder (PTSD)

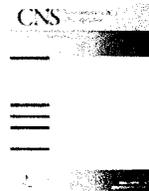
George A. Fraser

Issue

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Keywords: Cannabinoids; endocannabinoids; nabilone; nightmares; PTSD

Abstract

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This is the report of an open label clinical trial to evaluate the effects of nabilone, an endocannabinoid receptor agonist, on treatment-resistant nightmares in patients diagnosed with posttraumatic stress disorder (PTSD). **Methods:** Charts of 47 patients diagnosed with PTSD and having continuing nightmares in spite of conventional antidepressants and hypnotics were reviewed after adjunctive treatment with nabilone was initiated. These patients had been referred to a psychiatric specialist outpatient clinic between 2004 and 2006. The majority of patients (72%) receiving nabilone experienced either cessation of nightmares or a significant reduction in nightmare intensity. Subjective improvement in sleep time, the quality of sleep, and the reduction of daytime flashbacks and nightsweats were also noted by some patients. The results of this study indicate the potential benefits of nabilone, a synthetic cannabinoid, in patients with PTSD experiencing poor control of nightmares with standard pharmacotherapy. This is the first report of the use of nabilone (Cesamet; Valeant Canada, Ltd., Montreal, Canada) for the management of treatment-resistant nightmares in PTSD.

Background

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The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), defines posttraumatic stress disorder (PTSD) as the development of characteristic symptoms following exposure to an extreme traumatic stressor, involving direct personal experience of an event that involves actual or threatened death or serious injury or other threat to the physical integrity of another person, or learning about unexpected or violent death, serious harm or threat of death, or injury experienced by a family member or other close associate. The person's response must involve intense fear, helplessness, or horror (in children, disorganized or agitated behavior). There are many characteristic symptoms of PTSD including the persistent, intrusive recollections or re-experience of the original event (via dreams or nightmares and dissociative flashbacks), numbing and avoidance, and increased arousal [1]. The experience of these symptoms leads to functional impairment.

Although PTSD is often associated with military casualties, the majority of cases are related to traumatic events occurring in the general population. Such events may include physical or sexual abuse, traffic or natural disasters, and interpersonal violence. The lifetime prevalence of PTSD is 8.2% in the United States, and a Canadian study puts this rate at 9.2% [2,3]. PTSD's lifetime prevalence is higher than that of other anxiety disorders, including panic disorder, obsessive compulsive disorder, and generalized anxiety disorder.

Guidelines for the management of PTSD now exist [4]. However, recommended first-line and second-line agents, used alone or in combination to treat symptoms including nightmares, often show limited effectiveness in many patients. Subsequently, some patients may continue to experience symptoms, including debilitating nightmares, for years or decades. The negative impact of nightmares and the side effects of some of the current psychotherapeutic medications may potentiate other symptoms of PTSD, including those related to anxiety and depression. Other comorbid psychiatric conditions may also worsen. Commonly, patients with PTSD are receiving more than one medication. Polypharmacy is associated with the potential for side effects and drug interactions, thus possibly creating compliance and quality-of-life issues. On the basis of these experiences, there is a definite clinical need for a medication that is effective in treating nightmares related to PTSD, with positive effects on sleep and little potential for side effects or drug interaction.

Selective serotonin reuptake inhibitors (SSRIs) are considered first-line agents in the pharmacological treatment of PTSD in the United States (e.g., paroxetine and sertraline). Second-line agents include venlafaxine, prazosin, monoamine oxidase inhibitors, and tricyclic antidepressants. Other agents used in PTSD include atypical antipsychotics and anticonvulsants [5].

Sleep disturbances, mainly insomnia and nightmares, are present in about 70% of those with PTSD. The estimates of nightmares vary from 24.8% [6] to 60.0% [7].

Various medications have been used in attempts to control PTSD sleep disturbances, including nightmares. A review of the abovementioned classes of medications, as well as other specific agents such as clonidine and cyproheptadine, concludes, "to date an insufficient number of controlled studies are published to formulate evidence-based guidelines. Drawing on the available data it can be concluded that there is limited but promising evidence for prazosin and olanzapine for managing PTSD nightmares and insomnia" [8]. That article also points out that objective parameters for insomnia and nightmares need to be developed. The fact that so many agents have been used in attempts to manage nightmares highlights that management of these is difficult, and that there is room to explore other potentially useful classes of medications. Anecdotal reports of relief from psychiatric symptoms, with the use of marijuana or a pharmaceutical endocannabinoid receptor agonist, have created interest in investigating the role of the endocannabinoid system in PTSD and other mood disorders [5]. The endocannabinoid system has been implicated in the control of various behaviors including eating, addiction, and memory and in mediating both anxiolytic effects and pain responses [6–8]. Endocannabinoids are thought to exert an effect through a variety of interactions with the CNS related to PTSD. These include the hypothalamic–pituitary–adrenocortical (HPA) axis, function of the hippocampus and amygdala, and control of cortical regulation of memory processes [9–11].

