APPENDIX

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TESTIMONY IN SUPPORT OF A CONSTITUTIONAL AMENDMENT TO LEGALIZE CANNABIS FOR PERSONAL, NON-MEDICAL USE BY ADULTS WHO ARE AGE 21 YEARS OR OLDER (ACR840)

SARAH FAJARDO, POLICY DIRECTOR
AMERICAN CIVIL LIBERTIES UNION OF NEW JERSEY
ASSEMBLY OVERSIGHT, REFORM, AND FEDERAL RELATIONS COMMITTEE

Thank you Chairman Danielson, Vice-Chair Houghtaling, and members of the Assembly Oversight, Reform, and Federal Relations Committee for the opportunity to provide testimony at this important hearing regarding passage of a constitutional amendment to legalize cannabis for adult use on the November 2020 ballot.

Founded in 1960, the ACLU-NJ is the state's leading organization dedicated to defending and advancing civil rights and liberties. We are a nonprofit, non-partisan organization with more than 50,000 members and donors in New Jersey, and tens of thousands more supporters across the state. ACLU-NJ is also a founding member of New Jersey United for Marijuana Reform (NJUMR), a partnership of civil rights, public safety, medical, faith, and political organizations and individuals committed to ensuring that cannabis legalization in New Jersey is centered in racial and social justice.

Over the last four years, ACLU-NJ and NJUMR have advocated tirelessly for the inclusion of racial and social justice provisions in legislation to legalize cannabis for adult use, most recently in advocating for the New Jersey Cannabis Regulatory and Expungement Aid Modernization Act (A4497/S2703). This bill has been championed by Assembly Speaker Coughlin, Assemblymembers Quijano, Holley, Timberlake, and McKnight in the Assembly and Senate President Sweeney and Senator Scutari in the Senate, and. While we continue to support legalization through legislation, we acknowledge that the legislature is making efforts to advance legalization through a constitutional amendment. The ACLU-NJ supports this effort as it appears that this is the pathway being pursued, rather than legislation.

The ACLU-NJ joined the fight to legalize cannabis to end the rising arrest rates of cannabis-related offenses and to advance racial, social, and economic justice. In 2017 alone, 37,623 arrests were made for cannabis-related offenses. This averages out to one arrest being made every fourteen minutes.[1] In addition to these alarming arrest rates, data reveals entrenched racial disparity rates in arrests.

Black people in New Jersey were arrested for cannabis possession at a rate three times higher than white people, despite similar rates of use in 2013 and again in 2017. Communities of color are disproportionately burdened by the war on drugs and harmed by these penalties. These high numbers of arrests and high racial disparity rates have created a civil rights crisis in the state of New Jersey, and

[1] "Still Unequal, Still Unfair: An Update on New Jersey's Marijuana Arrests." ACLU-NJ, 2019: https://www.aclu-nj.org/theissues/criminaljustice/still-unequal-still-unfair

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result in far-reaching, negative collateral consequences that harm and disrupt the lives of individuals, families, and communities.

The ACLU-NJ strongly believes that the best path forward for cannabis legalization is through the passage of legislation. Legislation provides for negotiated and intentional policy change, and is the only way to ensure that racial, social, and economic justice remain at the core of legal reform related to cannabis. The New Jersey Cannabis Regulatory and Expungement Aid Modernization Act (S2703/ A4497) as currently drafted contains a number of critical racial, social, and economic justice provisions, including: expungement reforms, resentencing and dismissal of pending charges, non-discrimination for prior cannabis-related convictions, inclusive access to the industry, and the inclusion of a social justice advocate on the five person regulatory commission. Such provisions are vital to ensuring that racial and social justice reform accompany the legalization of cannabis.

Some of these components are currently being advanced by the Legislature in other pieces of legislation (specifically, expungement reform is being addressed in S4154/A5981), and for those efforts, the ACLU-NJ is grateful. We thank the drafters of the language proposed for the ballot for ensuring that the Cannabis Regulatory Commission oversees personal, non-medical cannabis use by adults, which was an important provision in the New Jersey Cannabis Regulatory and Expungement Aid Modernization Act. In lieu of an opportunity to pass A4497/S2703 to legalize cannabis, the ACLU-NJ will support the passage of a constitutional amendment to bring the question to the voters via a ballot question.

