ADAMHS BOARD
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ALCOHOL | DRUG ADDICTION | AND MENTAL HEALTH SERVICES

The 409 Building • 409 E. Monument Avenue, Ste 102 • Dayton, Ohio 45402-1226
(937) 443-0416 • Fax (937) 461-2204

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Chairman Wilkin, Vice-Chair White, Ranking Member Brown, and members of the House Government Oversight Committee, thank you for the opportunity to provide testimony on Senate Bill 261 to make changes to Ohio's medical marijuana program. My name is Tristyn Ball, and I am the Director of Prevention and Early Intervention Services at the Montgomery County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board. Our team has several concerns with SB 261.

We ask that you reconsider expanding the number of qualifying conditions, with special consideration to the piece stating that physicians are able to recommend marijuana for any disease or condition recognized by the State Medical Board. While the intent to expand access to marijuana to every adult and child in the state that may have one of any variety of ailments where marijuana could be considered beneficial by an individual medical practitioner, it is the stance of many reputable medical associations, including the American Academy of Pediatrics, American Cancer Society, American Medical Association, and many more that there is not enough scientific backing to support the use of marijuana for therapeutic purposes.

We ask that you reconsider shifting the oversight of the Medical Marijuana program from the Board of Pharmacy to the Department of Commerce as it severely undermines the argument for marijuana as medicine. Patients deserve to be treated as patients rather than customers. When considering that marijuana is a controlled substance used, in this case, for medicine, it is most appropriate for the oversight to be delegated to the Board of Pharmacy. Further, it is outside the scope for the Department of Commerce to oversee "the registration of patients and their caregivers" and "establishing standards and procedures for the medical marijuana control program." If the intent of this bill truly is to serve the patients in need of therapeutic intervention, the people of Ohio deserve to have marijuana regulated as medicine, supporting their overall quality of life rather than seeing each patient as a business transaction. Pharmacies oversee the distribution of medication which begs the question as to whether marijuana is being viewed as a legitimate medicine or a substance to be sold for profit. Further, the proposed business practices of opening more dispensaries to meet patient demand while rolling back restrictions on advertising to create more demand are counterintuitive and reflect a desire to increase the number of individuals using marijuana in the state. As more individuals are using marijuana, we can anticipate the number of marijuana use disorders to increase, which can be problematic not only for the individuals and their families but also for a behavioral health system that is already overwhelmed with a demand for services and workforce shortages.

We ask that you consider increasing the amount of education required for recommending physicians on the subject of addiction. Marijuana is classified as a Schedule 1 drug under the federal Controlled Substances Act. This classification specifies the drug's "high potential for abuse." The potential for abuse is great and should be weighed when physicians recommend to patients with a predisposition to marijuana dependence. Like any drug with a propensity for dependence, marijuana impacts the midbrain and releases dopamine through the prefrontal cortex (Bostwick, 2011). This leads to a physiological dependence leading to withdrawal (Budney et al., 2007). Cannabis withdrawal syndrome makes abstaining from the drug difficult for individuals attempting to quit. A review of studies found that between 61-96% of individuals experiencing cannabis withdrawal symptoms were not able to abstain from use after attempting to quit (Cooper and Haney, 2009). Unfortunately, physicians are often ill-prepared to understand and successfully mitigate the implications of addiction, given the lack of addiction-specific education provided in medical schools. In my time working with physicians, this is often a topic that is brought up as a concern as drug-related hospital visits are on the rise. In a study of over 100 medical school deans across the US, only 6% stated that their graduating students were even moderately prepared to prescribe marijuana to patients given the overall lack of education on the subject (Evanoff et al., 2017).

We ask that you consider weighing the social costs of expanding the medical marijuana program and investing in prevention and early intervention strategies. The subject of marijuana as medicine is not one to take lightly. As we look at expanding the number of individuals enrolled in the program, careful consideration should be taken to examine the social costs of this issue. In the past week, I have been working closely with leaders at Juvenile Court as they see rampant marijuana use among youth whose parents are cardholders and using medical marijuana in the home. This is leading to normalization of use and increased accessibility in the home. It is now on the backs of county taxpayers to foot the bill for intervention efforts in hopes of intervening early enough to prevent further use; however, if unsuccessful, these additional costs will also fall to taxpayers to fund efforts to treat their substance use disorders as well as their prolonged involvement in the court system. With any effort to increase accessibility to addictive substances, the diversion of these substances will increase. Locally, child protective services are seeing an increase in babies born with marijuana in their systems to mothers with medical marijuana cards. The impact of marijuana use on a developing fetus predisposes an unborn child to a variety of adverse outcomes, including congenital anomalies, stillbirth, growth restriction, and impaired neurodevelopment (Stickrath, 2019). Studies show that children exposed to marijuana in utero were more prone to cognitive impairment, substance dependence, hyperactivity, impulsivity, and poor academic scores (Campolongo et al., 2011; Goldschmidt et al., 2000; Goldschmidt et al., 2012; Strickrath, 2019). A concern is that by expanding the qualifying conditions of the program, more babies will be born having significant marijuana exposure. The State of Ohio has made a commitment to investing in evidence-based prevention programs to ensure young people have the skills and

resources they need to make healthy decisions into adulthood. As the state considers this bill leading to increased normalization of marijuana use and increased accessibility, two major risk factors for early initiation of marijuana use among youth, it will be essential to consider how to bolster protective factors to ensure young people are not using marijuana.

Thank you again for your consideration and for allowing me to speak on the matter. With a desire to ensure patients receive quality care and youth have the ability to lead healthy, drug-free lives, I ask that you consider the points laid out in this testimony.

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