The endocannabinoid system comprises two G-protein-coupled receptors (CB₁ and CB₂), possibly one or more atypical receptors, and several ligands (notably anandamide and 2-arachidonolglycerol [2-A]). The CB₁ receptor is distributed primarily within the CNS, particularly in the cerebellum, basal ganglia, amygdala, cerebral cortex, and

hippocampus [12,13]. The CB₂ is mostly distributed peripherally [13,14]. The cannabinoid receptors show pronounced selectivity in their binding and even have distinct binding sites for different classes of ligands [14]. This selectivity may partially explain why different agonists for the same CB receptor show differing therapeutic and side effect profiles. For example, at therapeutic doses, nabilone does not appear to produce the psychological high of inhaled marijuana.

Nabilone (Cesamet; Valeant Canada, Ltd., Montreal, Canada), an endocannabinoid receptor (CB₁ and CB₂) agonist, has been in use in Europe and Canada for over 25 years and was recently granted approval in the United States for the treatment of chemotherapy-induced nausea and vomiting. The identification and cloning of cannabinoid receptors in humans have led to a better understanding of the possible mechanisms of action of nabilone and support its potential use and safety in multiple clinical settings and various patient populations [12–26].

Rational for Therapeutic Trial of Nabilone in Patients with PTSD

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Patients with PTSD can be desperate to obtain relief from their symptoms and frequently turn to self-medication, including the use of alcohol and cannabis. On the basis of observations published in a single case study that mentioned nabilone's reduction of nightmares when it was employed to replace a patient's use of smoked marijuana for the relief of PTSD symptoms [22], the author of this current report decided to initiate nabilone as pharmacotherapy for several patients whose nightmares were not adequately controlled with standard therapies. When the initial three patients experienced abolition of their nightmares, it was decided to use nabilone in subsequent clinical cases with similar presentations and record the effect on nightmares.

Methods

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All 47 patients who agreed to participate in this clinical study had been referred to the author's private clinic for the management of PTSD by other physicians. The clinic specialized in the management of psychological trauma. Diagnoses for the study were confirmed by DSM-IV-TR criteria using a recognized PTSD questionnaire, the Posttraumatic Stress Diagnostic Scale [9]. All patients had at least a 2-year history of PTSD-related nightmares that had not responded to conventional therapies (Tables 1 and 2). Eligibility for this study stipulated that current nightmare frequency was a minimum of once weekly.

Table 1. Population profile

	Total	%
Total number of patients studied	47	
Mean age, years ± SD	44 ± 9	
Range	26–68	
Women/men	27/20	57/43
Time since PTSD onset (range in years)	2–30	

Table 2. Type of trauma

	Total	%
Repetitive childhood trauma (sexual/physical abuse)	18	38
Civilian adult trauma (accident, rape, injury, workplace trauma, and life-threatening illness)	18	38
Combat-associated trauma	11	23
Total	47	100

Nightmares were considered "treatment-resistant" when these persisted in spite of conventional medications employed for PTSD. Although these medications provided relief for various PTSD symptom clusters, as reported by the patients in this study, nightmares persisted unchanged and continued to cause clinical distress.

The author had to rely on subjective reports of nightmare presence and subsequent relief with the use of nabilone since, at present, there is no reliable test to objectively measure the presence or intensity of nightmares.

All patients were informed that nabilone was a synthetic cannabinoid and approved only for antiemetic use. The patients were screened for previous negative experiences with marijuana use and were advised to not use marijuana while taking nabilone. Conditions that were contraindicated with the use of nabilone were excluded from the study (e.g., sensitivity to cannabinoids and psychotic reactions). All patients were on psychotropic medications for PTSD at the start of the study, and a decision was made not to discontinue any of these in order to study the effect of the addition of nabilone. The patients were carefully monitored for any adverse reactions. Potential benefits and side effects were discussed, and the patients were advised to discontinue nabilone if they experienced any uncomfortable side effects. Verbal consent was voluntary, and continuing psychiatric treatment was not contingent on being a volunteer.

