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

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

HB 1342 Cannabis - Legalization and Regulation (Cannabis Legalization and Equity Act)
House Judiciary Committee March 8, 2022

LETTER OF INFORMATION

MDDCSAM applauds robust cannabis decriminalization and expungement measures generally, including reduction and elimination of unaffordable, harmful & unnecessary civil penalties.

Cannabis legalization can limit profound harms primarily borne by minority communities targeted by the failed War on Drugs and mass incarceration.

However, **a public health regulatory framework** is needed to reduce harms of increased **cannabis use disorder (CUD)**, aka addiction, which is not uncommon and can impair functioning just as severely as other substance use disorders.

Over time the cannabis industry will **increasingly resemble the tobacco and alcohol industries**; it will become increasingly consolidated, and will adopt marketing, promotion, government relations, and product design practices now used to increase sales. **Powerful economic incentives will lead to increased cannabis use**, and an increase in **unhealthy use, or use disorders, which account for a disproportionate share of sales in all of these industries.**

Therefore, independent entities similar to the 'Public Health Advisory Council,' and 'Cannabis Public Health Fund,' as described in HB 837, need a robust Conflict of Interest Policy for vetting Council members and guiding operations, which should conforms with Conflict of Interest best practices as described by the National Council of Nonprofits.

A 'Public Health Advisory Council' should collect information on health and other harmful impacts, and disperses funds to minimize these harms, as described in HB 837. However, this Council, and Fund, should be established with a more robust public health framework than is described in that bill.

Because of industry incentives to promote increased consumption (which are correlated with increased harmful use), **guardrails must be "built-in" to the regulatory framework, to protect against industry influence**. Only persons who are not directly or indirectly affiliated with the cannabis industry should be in a position to influence regulation and enforcement of the cannabis industry.

It should be specified that membership of the regulatory agency excludes persons that receive any items of value such as salary, payment, equity interest, investment instruments, benefits, or other forms of compensation from any cannabis-related business such as cannabis dispensaries, growers, processors,

other retail or wholesale cannabis-related businesses, or persons who receive similar items of value from business partners, consultants, suppliers or entities with any significant financial relationship with a cannabis business, or their immediate family members, with the exception of one representative of a laboratory that tests for cannabis, if said individual only receives items of value from the aforementioned laboratory.

Dr. Susan R.B. Weiss, Director of Extramural Research at the National Institute of Drug Abuse (NIDA), **reported to the Maryland House Cannabis Referendum and Legalization Workgroup** (Oct 2021) that cannabis business operatives should not be involved in setting or overseeing the implementation of regulations on the industry. She also expressed concern that federal legalization could lead to large alcohol and tobacco companies becoming more involved in the cannabis sector.

According to the October 2020 Public Policy Statement on Cannabis by the American Society of Addiction Medicine (ASAM), "The history of major multinational corporations using aggressive marketing strategies to increase and sustain tobacco and alcohol use illustrates the risks of corporate domination of a legalized cannabis market. . . **The marketing and lobbying muscle of a for-profit industry is likely to influence the future trajectory of cannabis policy. . . with regulators drifting over time toward more industry-friendly postures."** (1: ASAM)

A public health framework for legalized cannabis should be based on best public health practices established for tobacco control. (2. Barry RA et al). **The World Health Organization Framework Convention on Tobacco Control**, ratified by 180 parties, calls for protecting the policymaking process from industry interference. It states that **"[Governments] should not allow any person employed by the tobacco industry or any entity working to further its interests to be a member of any government body, committee or advisory group that sets or implements tobacco control or public health policy."** (2. Barry RA et al.)

In view of powerful incentives to expand consumption, and learning from decades-long efforts to "denormalize" tobacco consumption, avoiding the encouragement of increased consumption should be one of the goals of any adult use cannabis regulatory scheme. Promoting cannabis use is not socially or economically beneficial to our communities in the long run. (3. Gettingitrightfromthestart)

Public health education **should focus on prevention and intervention of unhealthy cannabis use IN ADULTS as well as youth**. Lessons learned from tobacco control efforts revealed that public health messages focused exclusively on youth were largely ineffective.

In addition, adult use cannabis **should be labeled with THC potency, and taxation should be based, at least in part, on THC potency**, as in several other states. THC potency is associated with adverse outcomes including the risk of CUD. (4) (5) (6) (7) (8)

Taxation based on weight incentives producers to create ever more concentrated products. Possibly as a result, the THC potency of retail cannabis products have roughly tripled in recent years. According to the

aforementioned ASAM policy statement, "The concentration of THC in commonly cultivated marijuana plants has increased three-fold between 1995 and 2014 (from 4% to 12% respectively), while THC concentrations in cannabis sold in dispensaries averages between 17.7% and 23.2%." (1. ASAM)

Respectfully,

Joseph A. Adams, MD, FASAM, Chair, Public Policy Committee

REFERENCES

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