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STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES
MICHIGAN MEDICAL MARIHUANA REVIEW PANEL

Dear, Director of LARA and the Michigan Medical Marihuana Review Panel,

It is with great importance that Four Freedoms submits the enclosed three packets of evidentiary documentation in response to the decision of the Michigan Medical Marijuana Review Panel to deny PTSd as a qualifying condition to the Michigan Medical Marijuana Act of 2008.

With respect to the process and individual members of the Michigan Medical Marijuana Review Panel, understanding panel's decision was based on a lack of scientific evidence and insufficient antidotal evidence.

Respectfully request the following three packages of information be presented to the Michigan Medical Marijuana Review Panel, in support of the recommendation to include PTSd in the MMMA of 2008.

Packet 1) 13 research papers supporting the use of cannabis to treat symptoms of PTSd.

Packet 2) 7 research papers supporting the use of cannabis as harm reduction.

Packet 3) New Mexico Medical Cannabis Program Advisory Board final report 7 Nov 2012, media reports relevant to issue from New Mexico, and additional antidotal evidence.

I am extremely grateful for the open and honest dialogue among the members of the panel. As a Veteran, all I can ask is that this issue be taken seriously, it is obvious from comments made by the MMMRP members, December 14, 2012 that members of the panel are focused on patient care and for that I am eternally grateful.

Additional information provided with the assistance of the following groups, Veterans for Medical Marijuana Access, The Drug Policy Alliance and Patients Out of Time.

Sincerely yours,

John Evans

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Packet #3, New Mexico Medical Cannabis Program Advisory Board final report, Media Coverage, Statements from psychiatrists, patients, and Veterans.

1) **Final report from New Mexico Medical Cannabis Program Advisory Board**, 7 Nov 12. Report of the advisory board that unanimously recommends the Secretary of Health reject the petition to rescind PTSd. (page 3)

2) **Media Coverage**;

a) Santa Fe New Mexican Editorial, PTSd sufferers should keep access to medical cannabis.13 Oct 12 (page 21)

b) Santa Fe New Mexican Editorial, Cannabis catch-22: PTSD patients could be dropped from state's medical program, Deborah Busemeyer, 14 Oct 12 (page 23)

c) New Mexico State Director, Drug Policy Alliance, Medical Cannabis for Patients with PTSD in New Mexico Is Under Attack, Emily Kaltenbach, 16 Oct 12 (page 29)

d) KOB TV (New Mexico) PTSD sufferers may lose access to medical cannabis, Jill Galus, 5 Oct 12. (page 32)

e) Village Voice: Toke of the Town, Continued access to medicine threatened by a request to withdraw PTSD as a qualifying condition for the New Mexico Medical Cannabis Program, Steve Elliott, 15 Oct 12. (page 33)

3) **Statements, personal and professional**;

a) Lisa Walker, MD, Board Certified Psychiatrist, Licensed in New Mexico (page 36)

b) Florian Birkmayer, MD. (page 39)

c) Carola Kieve, MD. (page 43)

d) Peter Anastasia RN. (page 45)

e) Air Force Veteran, Male, Las Cruces, NM (page 46)

f) Michael Innis, Albuquerque, Army Veteran, Purple Heart. (page 47)

g) Ms. Nat Dean, 110 Sirra Azul, Santa Fe, NM. (page 48)

h) Len Goodman, Santa Fe, NM. (page 49)

i) PTSd Nightmare Cure by Vietnam Vet 1968. (page 50)

j) PTSd by Dennis Geeham (page 52)

k) Marijuana and PTSd by Stephen Otero (page 54)

l) PTSd by Manzar (page 56)

Report & Recommendations to the New Mexico Secretary of Health

From the Medical Advisory Board to the Medical Cannabis Program

From a Public Hearing on Wednesday 7 November 2012 at the Harold Runnels Building Auditorium, 1190 St. Francis Drive, Santa Fe NM

Report prepared by Steven Jenison, M.D., Chair, for the Medical Advisory Board. This report was reviewed and approved by all Members of the Medical Advisory Board who participated in the Public Hearing.

A public hearing of the Medical Advisory Board to the New Mexico Medical Cannabis Program was held in the Harold Runnels Building Auditorium at 1190 St. Francis Drive in Santa Fe NM from 1:00 PM to 5:00 PM on Wednesday 7 November 2012.

A. Introductory Comments and Introduction of Board Members

Dr. Jenison called the meeting to order at 1:05 PM.

Board members present:

1. Eve Espey, MD, Obstetrics / Gynecology
2. Steven Jenison, MD, Infectious Diseases (Chair)
3. William Johnson, M.D., Psychiatry
4. Timothy Lopez, MD, Oncology
5. R. Elden Pennington, MD, Ph.D., Rehabilitation Medicine
6. Mitchell Simson, MD, Internal Medicine

Members excused:

1. Eve Elting, Internal Medicine

The position that became vacant upon the resignation of Dr. Erin Bouquin, MD, from the Medical Advisory Board on 1 February 2012 remains unfilled.

Present representing the Department of Health:

1. Chris Woodward, JD, Office of General Counsel
2. Kenneth Groggel, Director, Medical Cannabis Program
3. Andrea Sundberg, Program Coordinator, Medical Cannabis Program

B. Actions of the Secretary of Health on the Recommendations of the Medical Advisory Board from the Public Hearing on April 18, 2012

The Medical Advisory Board submitted its report from the public hearing of April 18, 2012, to Dr. Catherine Torres, M.D., Secretary of Health, on May 2, 2012. In the interim, Dr. Torres resigned from her position with the Department of Health. Interim Secretary of Health, Mr. Brad McGrath, reported actions on the Board’s recommendations on Tuesday, November 6, 2012. The document “Final Decision Regarding Petitions for the Approval of Conditions for Participation in

the Medical Cannabis Program" dated 11/06/2012 is attached to this report. The following summary statements are excerpted from that document below:

I. Decision:

I have reviewed the recommendations of the Advisory Board of the Medical Cannabis Program contained in their report based on the Board's findings at a public hearing held on April 18, 2012. Having reviewed the Advisory Board's recommendations and the available medical literature and materials, and in consideration of the purpose of the Lynn and Erin Compassionate Use Act to provide relief from pain and suffering associated with debilitating medical conditions, I am taking the following actions with regard to the petitions and recommendations submitted to the Department:

A. Conditions that were recommended for addition to the list of eligible conditions:

Spasmodic Torticollis (Cervical Dystonia)

I am adopting the recommendations of the Advisory Board to add this conditions to the list of eligible conditions.

B. Conditions that were not recommended for addition to the list of eligible conditions

Psychotic Disorders

I am adopting the recommendations of the Advisory Board to not add conditions to the list of eligible conditions.

C. Medical Cannabis Program Update

Mr. Kenneth Groggel, Director of the Medical Cannabis Program, presented an update of the status of the Medical Cannabis Program. The report is included as an attachment.

At the time of the public hearing, there were 8059 patients actively enrolled in the Medical Cannabis Program. Of these, 3040 had active Personal Production Licenses. 3350 (42 percent of total active enrollees) were enrolled under the qualifying condition PTSD. Mr. Groggel stated that the Department of Health has concluded that the supplies of medical cannabis available through licensed producers and through personal production are sufficient to meet the needs of the patients currently enrolled in the Program.

Prior to the public hearing, the Medical Advisory Board had requested from Program all documentation of adverse events related to participation in the New Mexico Medical Cannabis Program reported to the Department of Health from the time of first enrollment to the present, including all incidents of acute psychosis. Mr. Groggel states that there have been no incidents of adverse events related to participation in the New Mexico Medical Cannabis Program reported to the Department of Health from its inception to the present. Specifically, there have been no reports of acute psychosis reported to the Department. One concern that was brought

to the attention of the Department was in regard to pesticide / herbicide contamination of medical cannabis and a cannabis “gummy bear” from a licensed medical cannabis producer. The New Mexico State Laboratory Division tested samples provided to the Department. Three cannabis samples obtained in April 2012 were tested for 104 pesticides, herbicides and other organic compounds and were found to be negative for all of these compounds. The cannabis “gummy bear” was tested for 26 pesticides and was negative for all of these compounds.

Mr. Groggel had no information on specific policies and procedures that the Department of Health medical personnel followed in evaluating and approving PTSD applications, or whether or how frequently the DOH clinician evaluating the application spoke directly with the certifying clinician and/or psychiatrist. He stated that all Medical Cannabis Program patient applications are reviewed by DOH medical personnel, and that these clinicians spend about 6 to 8 hours each week reviewing applications.

Mr. Woodward, Office of General Counsel, had been asked prior to the meeting to provide the Medical Advisory Board with an explanation of the Department of Health’s authority to remove qualifying conditions from eligibility for participation in the Medical Cannabis Program. Mr. Woodward reviewed the Department’s opinion in that regard at the public hearing. The following is the written opinion provided to the Medical Advisory Board by Mr. Woodward in an email on October 24, 2012:

“In a nutshell, the Department’s legal authority to remove or modify a DOH-approved condition is the same as its authority to approve a condition – albeit with certain limitations imposed via DOH regulation.

The Compassionate Use Act at NMSA 26-2B-3(B) defines “debilitating medical condition” as including seven specified conditions (cancer, glaucoma, M.S., etc.). The definition also specifies “any other medical condition, medical treatment or disease as approved by the department.” By this text, the statute vests with the Department of Health the ability to identify conditions (in addition to those specified in statute) that may qualify someone for participation in the medical cannabis program. The Department’s authority to adopt and amend regulations is based in the Department of Health Act at NMSA 9-7-6(E), which provides that “[t]he secretary may make and adopt such reasonable and procedural rules as may be necessary to carry out the duties of the department and its divisions”. The requirements for adoption and amendment of rules are as specified in the Department of Health Act, the State Rules Act, and associated rules on rulemaking adopted by the NM State Records & Archives Center.

At the end of 2010, when the medical cannabis program regulations were last amended, the Department added a provision at 7.34.3.8(C) NMAC, which states:

Modification or removal of department-approved conditions: The secretary may remove or modify a department-approved condition only if the secretary determines, on the basis of substantial credible medical and scientific evidence, and after an opportunity for review of the proposed removal or modification by the medical advisory board, that the use of cannabis by patients who have the approved condition would more likely than not result in substantial harm to the patients’ health.

The Department’s ability to modify or remove a DOH-approved condition is limited as stated in this regulation. However, there is no other limitation identified in statute or regulation concerning the Department’s ability to amend its regulations to approve or not approve a

condition that is not otherwise identified as an approved condition in the statute. In other words, although the Department cannot modify or remove conditions that were specifically approved in the Lynn & Erin Compassionate Use Act (cancer, etc.),. the Department can modify or remove those conditions that the Department has approved, just as it can add new conditions."

D. Hearing of the Petition to remove Post-Traumatic Stress Disorder (PTSD) from the list of conditions eligible for participation in the New Mexico Medical Cannabis Program.

The petition is brought by Dr. William Ulwelling, MD, MPH, a psychiatrist from Albuquerque.

Technical evidence is submitted by 1) The Drug Policy Alliance, led by Emily Kaltenbach, Executive Director; and, 2) Bryan A. Krumm, Certified Nurse Practitioner.

1) <u>Presentation of the Petition and Testimony of Dr. William Ulwelling, M.D.</u>

The Petition submitted by Dr. Ulwelling to the Department of Health dated 7/29/12 is included as an attachment. In addition to the original petition, Dr. Ulwelling submitted an update on the petition to Mr. Brad McGrath, Interim Cabinet Secretary, in a letter transmitted by email on 10/27/2012. That document is included as an attachment.

In his oral testimony during the public hearing, Dr. Ulwelling restated the positions presented in his petition:

a) PTSD is associated with high rates of illicit substance use including marijuana use. The fact that PTSD is an eligible condition under the New Mexico Medical Cannabis Program promotes that use.
b) There is insufficient medical evidence to support the use of medical cannabis as a treatment for PTSD.
c) Marijuana use has been associated in some studies with early onset of schizophrenia and with episodes of acute psychosis.

In response to questions from Members of the Medical Advisory Board, Dr. Ulwelling provided the following information. Additional information was obtained from Dr. Ulwelling, the Psychiatric Medical Association of New Mexico, the American Psychiatric Association, the New Mexico Medical Society and the New Mexico Medical Board and other public sources in preparation for the public hearing.

Dr. Ulwelling graduated medical school from the University of California Los Angeles in 1980 and completed psychiatry residency training at UCLA, where he served as Chief Resident at the UCLA Neuropsychiatric Institute. He practiced general psychiatry in New Mexico from 1984 to 2006. He stopped providing direct patient care services and closed his medical practice in 2006. Since 2006, he has provided contract psychiatric consultation services on matters concerning personnel and security issues for the National Nuclear Security Agency of the U.S. Department of Energy. He was certified in Psychiatry by the American Board of Psychiatry and Neurology (ABPN) in 1987 and is currently Board certified. He is not required to follow the Maintenance of Certification (MOC) program of the ABPN, and he has not followed that program voluntarily. He states that his continuing medical education activities are those that are required for the

maintenance of his New Mexico medical license. He does not hold Board Certification in a subspecialty of psychiatry including Addiction Psychiatry, Brain Injury medicine, Child and Adolescent Psychiatry, Hospice and Palliative Medicine or Pain Medicine. He has published no original medical research papers. He has published no review articles on the topics of PTSD, marijuana abuse or psychosis. Dr. Ulwelling published one case report in 1985 (Ulwelling W, 'Pseudo-allergy: treatment with an MAO inhibitor, *Psychosomatics* **26**: 535-6, 1985) and two Correspondences in 1984 (Ulwelling W, Reflections of residents' values or the researchers'? *American Journal of Psychiatry*, **141**: 326-7, 1984) and 1985 (Ulwelling W, Winter births and seasonal affective disorder, *Archives of General Psychiatry* **42**: 105-6, 1985). He has not held a position on the academic faculty of a medical school. He is a Distinguished Life Fellow of the American Psychiatric Association and currently serves as the New Mexico representative to the Assembly of the APA. In his petition, he listed among his credentials "Clinical Assistant Professor, UNM School of Medicine". He states that this is incorrect and that his appointment as Clinical Assistant Professor expired on December 31, 2007 and was not renewed by the University of New Mexico. He states that this was an oversight on his part as he unaware that his clinical faculty position had expired because he did not receive the letter from the UNM Health Sciences Center notifying him of this. He became aware of the error after the submission of his petition and before the time of this public hearing.

