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Testimony to the Health and Human Services Committee
In Opposition to HB2152
March 15, 2017

Chairman Hawkins and Committee Members,

The concept of "medical hemp" as presented in this bill is so abundant with issues it is difficult to know where to start. It is logical to first focus on the "hemp" label as used in this bill. This is very clearly not really a hemp bill but a medical marijuana bill with THC limits. Hemp is a part of the cannabis plant.

> "Hemp" and marijuana are actually separate parts of the species of plant known as cannabis. Under federal law, Congress defined marijuana to focus on those parts of the cannabis plant that are the source of tetrahydrocannabinols (THC). THC is the hallucinogenic substance in marijuana that causes the psychoactive effect or "high." The marijuana portions of the cannabis plant include the flowering tops (buds), the leaves, and the resin of the cannabis plant. The remainder of the plant — stalks and sterilized seeds — is what some people refer to as "hemp." ". . .hemp and marijuana are both parts of the same plant and hemp cannot be produced without producing marijuana."[1]

You can see in the above reference when THC is the focus it is really marijuana we are talking about. In HB2152, there is a requirement of maximum THC level of 3%. There is no requirement of a minimal amount of CBD to be present. In fact, HB2152 doesn't require even trace amounts of cannabidiol CBD to be present. This indicates to us the authors of this bill are clearly aiming at THC legalization and not CBD legalization. Other states that have low-THC marijuana laws do not refer to it as "medical hemp." They call it "low-THC marijuana." Most also specify a minimum amount of CBD, the chemical from the marijuana plant considered to have potential of benefit. The reference to hemp in this bill, in our opinion, is a wolf in sheep's clothing. To illustrate this point, consider the up to 3% THC levels in this bill. In Florida, their THC limit is 0.8% and their CBD minimum is 10%.[2] Mississippi requires no more than 0.5% THC and no less than 15% CBD.[3] Missouri requires no more than 0.3% THC and no less than 5% CBD.[4] North Carolina requires 0.3% THC and at least 10% CBD. South Carolina requires no more than 0.9% THC and more than 15 % CBD.[5] And the list goes on. Even minimal research shows the effectiveness of the CBD is dependent on the high ratio to THC levels.

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[1] DEA News Release. *DEA Clarifies Status of Hemp in the Federal Register*. 10/9/2001
[2] Florida Department of Health, FAQ on low-THC Cannabis. (http://www.floridahealth.gov/programs-and-services/office-of-compassionate-use/_documents/faq.pdf#search=%22faq%20low-thc%22)
[3] National Conference of State Legislatures; *State Medical Marijuana Laws*. 1/8/16. http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx
[4] Same.
[5] Same.

Some states have passed laws that do not create the head shop sales culture or the problematic physician "prescription" process that circumvents established prescription drug laws.[6] Some states such as Alabama, Georgia, Kentucky, Mississippi, North Carolina, and Tennessee only provide for research in state university hospitals.[7] This assures the handling of these scheduled drugs in a safe and controlled research and medical environment. Some states are now requiring these products to be dispensed through pharmacies. (Minnesota, New York, and Connecticut)

In addition to that, GW Pharmaceuticals is concluding final testing on pharmacy grade CBD oil medication. THC based medications already are available through pharmacies. I would hope we would all agree the quality control, and more importantly the strength of the desired substances, are better controlled through existing pharmacy processes than through corner shops with only periodic random testing of the drugs they are selling. It is very likely this pharmaceutical grade CBD will be available through normal existing medical processes before the proposals in this bill can be fully implemented.

HB2152 proposes a high THC content, no CBD requirement, creates non-pharmaceutical headshop type store fronts, and a new "prescription" process specific to this product. All of this is unnecessary. Scheduled chemicals and compounds used for medical treatment should all flow through the established pharmaceutical or research avenues, not through backdoor experimentation.

The bill also allows for marijuana edibles. Colorado found this to be a major issue with overdoses and access to children. This doesn't seem like a good step for something that is supposed to be medicine.

