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 556 Cannabis Reform
Hearing: February 17, 2023. House Economic Matters Committee

LETTER OF INFORMATION

MDDCSAM recognizes that cannabis legalization will lead to profound reductions in harms related to over-criminalization and mass incarceration. In addition to the reduction of criminal penalties, we believe that civil penalties such as onerous fines for possession and use, which disproportionately affect low-income communities and communities of color, should be further reduced.

We are submitting this Letter of Information to encourage minimizing predictable harms of legalization, primarily increased rates of cannabis use disorder (CUD), i.e. cannabis addiction. Though most people who use cannabis do not experience problems, long-term CUD is a common disorder that can be mild, moderate or severe, and can impair functioning as severely as other substance use disorders.

Cannabis use frequency is associated with CUD. In the U.S. there has been a 20% average increase in cannabis use frequency attributable to recreational legalization, consistent across increasingly rigorous designs (Ref 1. Sellers). Also, legalization is associated with increased rates of CUD (Ref 2 Credo). Rates of CUD have increased markedly in recent years in the U.S. according to the October 2020 Public Policy Statement on Cannabis by the American Society of Addiction Medicine (ASAM) (Ref 3 ASAM).

We also strongly recommend that the public health regulatory framework be strengthened legislatively to minimize these trends, which are expected to worsen with legalization. This recommendation is based on the following background:

Over time the cannabis industry is expected to become increasingly consolidated, and to increasingly adopt marketing, promotion, government relations, and product design practices now used by the tobacco and alcohol industries. Tobacco and alcohol industries have strong economic incentives to increase sales to customers, including to customers with unhealthy use or use disorders who account for a disproportionate share of sales.

Robust guardrails are needed to protect the regulatory framework from industry influence over time. 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, and that large alcohol and tobacco companies may become more involved in the cannabis sector.

According to 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." (ref 3 ASAM)

A public health framework for legalized cannabis should be based on best public health practices established for tobacco control. (4. Barry). 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" (4. Barry).

Therefore, the Public Health Advisory Council should adopt transparent policies and procedures that include a Conflict-of-Interest Policy for vetting Council members and guiding Council operations, and which conforms with Conflict-of-Interest best practices as described by the National Council of Nonprofits.

Membership of the Public Health Advisory Council should exclude 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. In addition, meetings and reports of the Council should be publicly transparent.

It should be clarified that the Cannabis Public Health Fund shall allocate and disperse funds in accordance with the recommendations of the Public Health Advisory Council in a manner consistent with evidence-based best practices to the extent practicable, in a manner that is publicly transparent, and that is described in a Department website.

In view of powerful incentives to expand 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. (Ref 5 Gettingitrightfromthestart)

Taxation:

THC potency is associated with adverse outcomes including the risk of CUD (6) (7) (8) (9) (10). Taxation based on product weight will lead to ever more concentrated products. In recent years the THC potency of retail cannabis products have roughly tripled. According to ASAM (3) "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%" (3. ASAM). Adult use cannabis should be labeled with THC potency, and taxation should be based, at least in part, on THC potency, as in Connecticut, Illinois and New York (Ref 11 NPHL 2022)

Other recommendations:

Regarding Subtitle 9. Advertising. 36-902. . . medical or therapeutic claims shall: "Be supported by substantial clinical evidence or substantial clinical data." Add: 'AS DETERMINED BY THE PUBLIC HEALTH ADVISORY COUNCIL.'

Local control over all aspects of adult use cannabis should not be limited.

Home delivery licenses should be eliminated. At a minimum, they should be fully determined by local jurisdictions.

Under subtitle 10 'Responsible Vendor Training Program; 36-1001 (pg. 66) - should include risks of cannabis including CUD, risks of consumption by those who are pregnant or nursing, etc.

The Cannabis Public Health Fund should have funding increased from 1.5% to 5%.
Also, some funds should be devoted to the treatment and prevention of substance use disorders.

Advertising, marketing, and labeling requirements should be strengthened.

Registered nurses should not be qualifying providers to prescribe medical cannabis.

The Alcohol, Tobacco, and Cannabis Commissioners should include at least two members with expertise in public health and cannabis research who are not affiliated with the cannabis industry.

Respectfully,

Joseph Adams, MD, FASAM, member, Public Policy Committee

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