Dr. Ulwelling states that his petition represents only his personal position as a psychiatrist. Specifically, he states that it does not represent the position of the Department of Psychiatry at the UNM Health Sciences Center, the UNM Health Sciences Center, the Psychiatric Medical Association of New Mexico, the American Psychiatric Association or the New Mexico Medical Society. No individuals or organizations have submitted materials or letters in support of Dr. Ulwelling's petition.

Included in the petition is an "Action Paper" titled "Disapprove Medical Marijuana as a Treatment for PTSD" that Dr. Ulwelling prepared and presented to the Executive Committee of the Psychiatric Medical Association of New Mexico (PMANM) and to the Assembly of the APA. The Psychiatric Medical Association of New Mexico has between 150 and 170 physician members. [There are currently 401 licensed physicians in New Mexico who list psychiatry as their primary specialty. Of those, 265 list New Mexico addresses. There are 276 New Mexico psychiatrists who are certified by the American Board of Psychiatry and Neurology listed on the Board's website.] Dr. Ulwelling presented the Action Paper to the PMANM Board Meeting on January 10, 2012. By his report, no supporting materials were presented as part of the discussion of the Action Paper. Seven members of the Board were present and one participated by telephone. A motion to endorse the Action Paper passed unanimously. Dr. Ulwelling confirms that the Action Paper received consideration from only 8 members of PMANM (including himself) out of 150 to 170 PMANM members and approximately 270 psychiatrists practicing in New Mexico. Dr. Ulwelling presented the Action Paper to the Assembly of the American Psychiatric Association at its May 2012 meeting in Philadelphia PA. A representative of the APA, in an email in response to a request for information on the consideration of the Action Paper, states:

"However, unlike the policies and procedures of the American Medical Association, the APA Assembly's approval is only the first step in the APA's process for implementing association policy. The final decisions are reviewed and voted on by the APA Board of Trustees, the fiduciary body of the organization. This document is currently under review

by multiple components of the APA, has not yet been reviewed by the Board of Trustees and is, therefore, not current APA policy. Additionally, documentation pertaining to the deliberations of the Assembly is not shared."

More information was requested from the Psychiatric Medical Association of New Mexico and the American Psychiatric Association regarding the actions, process and timetable for the hearing of the Action Paper by the APA and its Board of Trustees; neither the PMANM nor the APA had provided that information at the time of this writing.

As part of his presentation, Dr. Ulwelling proposed that patients who were already enrolled under PTSD as a qualifying condition should be allowed to remain in the Program ("grandfathered-in") while discontinuing all new enrollment under that condition. This proposal was also presented in the update document that Dr. Ulwelling submitted to Mr. McGrath on 10/27/2012:

"While not discussed in my original petition, at the upcoming public hearing I will recommend that the 4000 people already in the medical cannabis program under the PTSD condition be "grandfathered" into the program if my petition is approved. I believe this is a liberal and humane accommodation. Even if only 10% of PTSD sufferers who try marijuana find it to be a safe and efficacious treatment, it is likely that these 10% are among the current 4000, and it would not be compassionate to remove their marijuana. I say this accommodation is 'liberal' because many believe that a large number of the 4000 are not truly PTSD sufferers, but are simply using the fact that the PTSD medical indication is based on subjective report and thus provides the easiest 'end-run' around marijuana laws. A second reason to 'grandfather' in the 4000 is that they could argue that they have in good faith followed the medical advice of the State of New Mexico and have taken marijuana to treat their PTSD. Some may now be addicted. It would seem unfair for the State to turn around and effectively say,' We've changed our mind. Now we will arrest you if you keep using marijuana'".

Dr. Ulwelling was asked if he was aware of any statements or documents in which the Department of Health or any agency of the State of New Mexico gave people medical advice that they should use of cannabis for the treatment of PTSD. He said that he was not, but that the inclusion of PTSD as an eligible condition implied to the layperson that it was a treatment recommended by the State. He was asked the basis for the estimate that 10 percent of PTSD patients might benefit from the use of medical cannabis. He stated that he made that number up. Dr. Ulwelling was asked whether he or any other member of the Psychiatric Medical Association of New Mexico had presented any Action Papers to PMANM or to the American Psychiatric Association seeking to promote better access to effective treatments for PTSD patients including recent combat veterans. He stated that he was unaware of any such actions. Dr. Ulwelling was asked to provide more information on his statement *"Some may now be addicted"* in terms of his understanding of the addictive potential of cannabis. He stated that cannabis does have addiction potential, but that potential is less than that of other commonly used drugs of abuse including alcohol.

2) <u>The Drug Policy Alliance –presentation of technical evidence</u>

The written technical evidence submitted by the Drug Policy Alliance is included as an attachment.

The following individuals presented evidence through oral testimony:

a. Dr. Florian Birkmayer, Psychiatrist, Albuquerque
b. Dr. Lisa Walker, Psychiatrist, Santa Fe
c. Dr. Carola Kieve, Psychiatrist, Las Vegas
d. Keith Marker, Patient
e. Vicky Eckerdt, Mother of patient
f. Nat Dean, Patient
g. Cisco McSorley, New Mexico State Senator
h. Antonio Maestas, New Mexico State Representative
i. Gerald Ortiz y Pino, New Mexico State Senator

Three New Mexico physicians (Drs. Birkmayer, Walker and Kieve) presented their experience as currently practicing psychiatrists who care for PTSD patients enrolled in the Medical Cannabis Program. Letters from each of these psychiatrists is included in the technical information submitted by the Drug Policy Alliance. They stated that some patients benefit in terms of their PTSD symptoms when other treatment options have failed to bring relief or have caused unacceptable side effects. They were unaware of patients who had developed signs or symptoms of acute psychosis as a result of the use of medical cannabis. They recommended retaining PTSD on the list of eligible conditions for participation in the Medical Cannabis Program so that it would be available as an option for those patients for whom other treatment options had failed.

Two PTSD patients currently enrolled in the Medical Cannabis Program (Keith Marker & Nat Dean) and the mother of a PTSD patient (Vicky Eckerdt) testified that medical cannabis had provided symptomatic relief for their PTSD symptoms when prescription medications had failed to do so. They stated that previous prescription medications had caused severe and debilitating side effects.

Three current members of the New Mexico Legislature (Sen. Cisco McSorley, Sen. Jerry Ortiz y Pino, and Rep. Antonio “Moe” Maestas) stated their support for retaining PTSD as a qualifying condition under the New Mexico Medical Cannabis Program. They pointed out that some of the arguments presented in the petition were arguments against medical cannabis program in general, and that the appropriate place for those arguments was before the New Mexico Legislature. They warned that the suggestion that current patients enrolled under PTSD should be “grandfathered-in” while discontinuing new enrollments was a double standard that would not withstand legal challenges.

3) <u>Mr. Bryan Krumm, Clinical Nurse Practitioner and representing the Zen Zion Coptic Orthodox Church – presentation of technical evidence</u>

The written technical evidence submitted by Mr. Krumm is included as an attachment.

Mr. Krumm is a psychiatric Clinical Nurse Practitioner. He presented his experience in providing care to PTSD patients including many enrolled in the Medical Cannabis Program. He provided extensive information on the biological and clinical rationale for the use of medical cannabis in the management of PTSD.

Mr. Krumm’s petition includes a draft of a journal manuscript that he wrote titled

"Cannabis in Post-Traumatic Stress Disorder (PTSD): A Neurobiological Approach to Treatment", submitted for publication on April 20, 2012.

E. Recommendation of the Medical Advisory Board to the Secretary of Health

It is the unanimous recommendation of the Medical Advisory Board to the New Mexico Medical Cannabis Program that the Secretary of Health reject the petition to remove Post-Traumatic Stress Disorder (PTSD) from the list of conditions eligible for participation in the New Mexico Medical Cannabis Program.

The New Mexico Medical Cannabis Program Regulations at 7.34.3.8(C) NMAC state:

"Modification or removal of department-approved conditions: The secretary may remove or modify a department-approved condition only if the secretary determines, on the basis of substantial credible medical and scientific evidence, and after an opportunity for review of the proposed removal or modification by the medical advisory board, that the use of cannabis by patients who have the approved condition would more likely than not result in substantial harm to the patients' health."

Based upon our review of the petition, technical evidence, testimony presented at this public hearing and other information discussed below, it is our opinion that this petition falls far short of the standard of providing "substantial credible medical and scientific evidence", and that insufficient evidence was presented to support the contention "that the use of cannabis by patients would more likely than not result in substantial harm to the patients' health." Indeed, it is the position of the Medical Advisory Board that removal of PTSD from eligibility in the Medical Cannabis Program would more likely than not result in substantial harm to patients.

F. Discussion of the Medical Advisory Board Recommendation

The petition to add PTSD to the list of conditions eligible for participation in the New Mexico Medical Cannabis Program was considered in public hearing on January 15, 2009. At the hearing, many individuals with PTSD resulting from combat or from sexual abuse stated that they had derived relief from unrelenting symptoms related to their PTSD (re-experiencing, hyperarousal, sleep disturbances) when other treatments had either failed or had caused intolerable side effects.

At the time that the original PTSD petition was considered, only one large meta-analysis of PTSD treatments was available – an Institute of Medicine (IOM) study commissioned by the U.S. Department of Veteran Affairs titled "Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence" published in 2007 (Berg AO et al., 2007). Quoting from the Summary:

"The committee applied contemporary standards in evaluating studies, including research dating back to 1980 when PTSD was first formally defined. The principal finding of the committee is that the scientific evidence on treatment modalities for PTSD does not reach the level of certainty that would be desired for such a common and serious condition among veterans. For some modalities, for example novel antipsychotic drugs and SSRIs [selective serotonin reuptake inhibitors], the committee debated whether to characterize the body of evidence as 'suggestive' or 'inadequate'. It is important to emphasize that in the larger picture of PTSD treatment, had the debate

ended with 'suggestive' conclusions (rather than the 'inadequate' conclusions the committee finally reached), the core message that better-quality research is needed would not have been rendered less urgent in consequence."

At that time, the IOM study concluded that there was inadequate evidence to support any psychopharmacologic treatments for PTSD, and sufficient evidence only for "exposure therapies" as a behavioral treatment. Other key findings of the IOM study included:

"The majority of drug studies were funded by pharmaceutical manufacturers and many of the psychotherapy studies were conducted by individuals who developed the techniques or their close collaborators."

"Available research leaves significant gaps in assessing the efficacy of interventions in important subpopulations of veterans with PTSD, especially those with traumatic brain injury, major depression, other anxiety disorders, or substance abuse, as well as ethnic and cultural minorities, women and older individuals."

"The research on treatment of PTSD in U.S. veterans is inadequate to answer questions about interventions, setting, and lengths of treatment that are applicable in this specific population."

"Studies of PTSD interventions have not systematically and comprehensively addressed the needs of veterans with respect to efficacy of treatment and the comparative effectiveness of treatments in clinical use."

In the interim, one large meta-analysis of pharmacotherapy for PTSD has been published through the Cochrane Collaboration (Stein DJ, 2009). Quoting three key statements from the study:

"This is a systematic review of 35 short-term randomized controlled trials of pharmacotherapy for PTSD (4597 participants). A significantly larger proportion of patients responded to medication (59.1%) than to placebo (38.5%) (13 trials, 1272 participants). Symptom severity was significantly reduced in 17 trials (2507 participants). The largest trials showing efficacy were of the selective serotonin reuptake inhibitors (SSRIs), with long-term efficacy also observed for these medications."

"Neither the potential clinical (presence of combat trauma, comorbid expression) or methodological (single versus multi-centre trials, industry versus non-industry funding) predictors of medication response tested in this review can account for the substantial proportion (41%) of patients who do not appear to respond to medication."

"This review found some evidence that war veterans are more resistant to pharmacotherapy than other patient groups, at least with regards to the reduction of symptom severity."

A recent meta-analysis of treatment of PTSD in U.S. combat veterans within the VA system by Goodson et al. found a "medium" effectiveness of PTSD treatments such that the average treated patient fared better than 66 percent of untreated patients (Goodson J et al., 2011).

In conclusion, neither at the time of the original consideration of the PTSD petition nor at the present time is there strong evidence to support the efficacy of most treatments for PTSD, and even those treatments for which there is some efficacy data are not effective in a high proportion of treated individuals.