Aside from those obvious efforts to minimize control of abuse of these substances, there are direct law enforcement concerns:

LAW ENFORCEMENT OPERATIONAL CONSIDERATIONS

The legalization of cannabis in any form has tremendous implications for law enforcement.

1. Law enforcement must retrain, develop new policy and formulate new investigative techniques to enforce remaining laws relating to cannabis. State legalization creates a conflict between state and federal laws on cannabis. But enforcement must continue for violations that do not fall under the new legalized parameters. These investigations are complicated as some possession is legal while others are not.
2. Probable cause for searches and arrests become clouded requiring error on the side of caution by not arresting or not searching unless clarity exists. New standards and procedures must be developed by law enforcement leaders, district and city attorneys and policymakers clarifying the criteria for determining an illegal marijuana operation and providing guidance for acceptable criteria for marijuana based search warrants.
3. Once marijuana is seized, if later investigation reveals the possession did not violate state law, a dilemma is created for law enforcement in returning the property to the person from whom it was seized which would still violate federal law.
4. Drug dogs must be retrained or replaced. Drug dogs are trained to "hit" on various drugs. Unfortunately, they can't tell us what drug they smell. So, dogs that have been trained to detect drugs including marijuana are rendered useless since the mere detection of marijuana may not indicate a criminal violation. This will result in not only an expense, but also a degradation of our ability to locate and seize other illegal drugs.

[6] Same.
[7] Same.

5. Enforcement of marijuana violations under the newly created laws and regulations will require a multi-team approach involving law enforcement, prosecutors, zoning professionals, fire inspectors, building inspectors, food inspectors, code compliance inspectors, medical professionals and others.
6. Liability issues will be difficult as law enforcement walks a thin line between potential violations of the rights of those who can legally possess and being liable for not taking action which may lead to harm to others when encountering a person who is not legally authorized to possess marijuana.
7. Law requirement analysis of percentage content of THC and CBD create an enormous burden on crime labs. Quantitative analysis requires 7 times longer to analyze and requires additional equipment and training. The additional cost is very significant.

There is also growing evidence of the damage legalized medical marijuana availability presents for our youth and for public safety. The attached data is from the Colorado experience. I have intentionally not provided post 2014 data in this discussion because that is when Colorado passed their recreational marijuana law. Medical marijuana was first allowed in Colorado in 2010 and the data shows the effect of medical marijuana legalization, not recreational marijuana legalization. So the data reflects only there experience during the period when medical marijuana was legalized, not full recreational legalization.

We encourage you to carefully consider the data we have presented and the potential unintended consequence, and to not recommend HB2152 for passage.