ACLU-NJ has a number of significant concerns about leveraging the constitutional amendment process to effect policy change—it will delay justice and leverage New Jersey's constitutional amendment process for policy change that should be made legislatively. New Jersey rarely makes changes through amending the Constitution for sound reasons. Importantly, proposing an amendment doesn't actually prevent the need to pass legislation. Even if voters do approve a change to the Constitution, cannabis will not immediately be legalized, and both chambers of the Legislature would still have to pass enabling legislation at a later date. The New Jerseyans that vote on a ballot question would only learn the details of what they've voted on after the fact, when the Legislature has finished translating a broad constitutional change into specific policy. This process necessitates continued efforts from legislators and advocates to enact enabling cannabis legislation that is intentionally centered in racial and social justice.

However, by virtue of the nature of constitutional amendments, the draft as written does not and cannot provide voters with adequate detailed information about what the eventual model of cannabis legalization will include. As the ACLU-NJ and NJUMR have done for years, we hope to work with the Legislature to ensure that the model of cannabis legalization that is developed and implement in New Jersey contains racial and social justice provisions at its core.

If the Legislature votes to move forward with the constitutional amendment on the November 2020 ballot, the ACLU-NJ believes that is imperative that a robust decriminalization bill be passed in New Jersey as an interim measure to partially address the civil rights crisis of cannabis criminalization. Decriminalization is not a comprehensive solution to the civil rights crisis resulting from cannabis prohibition. However, arrests cannot continue to break apart lives and families while the constitutional amendment process is finalized over the coming years. We as New Jerseyans must make the choice to mitigate the harm caused by the criminalization of cannabis through this stop-gap measure.

The ACLU-NJ would like to thank the sponsors of S3801, which would decriminalize personal

possession of small amounts of cannabis, and we recommend that the Legislature consider enacting this bill with some recommended amendments.

As drafted, A5325 provides a progressive structure for reversing some of the negative impacts mentioned above. Additionally, the ACLU-NJ recommends the following changes to strengthen the bill, which we have also appended to our written testimony in the form of a memo.

1. Remove all civil penalties from the bill. Research has consistently shown that the use of civil penalties disproportionately impacts communities of color.
2. Explicitly decriminalize paraphernalia.
3. Explicitly state that personal possession of cannabis is a non-arrestable offense.
4. Raise the amount allowed for personal possession to 100 grams.
5. Extend additional legal protections to people committing civil violations.
6. Provide additional non-discrimination protections for prior offenses.
7. Bar the categorization of cannabis possession and positive drug testing violations as parole, probation, or pretrial release violations.

We believe that implementing these recommendations will help ensure that the substance of this decriminalization bill matches the goal of ending criminal prosecution of cannabis possession. We would warmly welcome the opportunity to collaborate with the Legislature on the advancement of a decriminalization bill.

As laid out above, the constitutional amendment process will add months, if not years to a process that could be handled legislatively. In the meantime, the egregious cannabis related arrest rates continue to impact the people of New Jersey, especially in communities of color. Voters will have very little information about legalization will look like in New Jersey, or whether it will contain essential racial and social justice provisions.

The ACLU-NJ has been proud to partner with the Legislature on advancing cannabis legalization legislation that is centered in racial justice. We urge the Legislature to build on this commitment, as well as its legacy of supporting criminal justice reform. Thank you.

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AMOL SINHA
Executive Director
MARC BEEBE
President

To: New Jersey Senate and Assembly
From: American Civil Liberties Union of New Jersey
Date: December 12, 2019
Re: Survey of marijuana decriminalization models and recommendations for New Jersey

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The American Civil Liberties Union of New Jersey (ACLU-NJ) recently surveyed the least punitive models of decriminalization of cannabis currently in place in other states and identified components of those models that should be advanced in New Jersey.

The decriminalization bill (S3801/A5325) that you sponsored in May 2019 was a bill that the ACLU-NJ was interested in supporting. At that time, the ACLU-NJ recommended amendments to that bill before it was heard in the Assembly Appropriations Committee (see Attachment A). This memo includes those initial recommendations, as well as additional recommendations.