The findings of these large meta-analyses are not supportive of the suggestion that "20 medications listed as first line or second line treatment possibilities for PTSD" (Exhibit 5 in the Petition – "Action Paper) in the updated APA practice guidelines (Exhibit 1 in the Petition -- Benedek DM et al., Guideline Watch (March 2009): Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder. *The Journal of Lifelong Learning in Psychiatry*, 7: 204, 2009) represent an acceptable and accepted available armamentarium in the treatment of PTSD, in the context of which the therapeutic possibilities of cannabis in the setting of a medical cannabis program should be dismissed. In fact, that Treatment Guideline presented in Exhibit 1 of the Petition includes the conclusion:

"with the exception of the alpha-adrenergic antagonist prazosin, the evidence base for pharmacological intervention in combat-related PTSD has not been significantly augmented by recent studies. Indeed, these studies suggest that SSRIs may not be recommended with the previous level of confidence for the treatment of PTSD in this particular population."

In our reading of the Practice Guidelines overall, we find them to be highly circumspect, very tentative in their recommendations and highly cognizant of the profound limitations of the data upon which those recommendations are made.

At the time that the original PTSD petition was under consideration by the Medical Advisory Board and by the Secretary of Health (Dr. Alfredo Vigil, M.D.), the number of combat veterans returning from the conflicts in Iraq and Afghanistan was rising dramatically. It is estimated that somewhere between 14 and 25 percent of combat veterans returning from recent wars will suffer from PTSD (Goodson J et al., 2011; Hermann BA et al., 2012). It was not clear then, and it is not clear now, that the needs of those veterans are being well served. A study published in 2008 by the RAND Center for Military Health Policy Research (Tanielian T & Jaycox LH, eds.: "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery") states:

"Even when individuals receive care, too few receive quality care. Of those who have a mental disorder and also sought medical care for that problem, just over half received a minimally adequate treatment. The number who received quality care (i.e., a treatment that has been demonstrated to be effective) would be expected to be even smaller."

"Survey respondents identified many barriers that inhibit getting treatment for their mental health problems. In general, respondents were concerned that treatment would not be kept confidential and would constrain future job assignments and military-career advancement. About 45 percent were concerned that drug therapies for mental health problems may have unpleasant side effects, and about one-quarter thought that even good mental health care was not very effective."

As recently as 2012, a study published by Wisco et al. titled "Screening, Diagnosis and Treatment of Post-Traumatic Stress Disorder" in the journal *Military Medicine* concluded:

"The VA has initiated a "national rollout" providing training in CPT (Cognitive Processing Therapy) and PE (Prolonged Exposure) to providers across the country to increase patient access to these two therapies. However, the actual implementation of such interventions across large institutions like VA and the DoD can be a substantial challenge. Another related challenge to accessing these treatments is the significant time commitment that is required, which can be difficult for active duty personnel, working veterans, and individuals living in rural locations who may have to travel long distances to meet with a therapist. Telehealth and intern-based interventions have been proposed to increase access to care in remote locations, and such treatments are currently under investigation. Pharmacological treatments are thought to be easier to disseminate, but not all veterans are willing to take psychotropic medications, and pharmacological treatments for PTSD are only modestly effective. Additionally, many pharmacological interventions have undesirable side effects, such as impaired sexual functioning, making compliance difficult." (Wisco TE et al., 2012).

The intent of the New Mexico Legislature and the New Mexico Governor in enacting the Lynn & Erin Compassionate Use Act was not to promote cannabis for the treatment of any condition. Rather, it recognized that many individuals have found relief through the use of medical cannabis for certain serious conditions where they found no relief through standard medical treatments, and that those individuals should not be liable for criminal prosecution and imprisonment for the use of medical cannabis. In cases in which the condition causes considerable distress or is life-threatening, in which there is biological plausibility for efficacy, and especially in cases in which standard therapies are either lacking entirely or are ineffective in a large proportion of patients, inclusion for eligibility in the New Mexico Medical Cannabis Program is warranted. These considerations were carefully weighed at the time that the original PTSD petition was heard. It was the conclusion of the Secretary of Health that PTSD met the intent of the Lynn & Erin Compassionate Use Act, and Dr. Vigil adopted the recommendation of the Medical Advisory Board in that regard. Since the addition of PTSD to the conditions eligible for enrollment in the New Mexico Medical Cannabis Program, there have been no adverse events reported to the Department of Health related to PTSD patients in the Program. In the opinion of the Medical Advisory Board, there is no new compelling medical or scientific evidence that should cause a serious reconsideration of that decision.

There is an association between PTSD and cannabis use. Cannabis use is strongly associated with severity of PTSD symptoms and is inversely related to Distress Tolerance (Bonn-Miller MO et al., 2011; Bremner JD et al., 1996; Cougle JR et al., 2011; Hogan J et al., 2010; Potter et al., 2011; Tepe E et al., 2012; Villagonzalo, K-A et al, 2011; Zvolensky MJ et al., 2009). There are considerable data that support the hypothesis that cannabis is used by patients as a coping mechanism to decrease symptoms associated with PTSD, notably anxiety symptoms, hyperarousal and sleep disturbances. One study of cannabis use among patients with concurrent Social Anxiety Disorder (SAD) and Cannabis Use Disorder (CUD) found:

"although not statistically significant, there was a trend toward patients with the SAD-CUD comorbidity being more likely to be rated as having better adolescent and current psychosocial functioning compared to SAD patients without CUD. This could perhaps support findings from previous studies that suggest that marijuana may be used as a social lubricant to facilitate social interactions, similar to alcohol, amongst individuals

with SAD in order to alleviate anxiety specifically in social situations." (Tepe E et al., 2012).

It has been proposed that cannabis use in PTSD fits within the "Self-Medication" model (Bujarski SJ et al., 2012; Villagonzalo, K-A et al., 2011) in which patients use cannabis as a medicine for the treatment of specific symptoms. There is biological plausibility to the role of cannabinoid compounds, especially cannabidiol, in affecting neurologic pathways involved in the pathology of PTSD, notably pathways involving the amygdala, the hippocampus and the anterior cingulate gyrus (Agren T et al., 2012; Campos AC et al., 2012; Englund A et al, 2012; Hsiao Y-T et al., 2012; Mechoulam R et al., 2013; Passie T et al., 2012; Schier ARdM et al., 2012).

There are concerns about the possible association of cannabis use and psychosis. These concerns arise mainly from studies that have shown an association between cannabis use and younger age at first episode of psychosis among individuals ultimately diagnosed with a chronic psychotic disorder, particularly schizophrenia (Auther AM et al., 2012; Kuepper R et al., 2011; Manrique-Garcia E et al., 2012; Najolia GM et al., 2012; Saha S et al., 2011). It is not clear at this time whether the observed association reflects a causal relationship between cannabis and psychosis, or whether the two are related through some other as yet uncharacterized factor or factors. For example, there have been recent data to suggest that childhood sexual abuse might be a common factor that both predisposes a young person to cannabis use and to the development of psychosis (Bebbington P et al., 2011; Houston JE et al., 2011; Murphy J et al., 2012; Sideli L et al., 2012). Also, it is possible that the Self-Medication model applies to those with a psychosis diathesis (whether due to genetic factors or environmental factors or some combination) in adolescence, and that those individuals with more severe symptoms are those who are more likely to self-medicate with cannabis at an earlier age. Regardless, estimates of the risk of psychosis conferred by cannabis use are low. An analysis by Hickman et al. published in the journal *Addiction* estimated the number of cases of heavy and light cannabis use that would need to be prevented in order to prevent one case of psychosis (based upon previously described associations between cannabis use and psychosis, and based upon an assumption of a causal relationship between cannabis use and psychosis). Quoting from the study:

"*We calculated how many heavy or light cannabis users would need to be prevented (NNP) in order to prevent one case of schizophrenia or psychosis in men and women under 40. These estimates were considerably high, even for young people with the highest rates of schizophrenia, ranging for men aged 20 – 24 from 2800 for heavy cannabis users to more than 10,000 for light cannabis users; and for women aged 20 – 24 from 7700 for heavy cannabis users to 29,000 for light cannabis users*." (Hickman M et al., 2009).

It seems unlikely that the presence or absence of PTSD on the list of conditions eligible for the New Mexico Medical Cannabis Program would have a significant impact on the number of people with PTSD who are using cannabis to treat their symptoms to the extent that it would significantly affect the population risk of psychosis (assuming a causal relationship between cannabis and psychosis). As was the intent of the Lynn & Erin Compassionate Use Act, the inclusion of PTSD in the Medical Cannabis Program affects mainly their legal status under New Mexico law of PTSD patients who use cannabis. Participation in the Medical Cannabis Program also makes it more likely that the PTSD patients will have some regular interaction with medical professionals who will

be able to monitor their clinical outcomes and make recommendations for other treatment options. There are also some data that suggest that the cannabinoid compound cannabidiol has anti-anxiety and anti-psychotic effects whereas the cannabinoid delta-9-tetrahydrocannabinol (THC) may have the opposite effects. It may be an advantage to those individuals who are using medical cannabis to treat their symptoms to have access to well-characterized cannabis with known cannabidiol and THC content available through licensed medical cannabis producers.

Dr. Ulwelling's petition raised the issue of the addiction potential of cannabis use. It is generally held that cannabis has both psychological and physical dependency potential, more so in some people than in others. A survey was conducted among psychiatrists and addiction specialists in Britain in order to attempt to rank illicit drugs and legal drugs of abuse with regard to dependency and harm (Nutt D et al., 2007). In the ranking of drugs by dependency potential, cannabis ranked below heroin, cocaine, barbiturates, street methadone, alcohol, ketamine, amphetamines, tobacco and buprenorphine; it ranked above LSD, anabolic steroids and Ecstasy. In the ranking of physical harm, it ranked below all of these other drugs. The abuse potential of the major cannabinoids present in marijuana, Δ-9-tetrahydrocannabinol and cannabidiol, was recently assessed by reviewing all published papers on the use of the prescription medication Sativex®. (Robson P,., 2011). Sativex® is an inhaled oromucosal spray that contains these cannabinoids extracted from *Cannabis sativa* leaves and flowers. It is currently licensed in the United Kingdom, Spain, Germany, Denmark, the Czech Republic, Sweden, New Zealand and Canada for the treatment of moderate to severe spasticity associated with multiple sclerosis (MS); it is not currently licensed in the United States. Based upon a review of all of the clinical trials and the integrated safety analysis data for Sativex®, the study concluded:

"In clinical trials, intoxication scores have been low and euphoria reported by only 2.2% of patients. Tolerance has not occurred, abrupt withdrawal has not resulted in a formal withdrawal syndrome, and no cases of abuse or diversion have been reported to date. A formal abuse liability study of Sativex in experienced cannabis smokers showed some abuse potential in comparison with placebo at higher doses, but scores were consistently lower than equivalent doses of THC. Evidence to date suggests that abuse or dependence on Sativex is likely to occur in only a very small proportion of recipients.

There are as yet no clinical trials data on the safety and efficacy of medical cannabis in the treatment of PTSD. It is widely perceived by those who seek to investigate medical cannabis that the National Institute on Drug Abuse (NIDA) has created and maintained barriers to medical cannabis research, both by limiting funding and by denying access to medical cannabis grown for NIDA by the University of Mississippi (the sole source of medical cannabis that is legal according to Federal law). Federal barriers to medical cannabis research led the State of California to establish the Center for Medicinal Cannabis Research at the University of California at San Diego (www.cmcr.ucsd.edu) funded through the state. Dr. Sue Sisley, a psychiatrist and professor at the University of Arizona downtown Phoenix campus, began application to NIDA in 2010 for a study of medical cannabis in veterans with chronic, treatment-resistant PTSD. That study has received Institutional Review Board approval from the University of Arizona, and the protocol has been approved by the Food & Drug Administration. Dr. Sisley is awaiting a response from NIDA on whether they will allow her the necessary access to federal cannabis for the purposes of her study. Dr. Sisley's experience prompted the Arizona Medical Association House of Delegates on June 2, 2012, to unanimously adopt a

resolution titled “Support for ending the sole domination of the National Institute on Drug Abuse (NIDA) and to allow privately-funded FDA-regulated clinical trials on Cannabis to proceed without unwarranted barriers”. In August 2010, a group of researchers from New Mexico (Catie Willging, Ph.D.; Sandra Lapham, M.D.; William Johnson, M.D.; Steven Jenison, M.D.; Linda Gorgos, M.D.), led by investigators with a long track record of population-based behavioral health and substance use research, made application to NIDA to investigate PTSD patient characteristics and outcomes related to participation in the New Mexico Medical Cannabis Program. In October 2010, we were notified that the proposed project had not been funded.

The input and perspective of medical professional organizations such as the Psychiatric Medical Association of New Mexico and the American Psychiatric Association is potentially important and valuable in considering medical cannabis use for PTSD and other psychiatric conditions. However, our experience in reviewing the actions of PMANM and the APA on the “Action Paper” titled “Disapprove Medical Marijuana as a Treatment for PTSD” has not been encouraging. Reportedly, the Action Paper was approved by eight (including Dr. Ulwelling) of 150 to 170 PMANM members without the input of the general membership of PMANM. The minutes of the Executive Committee Meeting at which the Action Paper was accepted do not note the submission of supportive materials, the active solicitation of differing perspectives or the details of extended discussion. Subsequently, the Action Paper advanced to the Assembly of the American Psychiatric Association where it was approved. The response of the APA to a request for information on that process was *“documentation pertaining to the deliberations of the Assembly is not shared.”* It is hoped that the future considerations of the American Psychiatric Association with regard to this Action Paper will be more inclusive of diverse perspectives and stakeholders, more rigorous and thorough in the analysis and discussion of the available information, more transparent, and more solicitous of input from the medical cannabis programs and patients who could be impacted by their actions.