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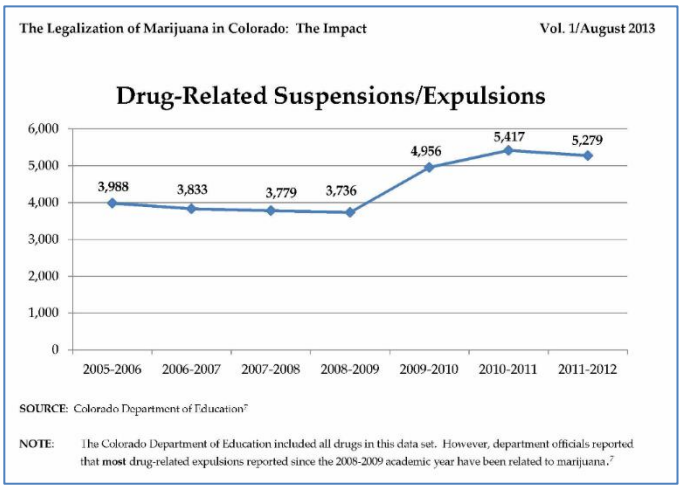
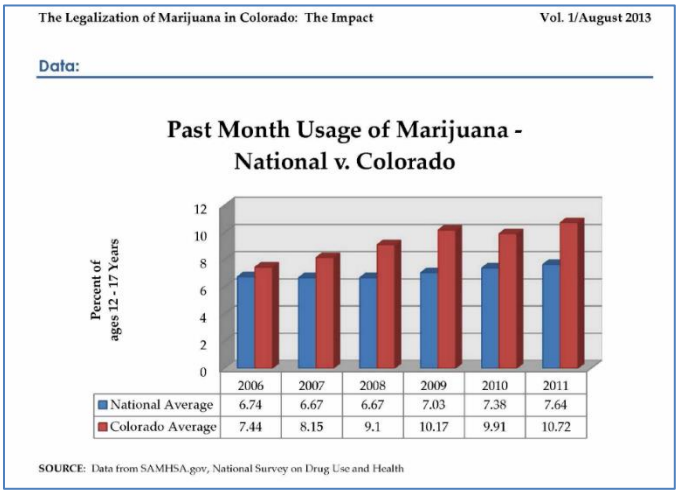
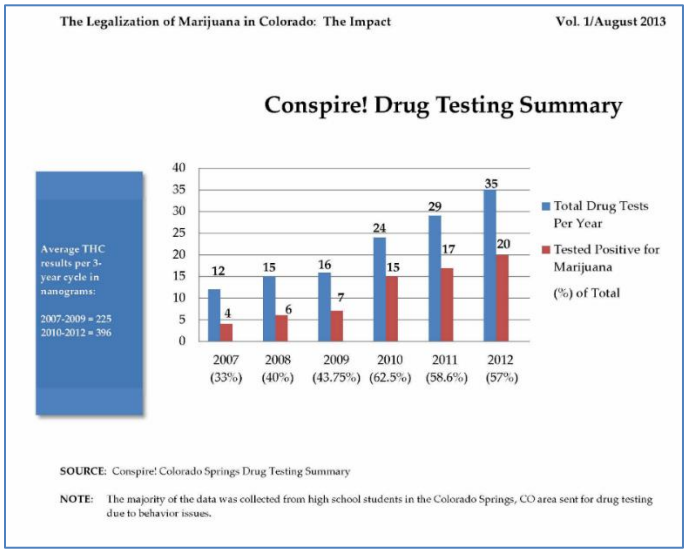
PUBLIC SAFETY CONSIDERATIONS

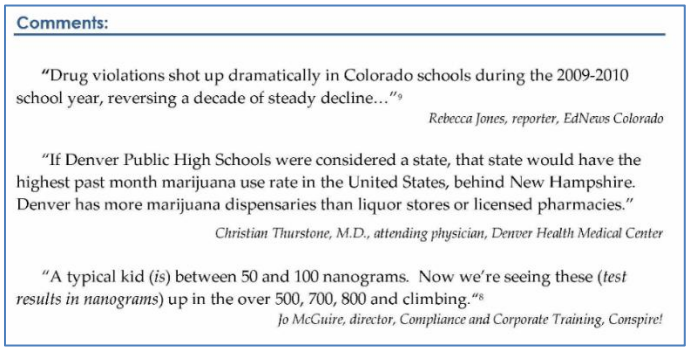
In the following discussion, keep in mind Colorado commercialized medical marijuana (dispensaries started opening) in 2010 and legalized commercialization of marijuana (recreational use) began January 1, 2014.

1. How will legalization for either medical or recreational use effect our children?
   I learned in Colorado the data does indicate an increase in drug use over the same years marijuana was legal for medical purposes. It is too early to see an impact from legalization for recreational purposes, but there doesn't seem to be any signs legalization has no impact or a positive impact on use by children.
2. **Colorado Youth Marijuana Use**: In 2011, the national average for youth 12 to 17 years old considered "current" marijuana users was 7.64 percent which was the highest average since 1981. The Colorado average percent was 10.