Prior to starting nabilone, the patients were given a tracking sheet that asked them to record the intensity of nightmares from 1 to 5 (5 being the most intense) and hours of sleep and provided a space for comments about that night's sleep. This nightly charting began 1 week prior to commencing the trial and weekly thereafter until satisfactory results or the trial being ended due to side effects. Previous medications, which ranged from a single SSRI to polypharmacy, were not changed during the study.

The patients were started at a dose of 0.5 mg 1 h prior to bedtime (the first patient was started at 1.0 mg based on dose availability. Soon after, the 0.5-mg capsule became available). The patients were seen within 7 days of initiating nabilone in order to determine dose response and monitor for side effects. Titration of nabilone was indicated if the medication was well tolerated and effective control of nightmare symptoms had not been achieved. The patients continued to be seen weekly until a satisfactory response was achieved or nabilone was stopped due to side effects. All doses were kept below the maximum 6 mg daily, as per the Cesamet (nabilone) product monograph [28]. Patients having a positive response to nightmare cessation or reduction were permitted to continue nabilone therapy and were individually monitored for its use in ongoing therapy. All patients gave consent for a review of their clinical charts in order that their response to nabilone therapy be documented.

Results

Jump to...



For 47 patients, standard PTSD medications being maintained, the usual starting dose was 0.5 mg and was titrated up or down to effect. The average effective dose of nabilone was 0.5 mg one hour before bedtime, with an effective dose range of 0.2 mg to 4.0 mg nightly. Thirty-four (72%) patients experienced total cessation or lessening of severity of nightmares (28 patients had total cessation of nightmares and 6 had satisfactory reduction). The discontinuation of medication was successful in four patients following 4–12 months of nabilone therapy (nightmares did not return or returned at a reduced level, not needing further medication control), whereas the other patients experienced a recurrence of nightmares upon nabilone withdrawal (usually within the first two nights). These patients experienced control of nightmares once nabilone treatment was reinitiated. These patients were asked to attempt withdrawal at least every 6 months, but the therapy was ongoing at the time of this chart review. Three patients, who initially

responded positively, were lost to follow-up.

In some cases, the benefits including an improvement in sleep time and a reduction of daytime flashbacks were subjectively noted. Several patients also stated that they no longer experienced nightsweats while on nabilone. Once effective relief of nightmares was achieved, no further increase in nabilone was necessary (patients' doses remained stable). Thirteen (28%) patients experienced mild-to-moderate side effects (shortly following nabilone initiation), leading to discontinuation of nabilone therapy. The side effects experienced included lightheadedness, forgetfulness, dizziness, and headache.

Conclusion

Jump to...



A chart review of patients diagnosed with PTSD who were referred to a private psychiatric clinic suggests that the synthetic cannabinoid, nabilone, has beneficial effects beyond its official indication in regard to abolishing or greatly reducing nightmares that persisted in spite of treatment with conventional PTSD medications.

The subjects concomitantly received nabilone in addition to the one or more psychiatric medications that they were already taking for 2 years or more. No tolerance to nabilone was observed among the patients. This may indicate its potential longer-term safety and efficacy.

The author recognizes the limits of this study (e.g., there was no placebo control, the measurements were limited to subjective reports to nightmare changes, the study was on a small number of patients, and there was a selective bias by nature of referrals to a specific clinic from which the patients were selected). Nonetheless, on the basis of these retrospective findings, nabilone appears to be a significant treatment for nightmares in the PTSD population. This initial positive clinical report on 34 of the 47 patients will hopefully inspire other physicians to consider using nabilone in those with persistent PTSD nightmares. Nabilone should be evaluated further through randomized clinical trials involving PTSD patients, including studies looking at its effects on the full spectrum of PTSD symptoms. Baseline and follow-up polysomnography recordings for patients on nabilone therapy would likely provide useful information. In addition, nabilone's effect in other anxiety disorders and primary parasomnias may be the areas to investigate.

Addendum

Jump to...



Since this study was done, Health Canada has approved a 0.25-mg capsule of nabilone. This would be the preferred starting dose of this author. The United States has only the 1-mg capsule available, so dilution by a pharmacist for the initial doses is recommended. Available strengths may vary in different countries where nabilone is available.

Conflict of Interest

Jump to...



The authors declare no conflict of interest.

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Jump to...