In summary, the Medical Advisory Board recommended the addition of Post-Traumatic Stress Disorder to the list of conditions eligible for participation in the New Mexico Medical Cannabis Program in 2009. The Secretary of Health reviewed that recommendation in the context of the intent of the Lynn and Erin Compassionate Use Act and adopted the Board’s recommendation. There are currently 3350 patients enrolled under the primary diagnosis of PTSD, or 42 percent of current enrollees in the Medical Cannabis Program. To date, there have been no incidents of adverse events related to the participation of PTSD patients in the Program reported to the Department of Health. There is an extensive medical literature that documents the association between PTSD and cannabis use, much of it suggesting that PTSD patients use cannabis to alleviate debilitating symptoms of re-experiencing, hyperarousal, anxiety and sleep disturbances. Although there are meta-analyses that support the efficacy of some standard psychotherapeutic and pharmacotherapeutic treatments for PTSD, their estimated benefit is in most cases modest, their side effect profiles are troublesome and they are not effective in a sizeable proportion of patients (especially combat veterans). Many patients with PTSD do not have meaningful access to standard medical treatments, and many chose not to access standard medical treatments. It is not only biologically plausible, but also biologically probable, that cannabinoids have an affect in alleviating serious symptoms of PTSD. Hopefully, the barriers that have obstructed human clinical trials of medical cannabis in the treatment of PTSD will be removed so that these studies can proceed. In the meantime, the Medical Advisory Board

recommends retaining PTSD in the Medical Cannabis Program so that PTSD patients who have derived relief through the use of cannabis can continue to be protected from criminal liability under state law. In every regard, the inclusion of PTSD in the New Mexico Medical Cannabis Program meets the intent of the Lynn & Erin Compassionate Use Act. In our opinion, the petition to remove PTSD does not meet the standards set forth in the New Mexico Medical Cannabis Program Regulations at 7.34.3.8(C) NMAC, and the Secretary of Health should reject the petition.

Citations:

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G. PUBLIC COMMENT

Comments were taken from members of the public in attendance.

H. ATTACHMENTS

1. Actions of the Secretary of Health on the Recommendations of the Medical Advisory Board from the Public Hearing on April 18, 2012
2. Report of the Medical Cannabis Program
3. Petition to remove Post-Traumatic Stress Disorder (PTSD) from the list of conditions eligible for participation in the New Mexico Medical Cannabis Program, submitted by Dr. William Ulwelling, M.D.
4. Update on the Petition to remove Post-Traumatic Stress Disorder (PTSD) from the list of conditions eligible for participation in the New Mexico Medical Cannabis Program, submitted by Dr. William Ulwelling on 10/27/2012
5. Technical Evidence submitted by the Drug Policy Alliance
6. Technical Evidence submitted by Bryan Krumm
7. Emails and other communications received by the Department of Health in response to Dr. Ulwelling's petition

PTSD sufferers should keep access to medical cannabis

The New Mexican
Posted: Saturday, October 13, 2012

New Mexico's decision to allow post-traumatic stress disorder as a condition that can be treated with medical marijuana is helping sufferers across the state cope with their symptoms. Some 3,300 patients are taking advantage of that access, using medical-grade cannabis to treat symptoms of this little-understood malady. Many are veterans of war, others are survivors of tragedies, including sexual assault. Anecdotally, they tell us that marijuana helps them deal with life. Reporter Deborah Busemeyer details their stories — and the debate over PTSD and medical cannabis — in today's *Santa Fe New Mexican*, showing how desperate people turned to cannabis for help, many as a last measure.

That treatment could be taken away, though. Access to medical marijuana for PTSD is being questioned in New Mexico. To skeptics, there is not enough scientific evidence to prove that sufferers benefit from smoking or consuming pot. In November, the New Mexico Medical Cannabis Advisory Board will review a petition asking that PTSD be removed as a condition for which medical marijuana can be prescribed through the state's Medical Cannabis Program. Psychiatrist Dr. William Ulwelling is petitioning the state because he believes there is a lack of evidence showing that medical marijuana helps PTSD. What's more, he thinks that medical cannabis is a risk for sufferers of PTSD, leading to substance abuse problems and other injury. After the board considers his petition Nov. 7 — veterans are expected to turn out to testify in favor of keeping marijuana access — the interim deputy health secretary will make a final decision.

New Mexico is one of only three states allowing marijuana as a treatment for PTSD — Arizona and Colorado have rejected its use as treatment for the disorder, for example. It was added back in 2009, after then-Secretary of Health Dr. Alfredo Vigil decided patient testimony, as well as evidence that other medications weren't working, gave him enough grounds to include PTSD. "It seemed reasonable," he said. Nationwide, only 17 states allow medical marijuana at all.

Frankly, we like how California deals with the issue. Its state law doesn't allow PTSD as a reason — but it doesn't disallow it, either. Rather than tell doctors how and what to prescribe, California's law says cannabis can be prescribed for "any other chronic or persistent medical symptom that either substantially limits a person's ability to conduct one or more of major life activities as defined in the Americans with Disabilities Act of 1990, or if not alleviated, may cause serious harm to the person's safety, physical, or mental health." That way, the diagnosis is up to the physician, and a sick and hurting person doesn't have to prove to a panel of bureaucrats that she needs her medicine. Removing bureaucrats from health care decisions, after all, is an oft-stated goal of politicians.

Eliminating PTSD, of course, won't necessarily cut off patient access to the treatment they believe works best — many people will simply get cannabis for pain or another condition that is approved by the state. We believe, given the accounts of people who are using medical marijuana, that the state should err on the side of compassion. Doctors and patients, after all, are best able to judge what treatment works for ailments. Most health care providers who prescribe cannabis do so as a last resort, when other treatments fail. Dr. Ulwelling is correct — we need more science to support the treatment. Moving forward, the state also should encourage the federal government to allow more studies into how cannabis works in treating ailments. In the meantime, absent the proof of widespread harm, New Mexico's program should continue — with patients and doctors using the treatment they believe works.

SANTA FE NEW MEXICAN.com

Cannabis catch-22: PTSD patients could be dropped from state's medical program

By Deborah Busemeyer | For The New Mexican

10/14/2012

Photo by:

Valerie Romero, 30, grew up in a home with alcohol abuse and violence. She was 16 when the state of New Mexico took her and her sisters away from their parents. Later that year, she learned she had post-traumatic stress disorder.

Nat Dean, 56, was waiting to make a left turn near her San Francisco loft when another car crashed into hers. She woke up three days later and discovered her jaw bones were crushed. Twenty-five years later, as Dean was juggling 27 medications for such conditions as anxiety, sleeplessness, psychosis, pain and depression, she was diagnosed with PTSD.

Adam Kokesh, 30, was convinced he had combat stress when he would reach for a pistol that wasn't there several days after he returned from Iraq. The U.S. Department of Veterans Affairs gave him five prescriptions for his anxiety and sleeplessness; three listed suicide as a possible side effect. The only one he tried made him feel worse.

These Santa Fe residents are patients in the New Mexico Department of Health's Medical Cannabis Program, which allows them to use cannabis legally under state law. They say marijuana is the only treatment that provides them relief from their anxiety, panic attacks, sleeplessness, depression and confusion without causing toxic side effects.

"It's the safest alternative out there," said Romero, who has tried more than a dozen anti-anxiety medications that either didn't work or made her feel more depressed and anxious. "I know how much it helped me."

New Mexico is one of three states that allows PTSD patients to use medical cannabis. Now that right is threatened by a petition before the state Department of Health. Dr. William Ulwelling, a psychiatrist for more than 30 years in Albuquerque, plans to appear before the Medical Cannabis Advisory Board on Nov. 7 in Santa Fe to ask the board to recommend that the state's health secretary remove PTSD from the program.

Out of 7,924 patients enrolled in the state's Medical Cannabis Program, 3,288, or 41 percent, are diagnosed with PTSD. They are the largest patient population in the program, followed by 2,253 chronic pain patients. Many of those PTSD patients are veterans, but no one tracks that number.

Ulwelling bases his petition on two facts: There is no scientific evidence that cannabis treats PTSD, and there is evidence that people have been harmed by using cannabis. Ulwelling said he has no knowledge of any New Mexico medical cannabis patient being harmed. Instead, he cites his experience with one mental health patient, who became psychotic while using cannabis. However, the patient did not suffer from PTSD.

Also, Ulwelling refers to a published report of nine case studies showing that marijuana was a "component cause" in people becoming psychotic, meaning there is another reason for the reaction, such as genetic

vulnerability.

“If the studies are done, it might turn out that marijuana is a great treatment for PTSD,” Ulwelling said in a phone interview. “It’s doing it backwards to say, ‘Let’s give it to the citizens of the state of New Mexico and see if it works.’ Studies should be done first.”

Ulwelling is in the process of getting the American Psychiatric Association to accept his position that people with PTSD should not have access to medical cannabis. He said the district and regional branches of the association have accepted his paper, which reads like a resolution. It could become the official policy of the American Psychiatric Association if the Board of Trustees, which meets in October, approves it, he said.

“The American Psychiatric Association is a recognized authority for psychiatric treatment and diagnoses,” he said. “That’s why I’m hoping the state of New Mexico is going to listen to APA’s input on this matter.”

Ulwelling retired from his practice five years ago. He was a psychiatry resident at a veterans hospital at the University of California before moving to Albuquerque and caring for hospitalized patients with severe PTSD in a facility that has since closed.

Barriers to cannabis study

People involved with medical cannabis are outraged by Ulwelling’s petition because they believe cannabis benefits a population that suffers from a debilitating disease. However, they agree there isn’t enough scientific evidence, and they say that’s because the federal government routinely blocks proposed studies into the benefits of cannabis.

“I wish more than anything else that the federal government would drop its stigma of cannabis so research can get done in an objective way and we would find out what the benefits are,” said Dr. Alfredo Vigil, a former state health secretary who added PTSD as a condition for the Medical Cannabis Program.

So far, health officials have relied on case studies, anecdotal reports and some research conducted by the Center for Medicinal Cannabis Research at the University of California into how cannabis may help relieve pain, spasticity and nausea.

Researchers are trying to learn more about the 60-plus cannabinoids, or chemical compounds, that are present in cannabis because each has a different effect on the body. A week ago, the international *Journal of Psychopharmacology* published results from a study in the United Kingdom that found one of the major cannabinoids — cannabidiol (CBD) — can decrease psychosis symptoms and memory problems that are caused by another main cannabinoid, Delta-9-tetrahydrocannabinoil (THC).

A University of Arizona researcher, with the assistance of the Multidisciplinary Association for Psychedelic Studies, has proposed the first controlled study in the U.S. of medical cannabis’ effects on PTSD patients. Her study would examine the effects of CBD and THC by offering patients varying levels of the two cannabinoids.

The U.S. Food and Drug Administration approved the proposal in 2011 to study 50 veterans with PTSD, but the study hasn’t been able to get clearance from the federal government to buy research-grade cannabis from the National Institute of Drug Abuse, according to Dr. Sue Sisley, an Arizona primary-care physician and principal investigator for the study.

“As physicians, we want to be able to work with patients and counsel them on how to utilize the therapies we recommend,” she said. “In this case, we’re all clueless in how to counsel patients on how to use the drug because it’s never been allowed to go through proper drug development.”

Albuquerque nurse Bryan Krumm has certified about 1,000 patients for the Medical Cannabis Program. The *Nurse Practitioner Journal* recently accepted his research paper based on patient case studies in New Mexico. In "Cannabis in Post-Traumatic Stress Disorder (PTSD): A Neurobiological Approach to Treatment," Krumm outlines how cannabis can slow down an overactive amygdala in the brain, which can cause anxiety and a constant stream of negative thoughts.

Also, cannabis can help regulate neurotransmitters in the brain that affect mood, sleep, learning, pleasure and behavior, he said.

"We had a controlled clinical trial approved in New Mexico, but NIDA [the National Institute of Drug Abuse] refused to release their supply of marijuana to do the research," Krumm said. "I'm looking at this as a laboratory with state programs, reviewing the evidence and reporting on my findings. At this point, it's the closest we can come."

Sisley hopes that as more states adopt medical cannabis programs, the federal government will be pressured to allow studies. "It's heartbreaking how the federal government has halted any progress into researching medical marijuana," Sisley said. "Legitimate, high-level science will never be allowed under federal prohibition."

Valerie Romero

As a teenager and young adult, Romero tried any kind of illegal drug — and later legal ones — to prevent her from feeling anything. By 2006, the Santa Fe native got her first steady job and started to stabilize her life. But the layers of childhood trauma, sexual abuse, domestic violence and postpartum depression left her hopeless and suicidal.

"My doctor saw I was not making any progress, and we both agreed medical cannabis was the last resort," she said.

Medical cannabis allowed her to feel normal, she said. She no longer struggles to get out of bed. "I could go about life the way I needed to."

Romero, like the other patients, recognizes that medical cannabis isn't for everyone, and that people who have PTSD need more than medication to help them work through their past trauma. She sees a therapist every week and said she has learned tools to fight against negative thoughts. More than anything, she believes medical cannabis allowed her to reach out to God and renew her faith in a way that shapes her life now.