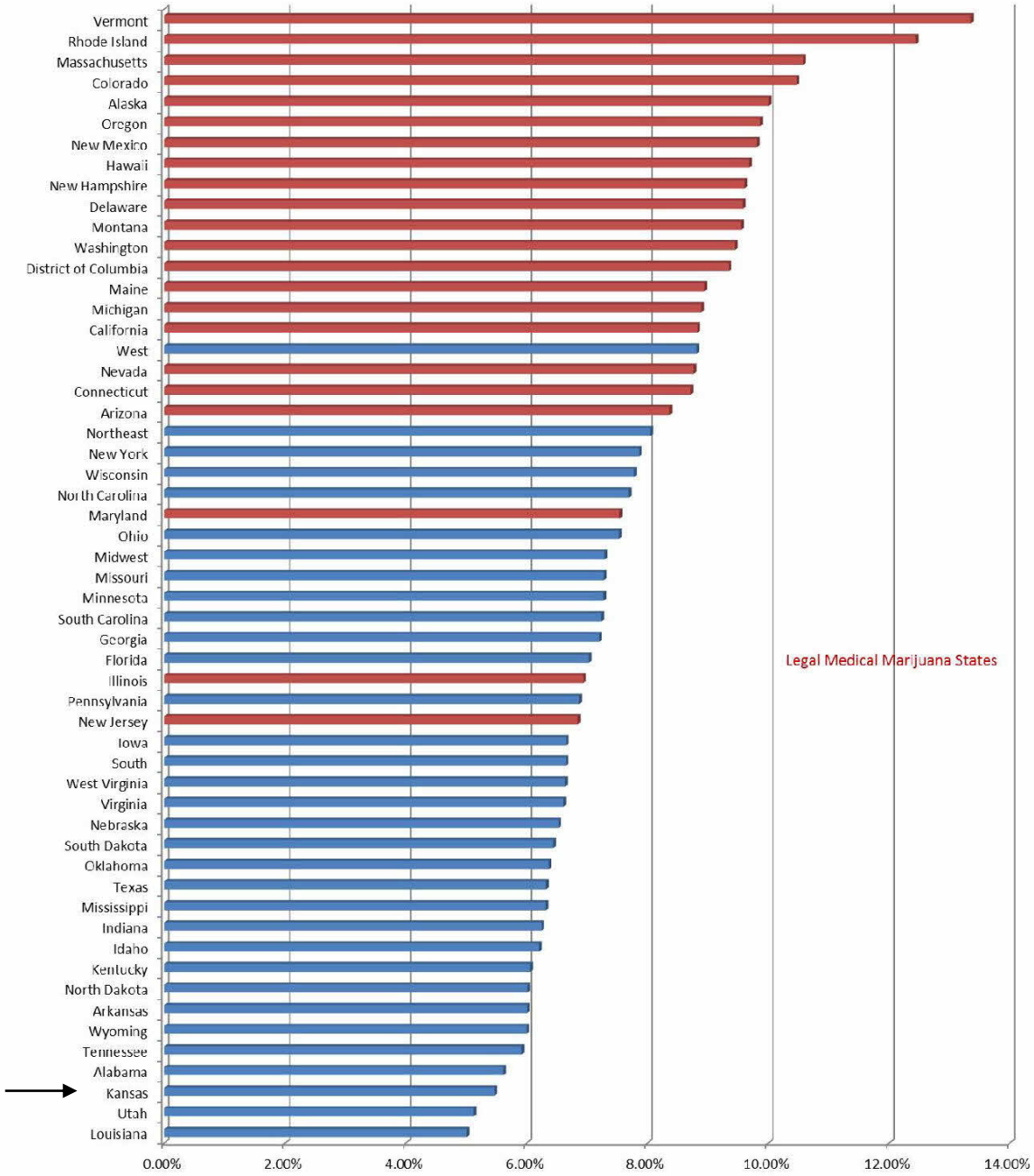






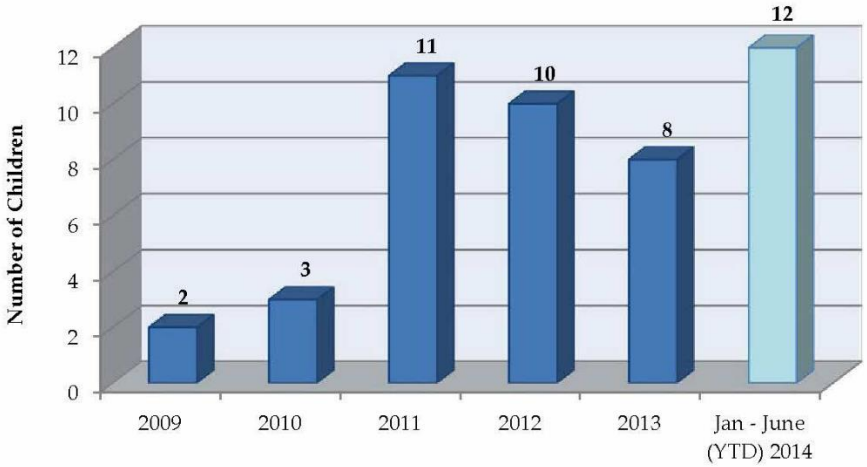


Past Month Usage by 12 to 17-Year-Olds in Medical Marijuana States, 2012



SOURCE: SAMHSA.gov, National Survey on Drug Use and Health, 2013

Marijuana Ingestion Among Children Under 12 Years-of-Age

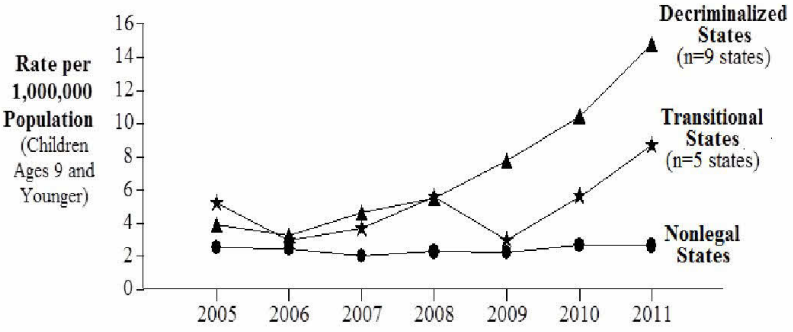


SOURCE: Dr. George Sam Wang, pediatric emergency physician, Children's Hospital Colorado, July 8, 2014

The Legalization of Marijuana in Colorado: The Impact Vol. 2/August 2014

Rate (per 1,000,000 population) of Unintentional Pediatric Marijuana Exposure Poison Center Calls, by Marijuana Legalization States*, 2005-2011[2]

(n=985 single substance, unintentional exposures in children ages 9 and younger)



* *Decriminalized States*: Passed marijuana decriminalization legislation (for medical and/or recreational purposes) before 2005 (AK, CA, CO, HI, ME, NV, OR, VT, and WA).

* *Transitional States*: Enacted legislation between 2005 and 2011 (AZ, MI, MT, NM, RI). Nonlegal States: Had not passed legislation as of December 31, 2011.[2]