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VA in a difficult position - 300,000+ brain-damaged veterans may NEED to use illegal marijuana to treat stress, anxiety and PTSD

By Norm Roulet

Created 2011/02/14 - 7:06am

Cannabidiol ^[1] - 2-[(1*R*,6*R*)-6-isopropenyl-3-methylcyclohex-2-en-1-yl]-5-pentylbenzene-1,3-diol

I was talking to my drug-dealing father, the other day, about the future of a class of drug he has never been allowed to deal - Marijuana, and its derivatives - cannabinoids patented by the United States Department of Health and Human Services ^[2], in 2003.

As a physician, in the psychiatry field, my father has prescribed 1,000,000s of doses - \$1,000,000s worth - of scores of pharmaceutical toxins - many which certainly proved ineffective, over the years, and may be addictive and fatal - to humans who were not born to take such drugs... in a society now being torn apart by the consequences. But, he has never had the opportunity to prescribe one dose of natural, safe, non-addictive, organic, God-given, freely-available marijuana or a derivative.

While marijuana has consistently been found to be safe and effective for 100s of medical

concerns, for over a century, and is increasingly being made legal at the local level, by enlightened communities, the use and abuse of pharmaceutical drugs has become one of our Drug Czar's greatest and most fatal crises across America... and getting worse daily.

This self-inflicted American healthcare crisis was driven home by the February 13, 2011, New York Times, which reported that well over 300,000 troops have returned from Iraq or Afghanistan with P.T.S.D., depression, traumatic brain injury or some combination of those.... and, when doctors diagnose post-traumatic stress disorder, they prescribe powerful cocktails of psychiatric drugs and narcotics, which are proving largely ineffective and often fatal - whereas safe marijuana is considered a valuable treatment for P.T.S.D..

From *For Some Troops, Powerful Drug Cocktails Have Deadly Results* [3]:

Across all branches, spending on psychiatric drugs has more than doubled since 2001, to \$280 million in 2010... But the response of modern day psychiatry to modern warfare has not always been perfect... Psychiatrists still do not have good medications for the social withdrawal, nightmares and irritability that often accompany post-traumatic stress, so they mix and match drugs, trying to relieve symptoms... "These decisions about medication are difficult enough in civilian psychiatry, but unfortunately in this very-high-stress population, there is almost no data to guide you," said Dr. Ranga R. Krishnan, a psychiatrist at Duke University... "The psychiatrist is trying everything and to some extent is flying blind."

The medical community's failure to address this crisis with pharmaceutical drugs is especially alarming and disgusting as marijuana is illegal, yet considered a valuable treatment for P.T.S.D. and anxiety. From *Medical Marijuana for PTSD* [4], November, 2009, in PsychCentral:

A new study carried out by Dr. Irit Akirav and research student Eti Ganon-Elazar, working at the Learning and Memory Lab in the University of Haifa's Department of Psychology, suggests the use of cannabinoids may help in the treatment of post-traumatic stress disorder patients. According to Dr. Akirav, the results of this study show that cannabinoids can play an important role in stress-related disorders. "The results of our research should encourage psychiatric investigation into the use of cannabinoids in post-traumatic stress patients," she concludes.

Beyond PTSD, our USA patent for cannabinoids proclaims:

"Cannabinoids have been found to have antioxidant properties, unrelated to NMDA receptor antagonism. This newfound property makes cannabinoids useful in the treatment and prophylaxis of wide variety of oxidation associated diseases, such as ischemic, age-related, inflammatory and autoimmune diseases. The cannabinoids are found to have particular application as neuroprotectants, for example in limiting neurological damage following ischemic insults, such as stroke and trauma, or in the treatment of neurodegenerative diseases, such as Alzheimer's disease, Parkinson's disease and HIV dementia."

And, Wikipedia writes... of the cannabinoid cannabidoil, mentioned in OUR patent:

Cannabidiol (CBD; pronounced /kænəbi'daɪ.əl/) is a cannabinoid [5] found in *Cannabis*. It is a major constituent of the plant, representing up to 40% in its extracts. It has displayed sedative effects in animal tests. Some research, however, indicates that CBD can increase alertness. Medically, it has been shown to relieve convulsion, inflammation, anxiety, and nausea, as well as inhibit cancer cell growth. Recent studies have shown cannabidiol to be as effective as atypical antipsychotics in treating schizophrenia. Studies have also shown that it may relieve symptoms of dystonia. In November 2007, it was reported that CBD reduces growth of aggressive human breast cancer cells *in vitro* and reduces their invasiveness.