ACLU-NJ Recommendations:

Although the ACLU-NJ supports advancing the New Jersey Cannabis Regulatory and Expungement Aid Modernization Act (S2703/ A4497) to legalize marijuana in New Jersey with racial and social justice provisions, as a stop-gap measure to address the civil rights crisis currently at play in New Jersey, the ACLU-NJ supports amending and passing S3801/A5325. With tens of thousands of arrests made every year, the ACLU-NJ supports interim policy measures to protect the lives of New Jerseyans, specifically New Jerseyans of color who are disproportionately harmed by our punitive and outdated laws governing cannabis. Additionally, we are concerned about the potential immigration impacts that can flow from marijuana arrests for our community members and will be conducting further research to develop recommendations on that issue. Twenty five states and the District of Columbia have decriminalized marijuana to date, and 9 of these twenty five states and the District of Columbia have subsequently legalized marijuana.[1] Marijuana has been legalized in eleven states and the District of Columbia thus far.[2] New Jersey must join the vanguard of more humane and sensible criminal justice policy.

As described in detail below, the New Jersey model of decriminalization should encompass the following features:

- No criminal or civil penalties
- Decriminalization of paraphernalia
- Non-jailable offense classifications
- Personal possession amounts of 100 grams
- Expungement provisions as necessary (given pending expungement legislation, S4154/A5981)
- Extension of legal protections for civil violators
- Non-discrimination protections for prior offenses

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[1] "States with Marijuana Decriminalization." NORML: https://norml.org/aboutmarijuana/item/states-that-have-decriminalized
[2] National Council of State Legislatures. "State Medical Marijuana Laws." October 16, 2019. http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx

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- A bar to the categorization of marijuana possession and positive drug testing violations as parole, probation, or pretrial release violations

Components of marijuana decriminalization legislation in the U.S. and recommendations for New Jersey

1. **Civil penalties: Decriminalization models leverage civil penalties in lieu of criminal penalties.**
   a. **The national landscape**
      i. **Fine Range:** Civil fines range from $50 to $1,000.
      ii. **Fines can be increased or remain the same for subsequent offenses.**
         1. States with the same punishments for subsequent offences: Delaware, Hawaii, Minnesota, New Mexico, New York, and Ohio.
         2. States with different punishments for subsequent offenses: Connecticut, Maryland, Mississippi, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, and Rhode Island.[3]
      iii. **Alternatives to Fines:**
         1. There are policy proposals that suggest alternatives to cash payments, such as community service.[4]
         2. In New Hampshire, violators who have only a single conviction within a 3-year period can have their fine waived upon proof of successful completion of a substance abuse assessment.[5]
   b. **ACLU-NJ recommendations:**
      i. A New Jersey decriminalization model should remove all criminal and civil penalties, as civil penalties criminalize poverty, disproportionately burdening low-income communities and communities of color.
         1. If both criminal and civil penalties are not removed, the ACLU-NJ strongly encourages New Jersey to implement a fine at the lowest end of the national range ($50), not increase fines for subsequent offenses, and provide alternatives to cash payment.
            a. If community service is offered as an alternative to cash payment, the number of hours of service should be determined by the fine, at a rate of no less $15/hour.
         2. We also recommend that the New Jersey decriminalization model first repeal New Jersey law creating a fourth degree crime for possessing more than 50 grams of marijuana or more than five grams of hashish [NJSA 2C:35-10a(3) and (4)], and then create a new, civil penalty aligning with the amount decriminalized. We also recommend that a new criminal penalty for the larger quantities be created to realign the fines and criminal consequences accordingly.
      i. As currently drafted, S3801/A5325 assesses a fine ("civil penalty") of $50. It also puts the burden on the State to prove that the marijuana is not medical marijuana before it can assess the $50 penalty, which should remain. S3801/A5325 should explicitly extend the $50 penalty for subsequent violations, which the bill is currently silent on.

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[3] *Ibid*

[4] The Marijuana Policy Project's model decriminalization bill includes a provision in which a violator can request community service in lieu of paying a fine. The $50 fine contained in S3801/A5325 should include a number of community service hours equivalent to the $15 minimum wage (3 hours). "Model State Civil Fine Bill." Marijuana Policy Project. https://www.mpp.org/issues/decriminalization/model-state-decriminalization-bill/

[5] New Hampshire House Bill 640, July 20, 2017. https://legiscan.com/NH/text/HB640/id/1478286

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ii. Revenue from fines should be deposited in a state fund to invest in the health and well-being of communities most impacted by the criminalization of marijuana, rather than being directed to municipal coffers. This structure would disincentivize fiscally-driven local enforcement of the civil penalties. Examples of investment opportunities include funding expungement processes, public substance abuse education, and substance abuse treatment, to name a few.