3. How will it affect highway safety? Advocates often site the decrease in fatalities in Colorado since legalization for medical purposes and again in 2014 with commercial recreational legalization. What they don't usually reveal is that traffic fatalities have been dropping in most states even those that haven't legalized commercialization of marijuana. They also usually don't mention that while the number of total fatalities is dropping, the number of drug related fatalities is increasing.
Colorado Driving Fatalities: From 2006 to 2011, traffic fatalities decreased in Colorado 16 percent, but fatalities involving drivers testing positive for marijuana increased 114 percent.

Definitions in Reviewing Fatality Data:

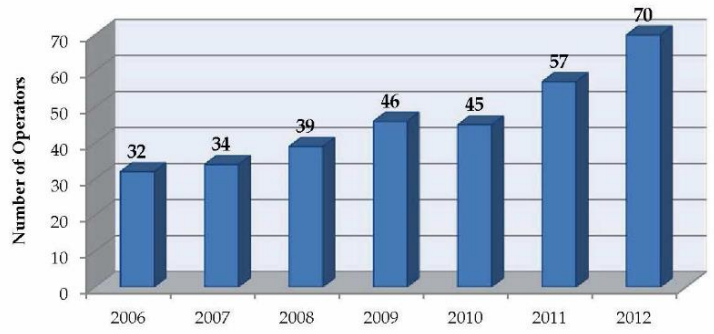
- **Marijuana:** Also called "marijuana mentions," is any time marijuana shows up in the toxicology report. It could be marijuana only or marijuana with other drugs and/or alcohol.
- **Fatalities:** A fatal injury resulting from a traffic crash involving a motor vehicle.
- **Operators:** Anyone in control of their movements such as a driver, pedestrian or bicyclist.