You just learned that marijuana has value treating dozens of mankind's worst conditions... and America's Drug Czar - a former Seattle Police Chief - acknowledges medical marijuana is not a negative concern, in his experience... from TheDC Interview, regarding our pharmaceutical crisis

[6]:

You know, this started in California in '96 and has been off the radar until the last few years. When I became police chief in Seattle in 2000, it had passed in 1999 in an initiative, and until the last year that I was there, medical marijuana wasn't even a subject of any discussion about anything.

The Drug Czar does have horrible things to say about America's addictions to pharmaceutical drugs, on the other hand:

When I talk to physicians, when I talk to pharmacists, that quest for those opioid painkillers is significant... Things like Dilaudid and Percocet have always been subject to abuse, but OxyContin is the one that's gotten so much attention... Next week I'm making a swing through Appalachia, where the problem is most significant right now. Then-Gov. Manchin, now Sen. Manchin said he can't go anywhere without people bringing up prescription drug problems... there isn't a lot of training, and often times there's no training, about prescription drugs for physicians. There's no training for recognizing dependence and addiction... The advertising is unbelievable. People say, "Are we becoming a pill nation?" They turn on the TV, and there's something out there to fix almost every problem we have... I'm thinking more about actual pill mills... these are MDs! People who are paid a lot of money to write a lot of prescriptions for pain... And it's not like buying heroin off the street, where you don't know the purity... You know what the dosage is, you know it's been manufactured, the purity levels, the cleanliness... You're not buying it out of the back of a gas station in a piece of tin foil.

As a psychiatrist, with an aging patient base, my father has certainly had to deal with many cases of stress and dementia, including from PTSD and Alzheimer's... including with his mother-in-law... my grandmother. Like with PTSD, science has not come up with pharmaceutical drugs to address Alzheimer's... because government outlawed marijuana.

My father should have been allowed to prescribe medical marijuana to my grandmother.

Perhaps medical marijuana would have helped my grandfather, as well, after his stroke... in his

early 40s.

Perhaps medical marijuana may help my sons, who are lead poisoned, as I believe lead poisoned victims self-medicate with marijuana because it is an effective treatment for permanent brain damage from exposure to toxic metals, like lead... as I believe may be supported by research published in 1978 [7] (and probably not researched further since):

Acute plumbism include recurrent seizures, cerebral palsy and mental retardations. The impairment of the central nervous system (CNS) with increased lead absorption is of paramount concern which remains unsolved because of the lack of specific and sensitive neurochemical/biochemical indicators of the effect of lead on the CNS. In our experimental acute lead-zinc poisoning, significant increase in noradrenaline and slight decrease in dopamine have been found in the brains of rats, which suggest that there is change in neurotransmitter metabolism in lead poisoning.

It is highly disturbing to me that America's incompetent healthcare "industry", and our foolish American society and corrupt government, made and kept all forms of the natural cannabis plant effectively illegal in America for over 70 years, causing my grandparents and 1,000,000s of other Americans unnecessary physical, social, economic, environmental and emotional harm... perhaps denying my sons and 1,000,000s of Americans effective care for their lead poisoning... and absolutely denying 100,000s of injured troops with a viable treatment for anxiety and PTSD today... all to benefit a few greedy, corrupting champions of industrial special interests, as is now well understood by the informed [8]:

Some parties have argued that the aim of the Act (1937 Marijuana Tax Act) was to reduce the size of the hemp industry largely as an effort of businessmen Andrew Mellon, Randolph Hearst, and the Du Pont family. With the invention of the decorticator, hemp became a very cheap substitute for the paper pulp that was used in the newspaper industry. Hearst felt that this was a threat to his extensive timber holdings. Mellon, Secretary of the Treasury and the wealthiest man in America, had invested heavily in the Du Pont families new synthetic fiber, nylon, which was also being outcompeted by hemp. In Western Europe, nobody banned the cultivation of hemp in the 1930s but the commercial cultivation ceased almost anyhow in the decades after the 1930s. Hemp was simply ousted by artificial fibres.