2. **Paraphernalia: In addition to decriminalizing possession of certain allowable amounts of marijuana, states have also decriminalized paraphernalia.**
    a. **Implemented in:** North Dakota, Nebraska, New Mexico, Delaware, Ohio, Maryland, Minnesota, and the District of Columbia. A decriminalization bill advanced in New Jersey in 2012 (A1465)[6] contained such a provision, attaching a $100 fine.
    b. **ACLU-NJ recommendations:**
        i. S3801/A5325 does not currently explicitly decriminalize paraphernalia, and ACLU-NJ recommends that this be added. Mirroring our recommendations above regarding civil penalties, ACLU-NJ recommends that there be no civil penalties for paraphernalia. If there is a fine imposed, we recommend that it only be available if a person is not also being fined for marijuana possession, that it only be imposed per incident (and not per item of paraphernalia), that it be the lowest possible amount, and that subsequent offenses not result in increased fines or arrest.

3. **Non-jailable offenses: Some states have created definitional classifications that prevent arrests for marijuana violations.**
    a. **Jailable offenses**: In some states that have decriminalized marijuana, the classification of marijuana possession could still result in arrests. This could lead to law enforcement making more arrests because there is a lesser burden on law enforcement and judicial administration, while the consequences are lower for the individuals violating the law ("net-widening").
        i. Minnesota: "A police officer may arrest someone without a warrant when a public offense has been committed or attempted in the officer's presence."[7]
        ii. Mississippi: "Offenders who provide proof of identity and agree in writing to appear in court are not subject to arrest."[8]
        iii. Missouri: "A person can be arrested, but cannot be sentenced to jail, for simple possession of up to 10 grams of cannabis."[9]
        iv. Rhode Island: "Any person in possession of an identification card, license, or other form of identification issued by the state or any state, city, or town, or any college or university, who fails to produce the same upon request of a police officer who informs the person that he or she has been found in possession of what appears to the officer to be one ounce (1 oz.) or less of marijuana, or any person without any such forms of identification who fails or refuses to truthfully provide his or her name, address, and date of birth to a police officer who has informed such person that the officer intends

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[6] In 2012, the NJ General Assembly passed a decriminalization bill (A1465) which was voted down in the Senate Judiciary Committee. This bill would have decriminalized the personal possession of up to 15 grams of marijuana. The penalty was $150 for a first offense, $200 for a second, and $500 for a third. Violators under 21 and adults charged three times would have to attend a drug education program. Violators under 18 will be referred to the Superior Court, Chancery Division, Family Part for appropriate disposition. It also decriminalized paraphernalia, attaching a $100 fine.

[7] "State Laws with Alternatives to Incarceration for Marijuana Possession." MPP, https://www.mpp.org/issues/decriminalization/state-laws-with-alternatives-to-incarceration-for-marijuana-possession/

[8] *Ibid*

[9] *Ibid*

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to provide such individual with a citation for possession of one ounce (1 oz.) or less of marijuana, may be arrested."[10]

b. Limits to using odor as probable cause:

i. Massachusetts: the smell of unburnt marijuana cannot justify a warrantless vehicle search.
ii. Vermont: a faint odor of burnt marijuana is not grounds to impound or search a car.
iii. Colorado: drug detection dogs cannot justify search of a car.[11]

c. ACLU-NJ recommendations:

i. A New Jersey decriminalization model must classify the "violation" in a way that prevents officers from arresting the violator and should include language that indicates that this is a non-arrestable offense (regardless of whether it is a first offense or subsequent arrest), and should proscribe the use of odor as the basis for a search.

4. Weight: Amounts of decriminalized marijuana possession range from 3 grams to 100 grams.

a. States' decriminalization thresholds:

i. Ohio: 100 g
ii. Minnesota: 42.5 g
iii. Mississippi: 30 g
iv. New York: 28g
v. Delaware Nebraska, Rhode Island: 1.0 oz.
vi. New Hampshire: 0.75 oz.
vii. Connecticut, New Mexico, North Carolina, North Dakota: 0.5 oz.
viii. Missouri and Maryland: 10 g
ix. Hawaii: 3 g[12]

b. ACLU-NJ recommendations:

i. A New Jersey decriminalization model should allow for the personal possession of an amount of marijuana at the upper range of decriminalization models. S3801/A5325 allows for decriminalization of up to 2 ounces (56g) of marijuana. At a minimum, the amount decriminalized should be no less than 2 ounces as currently written in the bill, and we recommend that New Jersey adopt Ohio's personal possession amount of 100g.