She said medical cannabis helped her through a very rough time in her life, but she stopped taking it because she wanted a more permanent solution to her depression and anxiety. She now relies on prayer to get beyond the past that haunts her. Still, she likes knowing medical cannabis is available if she needs the extra help.

As an alcoholic with past drug-abuse problems, Romero doesn't believe medical cannabis is a gateway drug, and she doesn't believe it is addictive. The prescribed drugs she took gave her cravings and withdrawal symptoms, but not cannabis, she said.

"I think people get addicted to feeling OK in their own skin," she said.

She doesn't agree with Ulwelling's petition or his theory that medical cannabis can cause harm.

"I don't think anyone's in a place to judge what medication is right or what's effective for people," Romero said. "I think people need to acknowledge the seriousness of PTSD. A lot of people experience it, and we just

want relief. I don't think it's right to deny them … something they need to get relief."

Ulwelling said even if the state drops PTSD as a condition for the Medical Cannabis Program, it may need to allow current PTSD patients to continue receiving their treatment.

But Nat Dean says it wouldn't be fair for some to have access to medication while others cannot.

Nat Dean

Dean's story is long and harrowing.

Because she didn't receive an accurate diagnosis, she spent many years struggling to understand the changes in her mind that caused her to lose her graphic design business and her role as a national leader in the art community.

Dean moved to Santa Fe 18 years ago after marrying an Albuquerque native. Over the years, she accumulated a host of chemicals in her body — 27 drugs, some to treat her symptoms and others to lessen the medications' side effects.

When she had her gall bladder removed due to a serious condition four years ago, she was taken off all her medications and began to regress. She started to believe that her car was talking to her. She tried to fill up her phone with water, mistaking it for a glass.

When she finally recovered from mania and depression, she vowed she would never take so many drugs again. She was nervous about trying medical cannabis because she doesn't like to feel high or out of control. She seeks out strains that have high concentrations of CBD, which reduce anxiety, and lower levels of THC.

"I believe medical cannabis has been a real effective tool for me so I don't have to add more chemicals to the mix," she said. "I think it creates a healthier lifestyle if you use it appropriately."

Now she takes only six medications for the chronic pain and traumatic brain injury from her car crash 28 years ago. She weighs 65 pounds less and no longer suffers from some of the health conditions that may have been caused by her past prescriptions. She held out a bright red, manicured pinky nail to show the amount of medical cannabis she takes before bed each night.

"It calms me down if I'm agitated," she said. "It bridges me through the pain until the next day."

She said she would not use marijuana if she had to get it illegally or if she couldn't be certain that the strain was higher in CBD levels than THC.

"Without [PTSD] being an approved condition," she said, "there could be a danger in people seeking [marijuana] on the street and not having control over how it affects them. Losing the approved condition would mean losing control over what you get and then losing control over your life."

Rallying for PTSD patients

The Drug Policy Alliance and the New Mexico Medical Cannabis Patient's Alliance are launching a campaign this week to convince the state to reject Ulwelling's PTSD petition and continue allowing patients safe access to their medicine.

"If this is a medication that works for you, you should have it," said Emily Kaltenbach, director of the Drug Policy Alliance. "If we are prohibiting a medication that works, is it causing harm to the patients and the

community?"

Kaltenbach talks to patients who have PTSD from being sexually assaulted, seeing combat or caring for trauma patients as first responders. Patients tell her they don't use as much — or any — opiates when they can have medical cannabis.

"As a state where we lead the nation in overdoses because of prescription drugs, isn't it a good thing if people can reduce their pain and their symptoms by using medical cannabis, but also reduce the potential harm of seriously addictive narcotics that made them feel like they couldn't function?" Kaltenbach questioned.

Adam Kokesh

Kokesh has lived in Santa Fe on and off since he was 10. At that time, his parents divorced and his father moved to Santa Fe.

He had his first anxiety attack a couple of days after returning home from service in Iraq. He said he felt as if he were doused in liquid, out of control and overwhelmed by anxiety. He would wake early in the morning, confused and feeling like he had to be somewhere.

He met older veterans with similar experiences and established the support group Homefront Battle Buddies in Washington, D.C. He credits talk therapy with enabling him to get control of his symptoms and understand how his previous experience affects his current state of mind.

When the VA offered medications with suicide risks, Kokesh turned to cannabis instead. "I said, 'this isn't working,' and decided to take charge of my own health instead of letting doctors make those decisions," he said. "I started smoking deliberately as a way to control anxiety and use it productively and positively."

At his support group, veterans used cannabis in different ways. Some needed to smoke before meetings so they were able to talk; others used cannabis as a way to relax afterwards.

"I think [cannabis is] very important for controlling the symptomatic problems," Kokesh said. "It's important to know it's not a cure, but being able to deal with temporary anxiety issues and have a relaxation effect is sometimes necessary in order to get to a point so you can properly engage in talk therapy."

New Mexico's decision

Critics of medical cannabis often cite the lack of scientific research as a reason to prohibit patients with PTSD from accessing that treatment. Colorado and Arizona's health departments have denied petitions to add PTSD into their medical cannabis programs for that reason.

It's an issue that gave former Health Secretary Vigil pause when the Medical Cannabis Advisory Board recommended he add PTSD as a condition in 2009.

In the end, Vigil was convinced that there was evidence showing some benefit for patients, and a lot of evidence showing that other medications haven't been that effective and have, in some cases, been harmful.

"It's a complex disease that causes a lot of suffering, and you have people who are risking legal punishment for using it," Vigil said. "It seemed reasonable."

Lacking scientific studies, health officials have to rely on patients' testimony and experience with the treatment, said Dr. Bill Johnson, a Santa Fe psychiatrist and a member of the Medical Cannabis Advisory Board since its inception. Medical cannabis patients have to learn how much cannabis they need, and what

strains are helpful.

“Cannabis requires a more collaborative relationship with the doctor whose knowledge base is not as great as the patient,” he said in an interview at his Zia Behavioral Health office.

Johnson has certified close to 250 adults with PTSD for the program. Like any medicine, cannabis doesn’t work for everyone. He finds that most patients have used it before and know it helped calm them.

Since there are no diagnostic tests for PTSD, some have questioned whether people could fake symptoms to get medical cannabis. Johnson said he doesn’t believe that’s prevalent, and he noted that people could claim any psychiatric condition to get medications, which is why psychiatrists screen patients. The state Health Department requires that a psychiatrist be involved in a PTSD patient’s care.

Both Dr. Johnson and Dr. Steve Jenison, who was medical director of the Medical Cannabis Program from 2007, when it started, until 2010, had reservations about adding PTSD in 2009 because of the lack of scientific evidence. PTSD remains the only psychiatric condition allowed under the Medical Cannabis Program.

In 2007, the Institute of Medicine issued a report based on its extensive review of available literature on PTSD. The nonprofit concluded that certain therapies, such as prolonged exposure and cognitive processing, could be helpful to treat the condition. However, it also found that half of PTSD patients weren’t seeking any treatment, and no studies supported the pharmaceuticals being used.

“At the time, there was a real sense that there were a lot of people who were sort of adrift and didn’t have access to care or didn’t believe that the care would be relevant to them,” said Jenison, who is now chairman of the Medical Advisory Board that will review Ulwelling’s petition.

The Medical Cannabis Advisory Board debated studies on both sides of the issue. Some studies found that PTSD patients reported that cannabis reduced their symptoms, including the frequency and intensity of their nightmares.

Other studies found that young people who used marijuana were more likely to have schizophrenia symptoms earlier than others. However, researchers couldn’t answer the question of whether marijuana caused early onset of schizophrenia, or whether people who had schizophrenia were more likely to take marijuana to feel better, Jenison said.

Faced with insufficient evidence, the advisory board turned to the intent of the Lynn and Erin Compassionate Use Act that then-Gov. Bill Richardson signed in 2006 — to protect individuals from state criminal liability for possession of a reasonable amount of marijuana for the treatment of their medical condition.

The board was unanimous in its decision. In Jenison’s role at the Health Department before he retired, he called every new physician who certified patients for the Medical Cannabis Program. He was impressed by how often psychiatrists told him they had tried everything else first — inpatient psychiatric hospitalizations, medications and behavioral health counseling.

“Many said, ‘I know why they are using marijuana. They are using it to relieve their PTSD symptoms, and the last thing I want is to have them arrested and prosecuted for the possession of marijuana. That’s not going to be helpful to their clinical situation.’ ”

Deborah Busemeyer is a freelance journalist in Santa Fe and a former communications director for the state Health Department. Contact her at dbusemeyer@gmail.com.

Medical Cannabis for Patients with PTSD in New Mexico Is Under Attack

Posted: 10/16/2012 5:23 pm

Today more than 3,000 New Mexican residents with Post Traumatic Stress Disorder (PTSD) are actively enrolled in New Mexico's Medical Cannabis Program. Most of them are military veterans, patients living with disabilities, and victims of serious trauma and violent crime. Unfortunately, their continued access to medicine is being threatened by a request to withdraw PTSD as a qualifying condition for the New Mexico Medical Cannabis Program.

On July 29th, 2012, William Ulwelling, M.D., a retired psychiatrist in New Mexico submitted a formal request to the state's Department of Health requesting PTSD be removed from the list of eligible medical conditions for enrollment in the NM Medical Cannabis Program. His petition, which claims cannabis use by patients with PTSD leads to psychosis, will be heard by the program's Medical Advisory Board in November in Santa Fe. Adhering to program's rules this Board, comprised of board-certified physicians, will offer a recommendation to the Secretary of Health who will have the final decision. The right to use medical cannabis was approved in 2009, when PTSD was added to the list of conditions eligible under the Lynn and Erin Compassionate Use Act. Since then PTSD has become the disabling condition most frequently indicated by patients in the program, and today

accounts for 40% of the diagnoses of the citizens in the State's medial cannabis program.

In defense of keeping PTSD as an eligible condition, the New Mexico Medical Cannabis Patient's Alliance, the Drug Policy Alliance, and others are banding together for a campaign they are calling, Don't Take Away Our Medicine - a campaign to make sure the voices of PTSD patients are heard loud and clear.

"When I returned home from Afghanistan I was diagnosed with PTSD. I worked with my doctor and tried many prescription drugs. Taking handfuls of pills every day, every one with a different set of side effects was hard on my body, and I still experienced some symptoms," said Michael Innis, who served in the General Infantry and who was awarded a Purple Heart after the convoy he was traveling with got hit by an IED and was then ambushed. "Cannabis was not my first choice of medicine, but I tell you first hand, this medicine works for me. Cannabis allows me to leave my house and has helped me to return to work."

Not all psychiatrists agree with Ulwelling's claim. Dr. Lisa Walker, a board-certified psychiatrist licensed in New Mexico says that "the current pharmaceutical cocktails given to sufferers of PTSD have limited efficacy, have significant debilitating side-effects, and have in many cases proven deadly. Given these facts, along with the experience of thousands of patients whose quality of life has been improved by its use, medical cannabis should continue to be an available treatment for the suffers of PTSD."

The Campaign is standing up to protect the legal rights of patients to access safe medicine and are asking for all compassionate New Mexicans to demand the New Mexico Secretary of Health and the Governor to protect the rights of seriously ill New

Mexicans and to reject the request to rescind PTSD as a qualifying condition by signing on to the Campaign.

Chris Hsu, NM Medical Cannabis Patient's Alliance's Vice President, believes all patients in the program deserve access to effective medical treatments whether they have just come home from combat or are suffering debilitating symptoms from other trauma.

The Campaign will not allow the removal of PTSD as a qualifying condition for the medical cannabis program to happen quietly. New Mexico's military veterans and victims of serious trauma and violence deserve the freedom to choose the safest treatment for their disabling conditions. "We deserve access to the medicine that works for us. Don't take away our medicine," exclaims Nat Dean, a medical cannabis patient diagnosed with chronic pain and PTSD from a horrible car accident. She is demanding that the State not to turn their backs on veterans, patients with disabilities, and victims of trauma and violent crime.

On November 8th, the Drug Policy is also re-launching an updated version of Healing a Broken System with current numbers and new material related to medical cannabis as a safe and effective treatment for veterans diagnosed with/suffering from symptoms of PTSD. This report examines the significant barriers that veterans of the wars in Iraq and Afghanistan face in obtaining effective treatment for mental health and substance abuse problems, and the tragic consequences of leaving these wounds of war untreated.

Emily Kaltenbach is New Mexico's State Director for the Drug Policy Alliance.

PTSD sufferers may lose access to medical cannabis,

Jill Galus, KOB Eyewitness News 4, Oct 5, 2012.

People who smoke medical marijuana to treat Post Traumatic Stress Disorder will lose their right to smoke it if a local psychiatrist gets his way.

Dr. William Ulwelling has petitioned the state to remove PTSD from the list of qualifying conditions.

"There's no good scientific link saying that marijuana treats PTSD," Ulwelling said.

It is that lack of evidence that Ulwelling said prompted him to write a petition to get PTSD knocked off the list of qualifying conditions for medical marijuana patients in New Mexico.

"People with PTSD are at special risk to be harmed by marijuana, as many as two-thirds of people who have PTSD, are subsequently developing substance abuse," Ulwelling said.

But one organization argues that removing PTSD as a qualifier would essentially disqualify nearly half of the state's medical cannabis patients, many who are also veterans.

"Their access to effective care is being threatened by this petition," Director Emily Kaltenbach, of New Mexico's Drug Policy Alliance said.