The American Medical Association (AMA) opposed the act because the tax was imposed on physicians prescribing cannabis, retail pharmacists selling cannabis, and medical cannabis cultivation/manufacturing; instead of enacting the marijuana Tax Act, the AMA proposed cannabis be added to the Harrison Narcotics Tax Act. The bill was passed over the last-minute objections of the American Medical Association. Dr. William Woodward, legislative counsel for the A.M.A. objected to the bill on the grounds that the bill had been prepared in secret without giving proper time to prepare their opposition to the bill. He doubted their claims about marijuana addiction, violence, and overdose; he further asserted that because the word *Marijuana* was largely unknown at the time, the medical profession did not realize they were losing cannabis. *"Marijuana is not the correct term... Yet the burden of this bill is placed heavily on the doctors and pharmacists of this country."*

The bill was passed on the grounds of different reports and hearings. Anslinger also

referred to the International Opium Convention that from 1928 included cannabis as a drug, and that all states had some kind of laws against improper use of cannabis. Today, it is generally accepted that the hearings included incorrect, excessive or unfounded arguments.

It is worth noting the Act was introduced by Rep. Robert L. Doughton, of North Carolina, who certainly would have been protecting the interests of the tobacco industry that has killed and shortened the lives of untold-millions of Americans... including my father's mother, who smoked deadly cigarettes throughout her adult life, as was encouraged back then by the tobacco industry and politicians from tobacco-country, like Doughton.

Three grandparents harmed by one corrupt government act... an act upheld and enforced by most of the ignorant, corrupt, incompetent politicians ruining America today.

The assault on good science, proper public health and the free will of Americans by corrupting businessmen like Andrew Mellon, Randolph Hearst, and the Du Pont family caused as much harm to Americans, global citizens and the environment as any industrial deceptions in history, as this outlawed the important ecology-balancing crop hemp, as well as marijuana.

Since I have taken-on the challenge to develop the cannabis economy in Ohio - and worldwide - and have been in the mainstream media for that - proposing a "New Cash Crop for Ohio [9]" and turning that into Pot Sauce for Hot Sauce's Greg Williams [10] - my psychiatrist dad is taking notice of medical marijuana issues, and slowly awakening to the question of why doctors in 16 states and DC may now prescribe medical marijuana, but Ohio leadership and the Federal government say he may not.

He has good reasons to question this stupidity, as in 2008 the AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION Resolution for Marijuana's Medical Use and Research (below) states:

"Legal access to marijuana for specific medical purposes has been supported by numerous national and state medical organizations, including the National Academy of Sciences' Institute of Medicine, American College of Physicians, American Psychiatric Association's Assembly, American Academy of Addiction Psychiatry, American Academy of Family Physicians, California Medical Association, Medical Society of the State of New York, Rhode Island Medical Society, American Academy of HIV Medicine, HIV Medicine Association, Canadian Medical Association, British Medical Association, and the Leukemia & Lymphoma Society; and Whereas, The Institute of Medicine concluded after reviewing relevant scientific literature – including dozens of works documenting marijuana's therapeutic value – that "nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana".

It seems medical students know better than practicing doctors, these days. Perhaps the students will grow into doctors who have the guts to act on their oaths.

I live in a community where healthcare is the #1 industry - the Cleveland Clinic is the #1 employer - yet medical marijuana is illegal and has not been raised as an issue of concern by any health professionals.

Are they all on drugs?

In his career, my father has had to treat the anxiety of 1,000s of people. Marijuana was perhaps the best treatment for many, but illegal to them.

Now we know marijuana is an effective treatment for Post Traumatic Stress Disorder (P.T.S.D.), but illegal to veterans and active troops.

In some states where medical marijuana is legal, MMJ is prescribed for P.T.S.D.... by doctors NOT AFFILIATED WITH THE VA... to excellent reported results. From National Public Radio, in MMJ-legal New Mexico - *Can Marijuana Ease PTSD? A Debate Brews* [11]:

The Department of Veterans Affairs finds itself in a difficult position because some vets want to use marijuana to treat symptoms of post-traumatic stress disorder. Pot possession remains illegal under federal law. The VA says that as a federal agency its doctors can't recommend using it.

The problem is especially acute in New Mexico, where one-fourth of the state's more than 1,600 medical marijuana patients are PTSD sufferers.

The agency (VA) responded to NPR's questions on the matter with this statement: "Based on guidance issued by the Drug Enforcement Administration and the Department of Justice, VA General Counsel has advised that completion of a state medical marijuana form is in violation of the Controlled Substances Act and subject to its enforcement provisions. Therefore VA physicians and practitioners may not participate in state medical marijuana programs. VA has addressed issues/questions regarding medical marijuana separately as they have arisen but is in the process of developing national policy."