Fatalities Involving Operators Testing Positive for Marijuana

Crash Year	Total Statewide Fatalities	Fatalities with Operators Testing Positive for Cannabis	Percentage Total Fatalities (Cannabis)
2006	535	37	6.92%
2007	554	39	7.04%
2008	548	43	7.85%
2009	465	47	10.1%
2010	450	49	10.89%
2011	447	63	14.09%
2012	472	78	16.53%

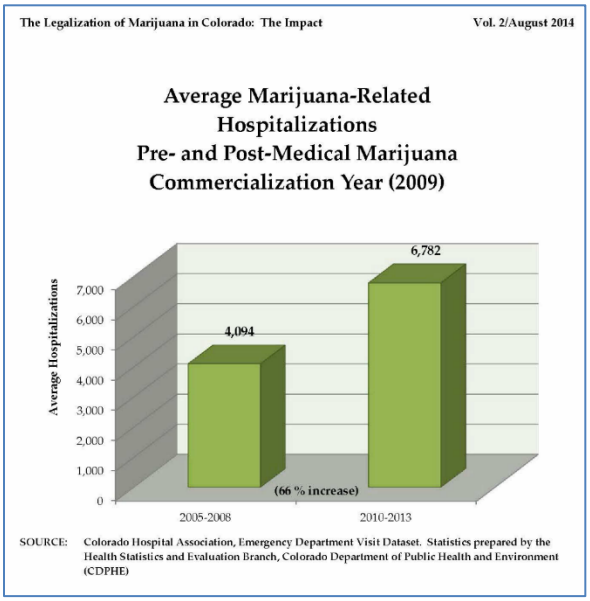
SOURCE: National Highway Transportation Safety Administration, Fatality Analysis Reporting System (FARS), 2006-2011 and RMHIDTA 2012 (See NOTE on page 8)

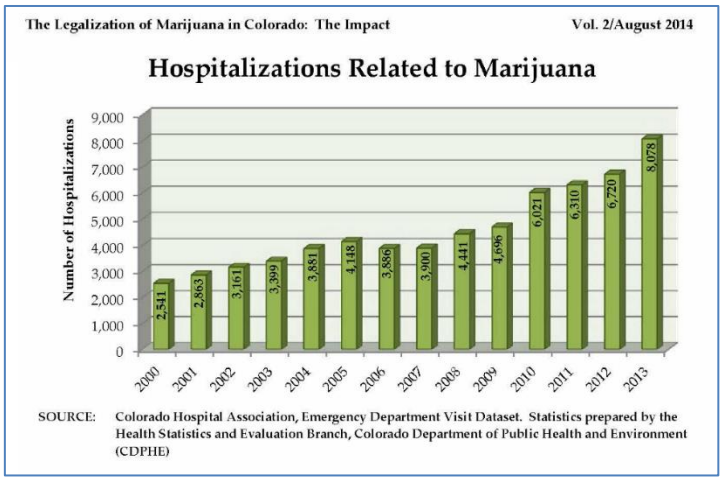
Operators Involved in Fatalities Testing Positive for Marijuana



SOURCE: National Highway Transportation Safety Administration, Fatality Analysis Reporting System (FARS), 2006-2011 and RMHIDTA 2012 (See NOTE on page 8)

4. Does marijuana legalization create more health emergencies?
   Colorado Emergency Room – Marijuana Admissions: From 2005 through 2008 there was an average of 741 visits per year to the emergency room in Colorado for marijuana-related incidents involving youth. That number increased to 800 visits per year between 2009 and 2011.





5. Does legalization create more unintentional drug poisoning?
   Colorado Marijuana-Related Exposure Cases: From 2005 through 2008, the yearly average number of marijuana-related exposures for children ages 0 to 5 years was 4. For 2009 through 2012, that number increased 200 percent to an average of 12 per year.