Maryland-DC Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

HB 1400. Del. David Moon et al. Cannabis - Legalization, Taxation, and Regulation

House Judiciary Committee March 6, 2020.
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OPPOSE

MDDCSAM appreciates the intent of the bill and especially the sections on decriminalization of possession, and expungement, which we are enthusiastically supporting in Delegate Moon's other bills.

Cannabis legalization (of production, distribution and marketing) is not a binary choice between full commercial legalization vs. none. Our goal should be to minimize the harms of both options.
Of course legalization of production and marketing would reduce the harms of black markets including violent criminal organizations, large numbers of murders throughout the world, and also cannabis products of unknown composition and safety that may be contaminated with illicit fentanyl.

On the other hand, full commercial legalization of production and marketing is likely to lead to increased rates of cannabis use disorder affecting a significant percent of the population.

To minimize all of these harms, many have proposed non-commercial models of legalization to minimize or eliminate the black market while also minimizing harms of commercialization such as production of more addicting products, aggressive marketing, and the influence of a multi-billion dollar industry on public health regulation. (1)

Commercial production is how Big Tobacco and Big Alcohol has led to what are considered to be the leading causes of preventable death and disease in the developed world, a cautionary tale for the harms of commercial legalization of products that can be addicting and harmful in many of those who use it.

Proposals have included limiting legal production, marketing and sale to nonprofits, 'Benefit Corporations,' co-ops, buyers' clubs, "growing your own," or a public authority similar to state liquor stores operating in 17 U.S. states for alcohol distribution. (1) The state store model significantly reduces alcohol sales to youth and alcohol related harms. (2) (3). Four Canadian provinces use this model for cannabis distribution. (4)

The industry is incentivized to promote initiation and heavy use because most sales and profits come from heavy users, and those with use disorders, just as in the alcohol and tobacco markets. (5)
We are now seeing data connecting cannabis marketing and reduced age of initiation. (6) (7) (8) (9)

According to a 2015 Rand Corporation report, "The marketing and lobbying muscle of a for-profit industry is likely to influence the future trajectory of marijuana policy. . . there is danger of regulatory capture, with regulators drifting over time toward more industry-friendly postures." (10)

Most people who use cannabis do not have problems from it. But a significant percentage do.
10 – 30% of cannabis users self-report significant problems, and meet the criteria for Cannabis Use Disorder (CUD), with the same standardized criteria used to identify other substance use disorders. (5)

The National Survey on Drug Use and Health (NSDUH) found that among past-year cannabis users, 11.6% had past-year CUD. (11)

The National Epidemiologic Survey of Alcohol and Related Conditions (NESARC) of the NIH indicate that nearly 30% of past-year cannabis users met criteria for CUD in 2013. (12)

The past-year overall prevalence of CUD was estimated at 3% in 2013 (NESARC survey) and at 1.5% in a separate 2015 (NSDUH) survey. The rate of CUD is estimated to be growing rapidly, almost doubling over 11 years in the 2013 NESARC survey.

Marijuana use overall is also growing rapidly, from 4.1% in 2001–2002 to 9.5% in 2012–2013. (12)

The many people with CUD who seek treatment, have an average of more than 10 years of near-daily use and more than six serious attempts at quitting on average. They commonly self-report that they continue to use the drug despite, consequences such as low energy, low productivity levels, sleep and memory problems, psychological problems and many others. Most report that they have been unable to stop, and experience withdrawal symptoms when they try.

Cannabis leads to physical dependence in about 9 percent of those who try it, compared to 15 percent of those who try cocaine and 24 percent of those who try heroin. However, cannabis use is so common that physical cannabis dependence is about twice as prevalent as dependence to most other illicit substances.

Withdrawal symptoms include irritability, anger, depression, difficulty sleeping, craving, and decreased appetite, beginning within 24 to 48 hours of abstinence and lasting 1 to 3 weeks.

Unfortunately, the goal of maximizing revenues from a commercial industry, is not fully compatible with minimizing significant and very real harms for thousands of Marylanders.

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