PTSD is the number one condition patients in New Mexico are approved under.

"Over 40 percent of medical cannabis patients are approved under PTSD," Kaltenbach said.

In other words, nearly 3,300 patients currently enrolled, who say medical marijuana works for them, would lose access to the medicinal drug, Kaltenbach said.

"Some of them have actually transitioned off other medications that were severely or really addictive medications, and they can use medical cannabis without serious side effects," Kaltenbach said.

The New Mexico Medical Cannabis Advisory Board will review the petition on November 7th. Veterans are planning to speak out against it.

The interim health secretary will make the final decision.

"I'm not even arguing that there might be some people currently in the program that are benefiting from it, I'm just saying there's no evidence at the current time to say, we could offer this to the people of New Mexico as an accepted treatment," Ulwelling said.

Continued access to medicine threatened by a request to withdraw PTSD as a qualifying condition for the New Mexico Medical Cannabis Program

By Steve Elliott, October 15, 2012

Military veterans and other patients to petition the Governor and the Secretary of Health: Don't Take Away Our Medicine

More than 3,000 New Mexican residents with Post Traumatic Stress Disorder (PTSD) are actively enrolled in the state's Medical Cannabis Program. Many of them are military veterans, patients living with disabilities, and victims of serious trauma and violent crime. Unfortunately, their continued access to medicine is being threatened by a request to withdraw PTSD as a qualifying condition for the New Mexico Medical Cannabis Program.

William Ulwelling, M.D., on July 29 submitted a petition to the Department of Health requesting PTSD be removed from the list of eligible medical conditions for enrollment in the New Mexico Medical Cannabis Program. His petition will be heard by the program's Medical Advisory Board at a public hearing, November 7, 1-5 pm at the Harold Runnels Building, 1190 St. Francis Drive in Santa Fe.The Secretary of Health will have the final decision.

"We deserve access to effective medical treatments whether we've just come home from combat or we are suffering debilitating symptoms from other trauma," said Chris Hsu, N.M. Medical Cannabis Patient's Alliance's vice president.

In defense of keeping PTSD as an eligible condition, the New Mexico Medical Cannabis Patient's Alliance, the Drug Policy Alliance, and others are banding together for a campaign they are calling "Don't Take Away Our Medicine - A Campaign" to make sure the voices of PTSD patients are heard loud and clear.

"When I returned home from Afghanistan I was diagnosed with PTSD," said Michael Innis, who served in the general infantry and who was awarded a Purple Heart after the convoy in which he was traveling got hit by an IED and was then ambushed. "I worked with my doctor and tried many prescription drugs. Taking handfuls of pills every day, every one with a different set of side effects was hard on my body, and I still experienced some symptoms."

"Cannabis was not my first choice of medicine, but I tell you first hand, this medicine works for me," Innis said. "Cannabis allows me to leave my house and has helped me to return to work."

The Campaign is standing up to protect the legal rights of patients to access safe medicine. They are asking for all compassionate New Mexicans to join them in telling the New Mexico Secretary of Health and the Governor to protect the rights of seriously ill New Mexicans and to reject the request to rescind PTSD as a qualifying condition by signing on to the Campaign.

"Tell them not to turn their backs on veterans, patients with disabilities, and victims of trauma and violent crime," said Nat Dean, another medical cannabis patient diagnosed with chronic pain and PTSD. "We deserve access to the medicine that works for us. Don't take away our medicine."

"New Mexico's decision to allow post-traumatic stress disorder as a condition that can be treated with medical marijuana is helping sufferers across the state cope with their symptoms," editorialized *The Santa Fe New Mexican* on Saturday.

"We believe, given the accounts of people who are using medical marijuana, that the state should err on the side of compassion," *The New Mexican* wrote.

"Doctors and patients, after all, are best able to judge what treatment works for their ailments."

The right to use medical cannabis was approved in 2009, when PTSD was added to the list of conditions eligible under the Lynn and Erin Compassionate Use Act. Since then PTSD has become the disabling condition most frequently indicated by patients in the program, and today accounts for 40 percent of the diagnoses of the citizens in our state's medial cannabis program.

"The current pharmaceutical cocktails given to sufferers of PTSD have limited efficacy, have significant debilitating side-effects, and have in many cases proven deadly," said Lisa Walker, M.D. a board-certified psychiatrist. "Given these facts, along with the experience of thousands of patients whose quality of life has been improved by its use, medical cannabis should continue to be an available treatment for the suffers of PTSD."

"We will not allow the removal of PTSD as a qualifying condition for the medical cannabis program to happen quietly," said Emily Kaltenbach, the New Mexico state director for the Drug Policy Alliance. "Patients deserve, above all, the freedom to choose the safest and most effective treatment for their disabling conditions -- whatever that treatment might be."

On November 8th, DPA is also relaunching an updated version of the report *Healing a Broken System* with current numbers and new material related to medical cannabis as a safe and effective treatment for veterans diagnosed with/suffering from symptoms of PTSD. The report examines the significant barriers that veterans of the wars in Iraq and Afghanistan face in obtaining effective treatment for mental health and substance abuse problems, and the tragic consequences of leaving these wounds of war untreated.

October 22, 2012

Department of Health
NM Medical Cannabis Program
Medical Advisory Board
1190 St. Frances Drive
Santa Fe, NM 87502

Dear NM Medical Cannabis Program's Medical Advisory Board Members and DOH Secretary,

As a Board Certified psychiatrist, licensed in New Mexico, who is also a US Navy veteran, I strongly support the Lynn and Erin Compassionate Use Act, which allows the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments.

I strongly disagree with Dr. Ulwelling's arguments against the use of medical cannabis based on the following points:

1. Dr. Ulwelling submitted the American Psychiatric Associations (APA), Practice Guidelines for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder which lists two dozen medications that can be used in treating PTSD. I would like to point out that only two of the medications included in that list are FDA approved for treating PTSD –sertraline (Zoloft) and paroxetine (Paxil). Thus, all of the other medications such as benzodiazepines, antipsychotics, and mood stabilizers are being used off-label. All of the medications have numerous unwanted side-effects that can range from nuisance level to life-threatening. Furthermore, they have demonstrated limited efficacy with approximately only 20-30% of combat veterans achieving remission of symptoms. Over 100 veterans with PTSD died between 2008 and 2010 as a result of deadly drug cocktails that included antidepressants and antipsychotics.

   I'm not sure if Dr. Ulwelling is aware, but earlier this year the Army Surgeon General and the Assistant Secretary of Defense issued statements warning against prescribing antipsychotics to Vets with PTSD and specifically contraindicated risperidone. I would also like to point out that the APA's own treatment guidelines for PTSD state that recent studies show less confidence in the use of selective serotonin reuptake inhibitors (SSRI's) in the treatment of combat-related PTSD.

   The National Institute on Drug Abuse has refused to provide cannabis to American researchers who have had FDA approval for a PTSD study for a year. However, there are government-supported human studies going on in other countries that offer data to

support the use of cannabis in PTSD patients. Peer-reviewed journals have published articles about the endocannabinoid system as a target for pharmacotherapy for insomnia, intrusive memories, nightmares, flashbacks, anxiety, depression and substance use. [1] Human research studies that have been done in Israel have found that, "use of medical cannabis is associated with a reduction in PTSD symptoms." [2]

PTSD patients in New Mexico may not realize the exact mechanism by which this medicine is helping them, but they can tell you that medical cannabis works. New Mexico veterans need access to safe and effective treatments for the symptoms of PTSD.

2. In his petition, Dr. Ulwelling states that, "offering cannabis to PTSD patients increases the risk of substance abuse." I think it is important to recognize that appropriate use of medical cannabis to relieve symptoms of PTSD is NOT substance abuse.

   I would like to present the other side of the story. Recent research suggests that the use of cannabis is actually related to a *decrease* in alcohol consumption. A 2011 study entitled, "Medical Marijuana Laws, Traffic Fatalities, and Alcohol Consumption," found that in states with legalized medical marijuana, alcohol consumption went down in 20-29 year olds which ultimately resulted in fewer alcohol-related traffic deaths.

   Veterans with PTSD and other mental health diagnoses are more likely than other Vets to be prescribed opiate pain medications and to have adverse clinical outcomes.[3] Other studies have demonstrated that medical cannabis is an effective analgesic that is safer than narcotic pain medications.[4]

   Imagine a world in which a medicine like cannabis could actually serve patients in treating both PTSD and pain. What if we could hit two birds with one, safer stone?

3. The concern about cannabis use increasing the risk of developing psychosis has relevance for a very limited portion of the patient population. Adolescents and young adults who have a family history that suggests a risk for psychosis are of most concern. We as a society rely on our physicians to make informed decisions about treatment recommendations in every clinical encounter, and that includes evaluations for the potential beneficial use of medical cannabis. Clinicians should not be recommending the use of medical cannabis to adolescents and would be able to determine through

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[1] Marsicano G, Wotjak CT, Azad SC, Bisogno T, Rammes G, Cascio MG, Hermann H, Tang J, Hofmann C, Zieglgänsberger W, et al. The endogenous cannabinoid system controls extinction of aversive memories. Nature 2002; 418 : 530-534

[2] Mordechai Mashiah. Open Pilot Study. Abarbanel Mental Hospital, Isreal.

[3] KH, Shi Y, Cohen, et. al. Association of mental health disorders with prescription opioids and high-risk opioid in US veterans of Iraq and Afghanistan. JAMA. 2012; 307(9): 940-47.

[4] Abrams. Clinical Pharmacology & Therapeutics. 2011; 90: 844-851.

appropriate history-taking when the use of medical cannabis is contra-indicated due to an apparent vulnerability to psychosis. Most cannabis users do not develop psychosis. The risk associated with cannabis occurs during vulnerable time of development and is modifiable.

Dr. Ulwelling cited in his petition that the responsibilities of the Medical Cannabis Program Advisory Board include a review of new medical and scientific evidence pertaining to currently approved conditions that would support the board taking action to remove a specific condition. I question whether or not in fact any such new research has come to light.

Since 2009, PTSD has been recognized as a qualifying condition by the Medical Cannabis Advisory Board. The current pharmaceutical cocktails given to sufferers of PTSD have limited efficacy, have significant debilitating side-effects, and have in many cases proven deadly. Given these facts, along with the experience of thousands of patients whose quality of life has been improved by its use, medical cannabis should continue to be an available treatment for the suffers of PTSD in the state of New Mexico.

Sincerely,

Lisa Walker, M.D.
Board Certified Psychiatrist
Licensed in New Mexico

October 22, 2012

Department of Health
NM Medical Cannabis Program
Medical Advisory Board
1190 St. Frances Drive
Santa Fe, NM 87502

Dear NM Medical Cannabis Program's Medical Advisory Board Members and Department of Health Secretary,

As a Board Certified psychiatrist, licensed in New Mexico, I strongly support the Lynn and Erin Compassionate Use Act, which allows the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments.

I ardently dispute Dr. Ulwelling's arguments against the use of medical cannabis. In my opinion, Dr. Ulwelling's petition lacks scientific rigor, does not provide adequate evidence, and misrepresents the research used to support his position that PTSD symptoms are the same as psychosis and using cannabis increases the risk of substance abuse. I disagree.

In my clinical experience I've had at least 20 patients who were able to stop using alcohol and other drugs to 'self-medicate' for PTSD symptoms when they were able to start using medical cannabis. I've had many patients who were able to get a job, have better relationships (with partners and children) and able to do more (instead of being isolated at home) when they started using medical cannabis.

Eliminating PTSD as a qualifying condition will cause enormous harm.

In response to Dr. Ulwelling's petition, I would like to address his exhibits and demonstrate why they, in fact, support New Mexico's Lynn and Erin Compassionate Use Act (LECUA).

Exhibit 1: March 2009: Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder from the American Psychiatric Association.

> LECUA was intended to provide patients with therapy that improves their quality of life and can reduce harm of other therapies that often have dangerous side effects
>
> It is well known that there are a number of treatment options for psychiatric conditions such as PTSD ranging from psychotherapy to pharmacological interventions. However, as the introduction in the American Psychiatric Association's (APA) Practice Guideline

for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder discusses, even these treatment options do not have a strong evidence base, as studies in PTSD are generally lacking.

We as a profession have tried our best to utilize the best tools possible for patients who suffer from debilitating symptoms of PTSD, but these tools do not work for everyone. PTSD, as many psychological conditions are, is complicated, and there is no one-size-fits-all approach to treatment. What we can do, is make referrals to what we know are safe and effective options.

As an experienced provider, I have seen patients fail other therapies for their condition and have also seen the benefits of medical cannabis, which is not listed in the guidelines but it is also not advised against. (There are several effective treatments for PTSD that are not mentioned in Exhibit 1 so medical cannabis not being included cannot be used to suggest it doesn't work. It is simply not mentioned, like several other treatments.) In submitting these guidelines as an exhibit in this petition, there is no scientific evidence that medical cannabis should not be considered as a clinically safe and reasonable therapy <u>if patients have failed other treatment options</u>.

In the section of the guidelines titled, "Neurobiology for PTSD: Implications for Treatment," the authors discuss developing research in neurotransmitter systems of the body, specifically the receptors involved in extinction learning which is a function altered in PTSD patients.

Dr. Ulwelling does not discuss this science in his petition, and does not acknowledge the growing body of scientific evidence that supports intervention opportunities for these patients, specifically, the use of cannabis for post-traumatic stress symptoms because of how it acts on the bodies' endocannabanoid system.