The arguments around marijuana and PTSD start running in circles at a certain point. Scientists say more research is needed. Activists counter that the federal government has blocked research because marijuana is illegal. The American Medical Association has called for controlled studies [12] to settle this and other questions about the effectiveness of marijuana.

Meanwhile, policymakers in states with medical marijuana programs have to make decisions now, and they're reaching different conclusions. While New Mexico found there's enough evidence to approve marijuana use for PTSD, next door in Colorado lawmakers recently rejected a similar proposal.

This prohibition now impacts well over 300,000 troops who have returned from Iraq or Afghanistan with P.T.S.D., depression, traumatic brain injury or some combination of those.

From the February 12, 2011 New York Times feature - *For Some Troops, Powerful Drug Cocktails Have Deadly Results* [3]:

After a decade of treating thousands of wounded troops, the military's medical system is awash in prescription drugs — and the results have sometimes been deadly.

By some estimates, well over 300,000 troops have returned from Iraq or Afghanistan with P.T.S.D., depression, traumatic brain injury or some combination of those. The Pentagon has looked to pharmacology to treat those complex problems, following the lead of civilian medicine. As a result, psychiatric drugs have been used more widely across the military than in any previous war.

But those medications, along with narcotic painkillers, are being increasingly linked to a rising tide of other problems, among them drug dependency, suicide and fatal accidents — sometimes from the interaction of the drugs themselves.

The article goes on to detail disgraceful industry and government response to the needs of the millions of veterans of war in our country, who are victims of foolish leadership on so many levels of society, and are in brain-damaged downward spirals in an uncaring place and time. Most fatal, for so many, is being put in the hands of drug-pusher Office of Veterans Affairs (VA) "psychiatrists", who are clearly no more than sales agents for pharmaceutical companies.

The military medical system has struggled to meet the demand caused by two wars, and to this day it still reports shortages of therapists, psychologists and psychiatrists. But medications have always been readily available.

Across all branches, spending on psychiatric drugs has more than doubled since 2001, to \$280 million in 2010, according to numbers obtained from the Defense Logistics Agency by a Cornell University psychiatrist, Dr. Richard A. Friedman.

But the response of modern psychiatry to modern warfare has not always been perfect. Psychiatrists still do not have good medications for the social withdrawal, nightmares and irritability that often accompany post-traumatic stress, so they mix and match drugs, trying to relieve symptoms.

"These decisions about medication are difficult enough in civilian psychiatry, but unfortunately in this very-high-stress population, there is almost no data to guide you," said Dr. Ranga R. Krishnan, a psychiatrist at Duke University. "The psychiatrist is trying everything and to some extent is flying blind."

Thousands of troops struggle with insomnia, anxiety and chronic pain — a combination that is particularly treacherous to treat with medications. Pairing a pain medication like oxycodone, a narcotic, with an anti-anxiety drug like Xanax, a so-called benzodiazepine, amplifies the tranquilizing effects of both, doctors say.

Similarly, antidepressants like Prozac or Celexa block liver enzymes that help break down narcotics and anxiety drugs, extending their effects.

"The sedation is not necessarily two plus two is four," said Cmdr. Rosemary Malone, a Navy forensic psychiatrist. "It could be synergistic. So two plus two could be five."

Regarding the scope of this crisis, a General watching his troops turned into pill-junkies told the Times:

"I'm not a doctor, but there is something inside that tells me the fewer of these things we prescribe, the better off we'll be," Gen. Peter W. Chiarelli, the vice chief of staff of

the Army who has led efforts on suicide, said in an interview.

The New York Times goes on to report:

The widespread availability of prescription medications is increasingly being linked by military officials to growing substance abuse, particularly with opiates. A Defense Department survey last year found that the illegal use of prescription drugs in the military had tripled from 2005 to 2008, with five times as many troops claiming to abuse prescription drugs than illegal ones like cocaine or marijuana.

The reporter from the New York Times, covering this issue, failed to intellectualize the importance of the war against marijuana by the Federal government in causing this pill-popper crisis. That is not a big surprise, as this whole anti-marijuana mess is the fault of corrupt news men.

"Rosebud".

