Kirk Manter

1 Whipoorwill Terrace,

Foster, R.I. 02825

Medical Marijuana Production and Distribution in Connecticut , How?

The Board of Physicians charged with the duty of answering this question is facing a daunting challenge. With the exception of scattered tests from the U.S. and abroad most of the information on strain specific efficacy is anecdotal. This is due in the most part, by the initial legal medical use coming from California, where certification for palliative use being based solely upon a patient's declaration of having successful results from using marijuana for basically any condition for which they are seeking relief. The phrase, "medically supervised, recreational use of marijuana", seems a more appropriate definition of California's law. When certifying physicians advertise "protect one's self", rather than "improve one's health", with a medical marijuana license, the legitimate medical use of marijuana seems to have been hijacked by the "recreational use, pro-legalization" marijuana campaign. Under these circumstances, which have followed medical marijuana legalization across the country, the more potent, higher level of THC strains of marijuana, have earned the labeling as the more beneficial medical strains.

Legitimate test results from both the U.S. and abroad, are showing that the more important component in the marijuana with regard to medical efficiency is the CBD and not the THC. Marijuana with higher CBD levels regardless of the THC content has been found to satisfy the requirements of true medical patients. The one exception may be that of pain relief, where the higher THC content, seems to create a greater sense of relief.

Aside from the chemical composition of particular strains, the method of introduction may be as important in determining the better strains for medical use. Vaporization, where the plant matter is not burned but is heated to the point at which the useful agents become transformed into a gaseous state and does not denigrate the active chemicals, as burning seems to. Ingestion, is also a more effective means of administering marijuana's active components. Some testing has shown that in the process of the liver breaking down the marijuana product; the chemical structures are changed into different agents which are not present in other forms of introduction. Also, with ingestion, the patient is using 100% of the active ingredients, whereas with smoking and most forms of vaporizing, as much as 30% of the marijuana is being wasted through burn off or "blow by", (the portion that goes off in the air between inhales by the patient).

Some brands of "vaporizers" capture the heated resulting vapor, containing the active ingredients, in a bag. This allows the consumer to inhale 100% of the medicine. The major benefit is economical as nothing is wasted, secondly, there are no tars from burning plant matter as the temperature required to change the active ingredients into gas is lower than the point of combustion.

Some individuals will continue to smoke their marijuana while others will venture into more effective modes, not being psychologically attached to smoking to achieve benefits. Edible forms, tinctures, and extracts allow for reliable dose control whereas a smoker will smoke enough to achieve the desired point of medication. The attempt by Canada's licensed medical marijuana producer, Prairie Plant Production, to deliver a homogeneous THC level in smokable marijuana as per Canadian law resulted in a near boycott by Canadian patients because one pinch of product would vary (sometimes drastically) in strength, to the next, due to the mixing of varying THC level strains to provide a product that when taken as a whole fell within the required strength. Having said that, the majority of any particular plant, or multiple plants of the same strain, grown under the same condition will result in levels close enough in strength to be insignificant when the patient smokes it.

For patients requiring or desiring tighter control over the dose, the other forms would be preferable. Once any form is manufactured, whether it be an extract or tincture, the levels per batch will be uniform. Tinctures and edibles can have their potencies altered by adding more or less of the benign carrying agent. By testing a cannabinoid enriched butter based product and doing the math it can be determined the potency of any products made using said mixture. It can also be decreased or increased as needed. Patients will know how much of which cannabinoids they will be receiving. These forms of medicine can be produced from the leaves and lower, smaller flowers (which may differ in strength from the majority of a plant), aiding in the uniformity of levels in dispensed smokable marijuana.

Another issue of great importance is avoiding shut-down or arrest by the Federal agencies tasked with enforcing drug laws. The largest hurdle is determining the number of plants any "Producer" will be allowed to possess. The sensible route to getting things up and running, would seem to keep that number below 100, as that is the cut-off between state and potential federal jurisdiction. Arrests of producers around the country, continues still (see link @ bottom of last page). The biggest factor seems to be profiting versus aiding patients. When I first became publicly involved in the struggle for sensible medical marijuana access for patients, one of the first things I did was contact the local DEA office. My concern was how to set up a patient assistance organization while avoiding similar consequences of many medical marijuana organizations in Ca.. I was told that as long as the phrase "helping patients" didn't ring hollow I would not see the DEA at my door. This proved to be true.

Because of marijuana's history as an illegal recreational drug, the street price has always been high. If the medical marijuana industry were starting from ground zero rather than from a point where marijuana cost has been determined by risk involved, the number of hands it passes through, and the level of supply, people would not be stuck with the mind-set that marijuana production/distribution, equals high prices. For Ct. to require higher fees than anywhere else in the U.S. feeds into if not being fueled by this misconception.

The Dept. of Consumer Protection doesn't track the number of patients in the program who are on SSDI or another form of disability income. In some states these patients make up a majority of their medical marijuana programs. The result is that the individuals that Legislators believe they are helping by ignoring Federal law and allowing the possession and use of marijuana, are unable to afford it, making the laws shams, and creates an incentive for diversion of product. The amount a patient should pay must be based on overhead and actual production cost and not by "street price". While we are on the subject of money, there is nothing in the law that would prohibit the state from seizing a producer's escrow account if a failure to maintain a steady supply were due to Federal intervention, be it shut down or arrest.

I applaud the panel for taking on such a multi-level, problematic task as trying to form a sensible, workable plan in an arena which has no uniformity among states with medical marijuana programs. My biggest suggestion would be to increase producers and limit the plant numbers below 100. As far as strain and product decisions, the consumers will answer that question through supply and demand. Also, the need to keep cost down should play a role in how the state decides the charges required to participate in this work in progress.

In closing I want to suggest that the number of patients enrolling in the program will sky rocket once there is a supply system in place, so increasing the number of producers will not be a pointless measure.

Thank you for your time, Kirk Manter (a Ct. native looking forward to moving home from R.I.)

1. http://www.thedailychronic.net/2013/17220/us-drug-czar-federal-marijuana-laws-will-prevail-expect-arrests-to-continue/