<u>Exhibit 2</u>: Cannabis, Synthetic Cannabinoids, and Psychosis Risk: What the Evidence Says by JM Pierre.

Interestingly, while this article discusses psychosis as a risk of cannabis use, the author does not provide any evidence that this is a legitimate risk in PTSD or other medical cannabis patients. The author in fact discusses that in a review of the literature related to medical marijuana, there has only been one, single case of psychosis reported. Furthermore, this patient had an underlying, undiagnosed case of schizophrenia which is not the case in most PTSD patients.

PTSD and schizophrenia are not the same psychological condition and thus no scientific conclusion about medical cannabis and PTSD can be drawn from this. In fact the author specifically states that, "causality cannot be established based on this report." One of his "clinical points" is that, "the magnitude of psychosis risk tied to cannabis use is modest and most users do not develop psychosis."

The author aims to caution clinicians of the potential side effects of cannabis but do we not, as a profession, have an ethical duty to do this with any of the well-established medications that we recommend?

PTSD patients are often prescribed benzodiazapines. While we may prescribe them because of the evidence supporting their efficacy in treating anxiety, there are serious risks associated with this treatment such as dependency (i.e. addiction), respiratory depression, and increased thoughts of suicide in certain patients.

Exhibit 3: Psychosis Associated with Medical Marijuana: Risks vs. Benefits of Medicinal Cannabis Use by JM Pierre

In this letter to the editor (which pre-dates the article above) Pierre discusses the same patient that was included in exhibit 2. Sadly, this patient went through a number of treatments without relief and was in fact dealing with undiagnosed schizophrenia. In his later, 2011, publication, it is worth pointing out again that the author acknowledges that no causal link can be made between the use of cannabis and the psychosis in this specific patient. This is not a peer reviewed, scientific article (letters to this journal are not peer reviewed). Rather, the author is only stating his opinion about medical cannabis programs and what he broadly judges as having "minimal restrictions on prescribing indications."

He is clearly not aware that our program in New Mexico serves as a national model. Other states actually look to New Mexico because it is so well regulated and monitored. Why are we questioning the decision of the Department of Health in 2009 –a decision based in science that was informed by board certified physicians who hold their ethical duty to patients to provide them with effective treatment in the highest regard.

Exhibit 4: Medical Marijuana for the Treatment of Post-Traumatic Stress Disorder: An Evidence Review. A report to Arizona Department of Health Services.

This exhibit is simply a report, no a peer-reviewed article in a scientific journal, thus, there is no reason this should be included in evidence to the New Mexico Department of Health to rescind PTSD as a qualifying condition in the Medical Cannabis Program. The ultimate finding in this report was that there was no study that focused on the treatment effects of cannabis in PTSD patients. Additionally, all but one of the 18 studies that were referenced ranged in quality from very low to moderate quality. We cannot make decisions based on very low to moderate quality evidence. There is no legitimacy in submitting this type of report as supporting evidence to take medicine away from thousands of patients who have benefited from it. Lacking in this exhibit, or any of the other exhibits, are the qualitative stories of patients' lives changed and quality of life improved. We should share with other states, the stories of those who previously suffered

debilitating symptoms of PTSD but are now able to maintain relationships with family and friends and hold down jobs.

Our ethical responsibility is to do no harm. Removing PTSD would cause more harm than good to patients whose lives have been changed for the better as a result of their option to use this medicine.

Our responsibilities also include making decisions grounded in science, none of which Dr. Ulwelling's exhibits adequately provide. Admirably, New Mexicans worked hard in 2009, bringing forward evidence that supported making available a medicine that I have seen work for patients suffering from PTSD. Let us not go backwards, but keep moving forward in improving access to safe medicine that works.

Sincerely,

Florian Birkmayer, M.D.

October 7, 2012

I practice Psychiatry at a Community Mental Health Center in semi-rural and rural Northern New Mexico. One of my days there is spent seeing patients via telepsychiatry. There is no on-site psychiatrist at that location. My patient population consists mostly of native Northern New Mexico Hispanics.

Of the patients I see, about 50 % carry a diagnosis of PTSD, usually co-morbid with one or several other conditions, including substance abuse. The most prevalent substance of abuse in this patient population is alcohol. Many of my PTSD patients carry this diagnosis because of childhood trauma (witnessing violence, including murder and domestic violence, traumatic accidents – often alcohol related and sexual abuse.) There is a sub-population who has combat related PTSD.

The availability of treatment, for any diagnosis in this area, is scarce. In addition, there are problems of patient non-compliance with treatment (often related to their PTSD – not being able to leave their houses) as well as economic (not having the money to get to their appointments).

Prior to re-locating to New Mexico in 2010, I practiced in a small, middle to upper middle-class community in Pennsylvania. Diagnoses of PTSD were fairly rare there and Medical Cannabis is not an option there. When I began practicing in Northern New Mexico, I began to get requests for certification for Medical Cannabis from many of the PTSD patients I care for. At the time, I was one of only two psychiatrists in the Las Vegas office; the other prescribers are Psychiatric Nurse Practitioners. I was and remain the only prescriber willing to certify patients for Medical Cannabis. While this has been a daunting task, for many reasons, including the lack of drug testing kits at my facility and the co-morbid use of other substances, there have been many success stories of treatment of PTSD with Medical Cannabis. I would like to cite two of these.

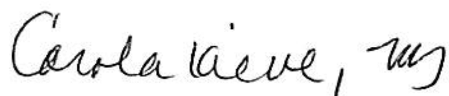
Cynthia M. is a lovely middle-aged woman who suffered terrible abuse and witnessed regularly occurring violence growing up. She turned to alcohol at an early age and soon began drinking alcoholically. Cynthia continued to drink alcoholically for years, something that was harmful to her, her marriage and her children. Almost two years ago, Cynthia made the decision to enter treatment for her alcoholism. Although she successfully completed treatment, Cynthia's diagnosis of PTSD was not touched by this treatment and she remained severely anxious, with isolation, avoidance, flashbacks, nightmares and a sense of impending doom. On one visit with me, she asked if I would be willing to fill out medical cannabis papers for her and I agreed. Cynthia received her Medical Cannabis card and came to Santa Fe to a "dispensary", where she was educated about the various types of cannabis and directed toward what would suit her particular needs/symptoms. Cynthia has

remained sober from alcohol as well as substances other than cannabis for over 17 months. I saw her two weeks ago. She is happy, health, vivacious and healing her relationships with husband and other family members. She is SO grateful for the ability to use Medical Cannabis for her symptoms when she needs it.

Anthony M. is a similar case, but he is younger and more recently sober. Anthony's case of PTSD is so severe that he is currently receiving disability because he has been unable to work. He has a wife and small children. His self-esteem is extremely poor due to his inability to support his family. He too is a recovering alcoholic. He did not stop drinking until AFTER he began using Medical Cannabis.

Anthony is receiving weekly individual psychotherapy and has been compliant with his appointments, something not common in this patient population, and has been making steady progress. He is less anxious, is sleeping better, is better able to relate to his wife and children and has hope for his and his family's future. He told me recently that the Medical Cannabis has enabled him to avoid drinking alcohol, even when people around him are drinking.

I do not believe that cannabis is a "gateway" drug. I do believe that adolescents should not use it, as it can stunt emotional development in this population, something that is never a good thing. However, I see absolutely no harm with its use in patients with PTSD and believe that it is an invaluable tool in the treatment of PTSD in selected patients.



Carola Kieve, M.D.

20 October 2012

To Whom It May Concern:

Before I became disabled in 1996, I worked in the nursing profession for 22 years. For 12 of those years, I worked as a psychiatric nurse. I have PTSD and I am a patient in the New Mexico Medical Cannabis program.

Before using cannabis indica to relieve my PTSD symptoms I was taking Ambien 10 mg. and Klonopin 0.75 mg for a sleep disorder and anxiety associated with my PTSD. Within a matter of 3 months of using cannabis I was completely able to safely wean myself off the Ambien that I had been taking for 4 years and weaned my Klonopin dosage by two thirds down to 0.25 mg. These powerful, pharmaceutical drugs indeed allowed me to get artificial sleep, but there was a heavy price to pay in terms of nasty side effects. They gave me such an inferior quality of sleep that I had a difficult time driving my automobile without getting sleepy at the wheel. They also contributed to the development of sleep apnea, weight problems accompanied by the onset of diabetes.

With the initiation of medical cannabis, the quality of my life gradually improved 100%. My sleep apnea has now disappeared along with a significant amount of weight and diabetes in control. I now weigh 40 pounds less than I did 3 years ago.

Cannabis is medicine! Medical cannabis is enhancing the quality of PTSD patient's lives like mine every single day. There is not a day that goes by that I do not give thanks and praise to the God above for His miracle of cannabis that allows me to function 100% better than I did when I was dependent upon addictive pharmaceuticals full of undesirable and potentially lethal side effects.

Let us take to heart the prudent words of Founding Father, Thomas Jefferson: "If people let the government decide what foods they eat and what medicines they take, their bodies will soon be in as sorry a state as the souls of those who live under tyranny."

I rest my case.

Sincerely,

Peter Anastasia R.N.
P.O. Box 22251
Santa Fe, NM 87502

Dear Governor Martinez and the Department of Health,

I am an Air Force Veteran and I have PTSD I get relief from medical cannabis, and I am not alone.

After serving in the Air Force I was diagnosed with mild PTSD. After doing research and reading about the potential side effects of the suggested pharmaceuticals, I chose the medical cannabis. I now get the relief I truly needed. I know cannabis is the safest drug available for treating my PTSD and associated symptoms.

Being part of the New Mexico Medical Cannabis program has significantly improved my quality of life. .

As a former member of the Air Force it's important to me to stay on the right side of the law. The right to safe and non-toxic medicine means much more to me than I can express in words. Incorporating medical cannabis into my treatment for my PTSD helps me sleep, manage my physical pain, and helps me enjoy my family.

Today I am standing up to protect the right to safe and legal access to medical cannabis.

-Air Force Veteran

Male

Age

Las Cruces, NM

Dear Governor Martinez and Department of Health,

Please don't to take away our medicine.

I am an Army Veteran and I have PTSD. I get relief from medical cannabis.

I was 19 when I left my home in New Mexico for my Army assignment in Afghanistan. I served in the General Infantry and was awarded a Purple Heart after the convoy I was traveling with got hit by an IED and was then ambushed. When I returned home I was diagnosed with PTSD. For 3 years I worked with my doctor and tried many prescription drugs. I tried a different pharmaceutical for every symptom I reported. Taking handfuls of pills every day, every one with a different set of side effects was hard on my body, and I still experienced some symptoms.

I come from a military family with conservative values; cannabis was not my first choice of medicine, but I tell you first hand: this medicine works for me. A year after becoming a patient in New Mexico's Medical Cannabis program, I am very happy to report that the quality of my life has improved greatly. Unlike the other drugs I was prescribed, cannabis is effective for multiple symptoms without debilitating side effects. This medicine is a miracle in my life; it allows me to manage my stress and the things that trigger it. Cannabis allows me to leave my house and helped me return to work. I now have confidence that I can manage my responses to triggers –like loud noises- that we all encounter every day in a busy city like Albuquerque. I am very grateful I live in New Mexico where I am eligible to be a patient in the Medical Cannabis program.

I deserve, above all, the freedom to choose the safest and most effective treatment for my condition--whatever that treatment might be. As a fellow veteran said, "It would be inconceivable to withhold weapons, equipment or training from our troops on the ground. Why are we denied access to a medication that might provide relief to us and our families when we come home?"

Fortunately the medical cannabis community in New Mexico is rallying around us. In defense of PTSD, the New Mexico Medical Cannabis Patients Alliance, Drug Policy Alliance and others are banding together for a campaign to make sure our voices are heard loud and clear. Removal of this condition will not happen quietly. It consoles me greatly to know we have strong allies willing to help in this campaign.

When veterans come home we deserve access to the medicine that works for us.

--Michael Innis

Albuquerque

Army Veteran, Purple Heart

Dear Governor Martinez and Department of Health,

My name is Nat Dean, I am 56, and I have PTSD. After being in a car accident 28 years ago I now live with multiple disabilities including traumatic brain injury, unremitting chronic pain and nausea, PTSD, depression and panic attacks.

My goals are to live well with a disability and avoid the traps that traditional chemical pharmaceutical treatments can cause. I have, in the past, had to take as many as 27 different chemical medications, with serious side-effects, on a daily basis to cope these challenges.

One medication treats one symptom, another treats one more, while another medication gets added to the mix to combat medication side effects. This snowball effect frequently happens to people with multiple severe and chronic illnesses.

Narcotics are often prescribed and tolerance quickly builds while simply seeking relief from pain. The complexity of treatment is magnified beyond proportions that most people can comprehend. The innocent desire simply to live without pain causes the undesired consequence of addiction, which in turn creates a nightmare for patients, family and friends. Both of these scenarios happened to me.

The availability of medical cannabis has facilitated managing many aspects of my condition over the past three plus years. It has allowed me a much milder form of treatment for many symptoms. I have cut down my daily medication intake to approximately six. Not only have my prescriptions decreased, but my number of doctor visits has gone down from almost seven per week to often less than one. This has been enormously positive and has meant huge economic relief to both to me and my insurance companies, including Medicare. More than anything else, I am no longer addicted to narcotics because I have alternative tools at my disposal.