5. Expungement

a. Automatic/Non-Automatic

i. Expungement is a court ordered process in which the legal record of an arrest or a criminal conviction is "sealed" or erased. The history of our country is marred by the war on drugs and the mass incarceration of black and brown people. These communities have been significantly and disproportionately impacted by marijuana convictions. Therefore, it is necessary to clear all prior marijuana convictions in order to address the harm done, and include provisions (such as vacaturs) to address potential immigration consequences of marijuana-related arrests. Additional recommendations on this issue will be forthcoming.
ii. New York's decriminalization legislation included a provision that automatically sealed marijuana convictions and provided a pathway for individuals to petition the court where the conviction occurred to expunge their records.[13]

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[10] RI. Gen. Laws § 21-28-4.01(vii). http://webserver.rilin.state.ri.us/Statutes/TITLE21/21-28/21-28-4.01.HTM
[11] Rubinkam, Michael. "In Era Of Legal Pot, Can Police Search Cars Based On Odor?" Associated Press, September 13, 2019. https://boston.cbslocal.com/2019/09/13/marijuana-pot-smell-police-car-searches-laws/
[12] "States With Marijuana Decriminalization." NORML: https://norml.org/aboutmarijuana/item/states-that-have-decriminalized
[13] Duster, Chandelis; del Valle, Lauren. "New York to expunge thousands of marijuana convictions." CNN, August 28, 2019. https://www.cnn.com/2019/08/28/politics/new-york-marijuana-convictions-expunged-trnd/index.html

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iii. Mississippi's decriminalization model provides for automatic expungement of new civil infraction records after two years.[14]
iv. States can choose to implement a number of different expungement processes. Generally, expungement requires an application in order to begin the process. However, an automatic expungement process in which no applications or lawyers are necessary is more effective and accessible, and a proposal to advance automatic expungement is currently before the New Jersey Legislature (S4154/A5981).

b. ACLU-NJ recommendations:

i. A New Jersey decriminalization model should align with the automatic expungement provisions advanced in S4154/A5981. The prior legalization bill that the ACLU-NJ supported included a robust automatic expungement system.[15] S3801/A5325 features a robust section on expungement, including introducing two new forms, "virtual" and "expedited expungements."

6. Due Process: Extending legal protections under decriminalization

a. The bill is ambiguous as to process.

i. Decriminalization by definition moves the possession of a certain amount of marijuana out of the criminal justice system. However, it is unclear what legal protections will then be extended to those subjected to civil penalties. While S3801/A5325 puts the burden on the state to prove that marijuana in question is not medical marijuana before they can assess the $50 penalty, it is unclear what avenues are available to challenge the assessment of fines, what is legally allowable to be discovered, and what options for representation are available for those illegally subjected to such fines and civil penalties.

b. ACLU-NJ recommendations:

i. The ACLU-NJ recommends that the full panoply of legal protections provided for criminal charges (e.g. proof beyond a reasonable doubt, right to counsel, right to compulsory process, right to confrontation, right to pretrial discovery, appeals as of right) be extended to those subjected to civil penalties under decriminalization.

7. Equal Protection: Non-discrimination for past marijuana convictions

a. ACLU-NJ recommendations:

i. A New Jersey decriminalization model should include a provision providing protections against discrimination for past marijuana convictions. This was included in the legalization bill[16], and appears to be contained in S3801/A5325.
ii. S3801/A5325 provides protections against discrimination in housing, loans, and employment. It should also provide protections for non-discrimination in child welfare, nutrition assistance, and access to other public benefits.
iii. The federal Marijuana Opportunity Reinvestment and Expungement (MORE) Act contains a provision that requires- "No discrimination in the provision of a federal public benefit on the basis of cannabis".[17]
iv. ACLU-NJ recommends that the definition of non-discrimination be expanded to include the broadest possible range of state-run programs possible.

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[14] Mississippi House 585, Regular Session 2014. http://billstatus.ls.state.ms.us/documents/2014/html/HB/0500-0599/HB0585IN.htm
[15] "Why NJUMR Supports S2703/A4497." New Jersey United for Marijuana Reform, 2019. https://www.njumr.org/facts/njumr-supports-s2703a4497
[16] *Ibid*
[17] H.R.3884 - Marijuana Opportunity Reinvestment and Expungement Act of 2019, 116th U.S. Congress (2019-2020). https://www.congress.gov/bill/116th-congress/house-bill/3884

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8. **Probation and parole violations: states have included provisions that bar marijuana violations from being considered as probation and parole violations.**
    a. Rhode Island's decriminalization model includes a provision that states that marijuana violations will not be considered probation/parole violations.[18]
    b. **ACLU-NJ recommendations:**
        i. This provision should be included in S3801/A5325. In addition, marijuana violations (including testing positive for marijuana use) should play no role in determinations of sentencing, pretrial release or detention.