From the AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION
Resolution 2 (A-08) - Subject: Marijuana: Medical Use and Research

Introduced by: Sunil Aggarwal, Aaron Flanagan, and Alicia Carrasco, University of Washington School of Medicine; Sonya Khan and Liisa Bergmann, University of California, Los Angeles, School of Medicine; Trace Fender, Northeastern Ohio Universities College of Medicine; Leo Arko, University of New Mexico School of Medicine

Referred to: MSS Reference Committee (Despina Siolas, Chair)

Whereas, The federal Controlled Substances Act of 1970 categorized marijuana as a Schedule I substance not permitted for prescription use¹, yet 12 states (AK, CA, CO, HI, ME, MT, NV, NM, OR, RI, VT, WA) have laws that permit the use of marijuana when recommended by a physician; and

Whereas, A ruling by the Ninth U.S. Circuit Court of Appeals reaffirmed and the Supreme Court let stand the right of physicians and patients to discuss the therapeutic potential of marijuana, but patients who follow their physicians' advice are put at risk for up to one year in federal prison for possession of marijuana, and up to five years in federal prison for growing one marijuana plant, as federal law does not make a distinction between medicinal and other marijuana use; and

Whereas, Legal access to marijuana for specific medical purposes has been supported by numerous national and state medical organizations, including the National Academy of Sciences' Institute of Medicine, American College of Physicians, American Psychiatric Association's Assembly, American Academy of Addiction Psychiatry, American Academy of Family Physicians, California Medical Association, Medical Society of the State of New York, Rhode Island Medical Society, American Academy of HIV Medicine, HIV Medicine Association, Canadian Medical Association, British Medical Association, and the Leukemia & Lymphoma Society; and

Whereas, The Institute of Medicine concluded after reviewing relevant scientific

literature – including dozens of works documenting marijuana’s therapeutic value – that “nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana”⁵; and

Whereas, Subsequent studies since the 1999 Institute of Medicine report, including randomized, double blind, placebo-controlled ones, continue to show the therapeutic value of marijuana in treating a wide array of debilitating medical conditions, including relieving medication side effects and thus improving the likelihood that patients will adhere to life-prolonging treatments for HIV/AIDS and Hepatitis C and alleviating HIV/AIDS neuropathy, a painful condition for which there are no FDA-approved treatments; and

Whereas, “Given marijuana’s proven efficacy at treating certain symptoms and its relatively low toxicity, reclassification would reduce barriers to research and increase availability of cannabinoid drugs to patients who have failed to respond to other treatments”⁷; and

Whereas, “Only two cannabinoid drugs are currently licensed for sale in the U.S. (dronabinol [Marinol®] and nabilone [Cesamet®]), and both are only available in oral form” and while “useful for some, these drugs have serious limitations”⁸; and

Whereas, Reclassifying marijuana as medically useful should draw from medical experience with opiates, which indicates that “opiates are highly addictive yet medically effective substances and are classified as Schedule II substances,” but “there is no evidence to suggest that medical use of opiates has increased perception that their illicit use is safe or acceptable”⁹; and

Whereas, “Preclinical, clinical, and anecdotal reports suggest numerous potential medical uses for marijuana ... unfortunately, research expansion has been hindered by a complicated federal approval process, limited availability of research-grade marijuana, and the debate over legalization”¹⁰; and

Whereas, the National Institute on Drug Abuse (NIDA) generally supplies marijuana for the research of harms and does not automatically provide marijuana to researchers who hold an FDA Investigational New Drug (IND) and a Drug Enforcement Administration (DEA) Schedule I researcher’s registration for marijuana¹¹; and

Whereas, The federal government has obstructed privately funded research through NIDA’s monopoly over the production of marijuana for research, as well as through the DEA’s refusal to license any privately funded marijuana production facilities, even though DEA-licensed, private facilities produce LSD, MDMA, psilocybin, mescaline, and other Schedule I drugs; and

Whereas, Despite these obstructions, the accumulated scientific data regarding marijuana’s safety and efficacy in certain clinical conditions and its increasingly accepted medical use in treatment can no longer be ignored¹²; therefore be it

RESOLVED, That our AMA support review of marijuana’s status as a Schedule I

controlled substance, its reclassification into a more appropriate schedule, and revision of the current protocol for obtaining research-grade marijuana so that it conforms to the same standards established for obtaining every other scheduled drug for legitimate research purposes; and be it further

RESOLVED, That our AMA strongly support exemption from federal criminal prosecution, civil liability, and professional sanctioning for physicians who recommend medical marijuana in accordance with state law, as well as full legal protections for patients who use medical marijuana under these circumstances; and be it further

RESOLVED, That this resolution be promptly forwarded to the House of Delegates at A-08 for national action.

Date received: 4/10/08

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