Ms. Nat Dean
110 Sierra Azul
Santa Fe, New Mexico 87507-0188
natdean@hubwest.com
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505-231-5445 cell

Dear NM Medical Cannabis Medical Advisory Board and Secretary of Health,

In 1992, I was involved in an auto accident in which a young boy died. I was driving. As a result, I now suffer terrible PTSD.

After the accident, I visited a psychotherapist six times per week and a psychiatrist prescribed me an anti-depressant and anti-anxiety cocktails plus sleeping medications. At first these medications helped a bit, but unfortunately, after a while the cocktail needed to modified once a year to provide me the relief I needed.

These medications caused significant side effects including loss of libido, low energy, lack of motivation, social withdrawal, and worst of all addiction. After 13 years on pharmaceutical medications for PTSD, I learned that I had a severe addiction to benzodiazepine when I forgot my medication on a trip out of the country.

Upon my return home, I went to see my primary care physician. She suggested working with my prescribing psychiatrist to gradually reduce my "benzo" intake. She suggested I should try medical cannabis and that it might help with my withdrawal from the medications.

I tried it and it worked! No more benzo addiction – plus I realized from the experience that cannabis was far more effective than the anti-depressant pharmaceutical cocktail for depression, anxiety and general sense of well-being. So I continued, under my psychiatrist's supervision, my gradual withdrawal from all my pharmaceutical medications.

It is now seven years since I have taken any pharmaceuticals for my PTSD. Medical cannabis is my sole medication for this condition - no more harmful adverse side effects, no more addiction.

Please, do not take away my medicine.

Len Goodman

Santa Fe, NM

PTSD Nightmare Cure
by VietnamVet1968

Marijuana is a PTSD nightmare cure. At least in my case, and among a group of people I know who suffer from PTSD nightmares.

I have searched quite a bit, and as far as I can discern, the fact that marijuana can stop PTSD nightmares in their tracks is NOT generally known. This really must be corrected because there are, no doubt, millions of people out there, police, fire, military, and just the general population, who wake up every night from recurring nightmares, and they don't know that marijuana would stop these traumatic dreams completely.

I have been trying to think of a way to get the word out to the public on the use of marijuana to stop PTSD nightmares, and this looks like a good place to try.

My story: I am a Vietnam veteran who served in Vietnam in 1968/1969. After I had been there almost a year, I was involved in an attack by the Viet Cong on the Marine Combat Base at Phu Bai, South Vietnam. It is not necessary to go into detail, just know that I thought I was about to be killed and went through all the trauma that this kind of thing can do to a person.

I obviously survived, and went on about my business, and then about two or three weeks after the incident, I started reliving this traumatic event every night in horrible nightmares. I didn't think too much about it at the time. I thought this kind of thing was probably normal for someone who experiences such shocks to the mind. But as time went on, the constant nightmares really became debilitating.

Then, I was introduced to Vietnamese marijuana. And the nightmares quit. I still did not think much about it, thinking the nightmares had probably run their course, and did not connect the stopping of my nightmares with smoking marijuana.

I smoked marijuana steadily for a few years after that, and then decided to quit because I was trying to get a job that required a drug test. After I quit smoking, within just a week maybe two, my PTSD nightmares were back full-blown! It was like they never had stopped. It was really quite disturbing to realize that something inside me was causing me this kind of distress even these many years later.

I still did not connect the marijuana with having anything to do with my nightmares.

After I got the job, I started smoking marijuana again, and the nightmares stopped. But I still did not make the connection.

I continued for several more years, and then quit smoking again, and the nightmares came back with a vengeance! This time I finally made the connnection: When I smoked marijuana, I did not have nightmares at all, or hardly any dreams; when I did *not* smoke, I relived the same nightmare.

So I started talking to some friends who had PTSD and every one of them said that marijuana helped them the same way it helped me. Then I got the book “The Science of Marijuana” and right there in the first part of the book it stated that “marijuana prevented the mind from entering into R.E.M. sleep. Instead, the mind bypassed the dream stage, and went directly to the deeper sleep stage[parapharased].

This information needs to get out to the general public. This medical effect of marijuana on people who suffer from PTSD nightmares alone might be the thing that finally pushes the legalization battle across the goal line.

This information has to be important to millions. Sleep deprivation is one of the most debilitating things that can happen to a human being. Sleep deprivation caused by PTSD nightmares can be cured!!! Permanently!!! No nightmares, no waking up in the middle of the night, no sleep deprivation.

I do not know how much of a dose of marijuana it would take to trigger marijuana’s ability to stop PTSD nightmares. I, personally, would be classified as a heavy smoker of marijuana, but for all I know, a merinol capsule might do the trick.

I cannot say for certain because again, as far as I can determine, this issue is not even being studied by the medical community or the marijuana legalization community. I'm not even sure they are aware of the the potential of marijuana to stop PTSD nightmares.

It just blows my mind sometimes when I think that nobody knows about this PTSD cure, but then again, it took me, a marijuana smoker, who should be more familiar with it than most, years, before I made the connection, so maybe it is not so strange.

Bottom Line: If you or a loved one are having PTSD nightmares and want them to stop, you should try some marijuana. Your first good nights sleep will be like Heaven.

If you are reluctant to try marijuana, I certainly understand, but it most certainly works for me and others I know, and you may not have to take much to get the desired effect. And marijuana is probably the most benign drug you can take.

Everything is a tradeoff. You will have to be the judge of what is best for you...

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PTSD by Dennis Geeham

I first smoked marijuana in Vietnam. I was in intelligence and associated mostly with other military intelligence analysts and military police. Most of both smoked marijuana on a semi-regular basis. I was opposed to it, but was persuaded that membership in the peer group included smoking it. I cannot and never have been able to smoke cigarettes or anything else. Marijuana was different. It provided a social outlet and a method of relaxation and was never done on duty by me. I also never drank alcohol or took any other drugs.

Even junior officers (I was enlisted) who had smoked during college joined in the "parties" which could not have been undetected by non-smokers. So those with the most elite trust to classified materials were largely overlooked in this aspect of their drug use as long as it did not affect their work. I, myself, received three Bronze Stars and an Army Commendation Medal and had my tour extended because I was declared "mission essential" during the 1972 North Vietnamese offensive.
Off and on through the years after returning to civilian life, I continued to use marijuana but never went on to smoke cigarettes or to drink alcoholic beverages or regularly use stronger non-prescription drugs.

About 15 years after Vietnam I began experiencing symptoms of posttraumatic stress disorder, or PTSD -- flashbacks and nightmares recalling traumatic experiences and things I had seen there.
I was in denial about this for years, but in 1999 these episodes accelerated. I noticed that I never had a flashback when stoned. I also never had dreams, not even nightmares, if I went to bed stoned.
But I asked for hospitalization and residential treatment in the Dayton, Ohio VA Medical Center when I had a car accident in 2000 after which I awoke and thought I was in Vietnam again.

Traces of marijuana were in my system, and they refused to treat me until it was gone even though drug use is prevalent among both veterans and those with PTSD.
Ultimately, I was dissatisfied with the Dayton program, ranked one of the worst by the PTSD Research Center in Connecticut, and they recommended the Seattle VA.
So I moved to Seattle where it did not matter to them if I were to use marijuana. It is legal to do so in Washington for medicinal purposes. But I agreed to try their alternative approaches such as Prozacin, an alpha-blocker hypertension medicine, which did help alleviate the nightmares, and a combination of Ambien for sleep, clonazepam for restless leg syndrome, and morphine, oxycodone, naproxen and tramadol for physical pain.

What I found, however, was that simple use of marijuana a few times a day eliminated the need for all of those other drugs. Biggest problem? Getting it and affording it. I could get morphine for free. But simple pot would cost $300 an oz. Fortunately, I used little at a time and I built no tolerance for it.

It is an exceptional way to suppress dreams and get a restful night's sleep and to diminish physical pain without opiates that can become physically addictive, constipating and require larger and larger amounts.
To obtain it medically, I must use the pain relief needs. Oddly, using it instead of morphine is not an acceptable reason and using it to ease stressors that lead to flashbacks or to suppress dreaming which leads to nightmares also are not among the acceptable reasons.

Neither is the fact that marijuana alone replaces ten t other drugs the VA prescribes for me. Consider the savings to the government. Those drugs cost about $600 a month. But $300 worth of pot can ease symptoms for six months.
Well, in brief, that is one vet's story. I do not smoke, drink or use any other non-prescription drugs. I alternate between use of my prescriptions and the pot to see if I notice any changes, but so far I don/t.

The only adverse effect is that pot seems to increase my blood pressure to about 145/100.

But flashbacks and nightmares, which it prevents, increase my BP to as high as 220/165.
Which side effect is worse?

I'm also ruled unemployable, so pot helps pass the day nicely. It also makes it tolerable to do some stretching, yoga and swimming. The other drugs make it difficult to exercise.

Marijuana and PTSD by Stephen Otero

My name is Stephen Otero. I am currently an active duty member of the US Air Force. I have been enlisted for 11 years now and heve been to war twice, in both Iraq and Afghanistan.

I am a combat photographer and have dealt with many difficult situations throughout my years.

In 2007 I was diagnosed with PTSD after my deployment to Iraq. In the years following initial diagnosis I struggled through multiple drug and therapy trial's. I also was suffering from nerve damage that resulted in 3, very painful, neuromas.

So I was fighting both physical and mental pain for a few years. But in 2009, I was afforded an opportunity to be sent to the eastern border of Afghanistan where once again I was involved in violent and strenuous operations. I call it an opportunity because I am a proud military member and enjoy serving my country when I am asked.

I returned in May of 2010 and immeiately began seeing a psychiatrist provided by the Air Force. I was doing a little bit better on this return transition, but my primary complaints were anxiety, insomnia, and depression. Partly due to physical pain. After struggling for a few months and ending up on a cocktail of approx 7 different drugs for pain and anxiety, a civilian friend of mine who saw me struggling, provided me with a small amount of marijuana.

Being a military member, I know that it is against federal law for me to ingest THC, but after so many years of struggling, I decided to take leave and tried smoking for approximately 7-10 days.

It was like a miracle. I did not need ANY other drugs and my body felt better than ever. I still had a minimal amount of pain due to the nerves, but nothing like before. I was not depressed, had little to no anxiety, slept through the night without nightmares, and even went to the gym.

So this substance that I had only really used as a teenager, became a true miracle for my mind and body.

I have been hospitalized twice over the past year for suicidal ideation, once was for 29 days and the second time was for 91 days. Locked away for my own safety I suppose. Now here's where it gets kind of funny... An Army Dr. at Walter Reed decided to try and prescribe 10mg's of Marinol, 3 times per day, to see what effects it would have. I immediately went from 11 different meds a day to 2, Marinol and Prilosec. It was not the same as real marijuana, but it did work wonders on my body.

My military separation board met last Thursday and after two hours of deliberation, the members of the board determined that I should be discharged Honorably.

I was informed by the lawyers involved that this is the first such case of an honorable discharge for drug use at Ramstein Air Base in Germany. So my story is unique in that aspect.

Many military people are very angry about this. But marijuana saved my life, my marriage and my sanity.

I will now be looking to the NORML community and many others to find out ways that I can participate in the movement and begin speaking out against prohibition. Marijuana could be just what we veterans have been looking for as a realistic treatment for PTSD and combat stress.

PTSD by “Manzar”

I was diagnosed with PTSD in 1988, as a direct result of my involvement in the Viet Nam war. My symptoms were typical. Night sweats, depression, flash backs, rage and suicidal ideations.

As I grew into my 30's, attempts at self-medication, mainly through the use of alcohol, were becoming disastrous. Lost jobs, relationships and self-esteem had all taken their toll. Somehow I was able to maintain a successful sales career during the day, while falling into a drunken state at night. By the age of 40, the two life styles began to merge and I opted for alcohol rehabilitation. With the absence of "MY medication", the symptoms became worse to the point of admission to a VA hospital for treatment. Three months later I was diagnosed with chronic PTSD, depression and suicidal tendencies. The next 11 years were a merry-go-round of psychotropic drugs, VA hospital stays (as long as a year at a time), cops, incarcerations, legal problems, involuntary commitments in mental wards, and suicide attempts.

In 1999, I visited another vet with whom I had developed a relationship in a year long stay at a VA hospital. He seemed to be doing surprisingly well, and I asked him for the secret to his success. He informed me that he had started smoking marijuana. This did not appeal to me due to the illegality and the subculture involved, but his recovery was truly remarkable.

In consultation with my psychiatrist, I was slowly weaned from my daily dose of 45-50 pills a day (Lithium, Prozac, trazodone, Ativan, Valium etc.) over a six- month period. I started smoking marijuana three years ago with immediate results. Today, I take no medications and my symptoms are manageable. I live a relatively normal life. I am active both socially and in my church. My marriage is restored and I am productive once again. Butt alas I have to keep my "Secret" hidden.

I smoke one or two joints a night, in the confines of my home. I never leave the house after I light up and never drive under the influence, but the threat of law enforcement is ever present. I guess that is a price I will pay for my own well- being.

Obviously, my results are anecdotal, but I have seen similar results in other vets who experience the debilitating effects of PTSD. I would encourage more research into this area just for the potential benefits it might propose. I have made my choice and the benefits far out weigh the stereotypes and the bias of marijuana use. As a person suffering from long-term, chronic PTSD any relief is welcome relief. I keep my "Secret" to myself and I am sure that you will respect my confidentiality.

Sincerely,
“Manzar”