9. **National and regional decriminalization models:**
    a. **National:**
        i. The Marijuana Opportunity Reinvestment and Expungement (MORE) Act (H.R. 3884)[19] was passed by the House Judiciary Committee on November 20, 2019. This bill would decriminalize marijuana on the federal level by removing the substance from the Controlled Substances Act, and would apply to prior and pending convictions.
    b. **Regional:**
        i. **New York:**
            1. Passed decriminalization in 1977 and expanded it in 2019.
            2. Allows for personal possession of one ounce, with a $50 fine attached, and no increased punishment for subsequent offenses.
        ii. **Delaware**:
            1. Passed decriminalization in 2015.
            2. Allows for possession of one ounce or less, with a $100 fine for those 18+, and no increased punishment for subsequent offenses.
        iii. **Maryland**:
            1. Passed decriminalization in 2014.
            2. Allows for possession of less than 10 grams; with a $100 fine for first offense; $250 for second offense; and $500 fine, mandatory drug education, and substance abuse treatment assessment.
        iv. **Rhode Island:**
            1. Passed decriminalization in 2012.
            2. Allows for possession of one ounce or less, with a $150 fine for those 18 and older. A third conviction within 18 months is a misdemeanor punishable by $200-500 fine and/or six months jail time. Civil violations for marijuana possession will not be grounds for revocation of parole or probation.
        v. **Connecticut:**
            1. Passed decriminalization in 2011.
            2. Allows for less than half an ounce, with a $150 fine attached, and a $200-$500 fine and drug awareness counseling for a third offense.
        vi. **Pennsylvania**:
            1. Marijuana possession is not yet decriminalized.

U.S. Decriminalization Statutes:
Connecticut- C.G.S.A. § 21a-279a
Delaware- Del. Code Ann. Title 16 § 4764
Hawaii- H.R.S. 712-1249
Maryland-Md. Code Ann., Crim. Law § 5-601.1

[18] RI. Gen. Laws § 21-28-4.01. http://webserver.rilin.state.ri.us/Statutes/TITLE21/21-28/21-28-4.01.HTM
[19] *Supra* note 16.

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Minnesota- M.S.A. § 152.027 (4)
Mississippi- Miss. Code Ann. § 41-29-139 (c)(2)
Missouri- Mo. Rev. St. §579.015
Nebraska- Neb. Rev. Stat. § 28-416 (13)
New Hampshire- RSA 318-B:2-c
New Mexico- NMSA § 30-31-23
New York- N.Y. Pen Law §§221.05 and 221.10, Criminal Procedure Law §§1.20, 440.10 and 160.50, Public Health Law §1399-n
North Carolina- N.C.G.S.A. § 90-95 (d)(4)
North Dakota- ND Cent. Code 19-03.1-23
Ohio- O.R.C. § 2925.11(c)(3)
Rhode Island- R.I. Gen. Laws § 21-28-4.01

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December 12, 2019

Re: ACR840 - Proposed Constitutional Amendment to Legalize Cannabis

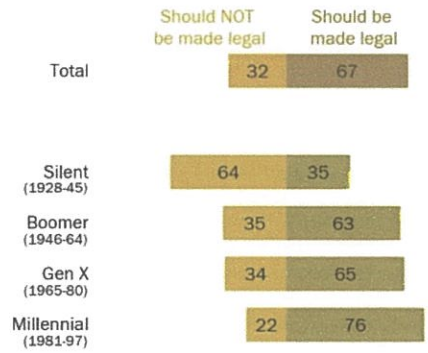
Dear Honorable Members of The Assembly Oversight Committee:

Amending the State Constitution by ACR840 does not create any regulatory power that the State Legislature doesn't already have. The State Constitution should properly be amended to secure the Blessings of Liberty on behalf of The Garden State's otherwise Free Citizens who already responsibly exercise the natural and unalienable right. Short of that, the responsible members of the Cannabis Community have spent a decade properly petitioning *their* government for redress. They are thankful to this honorable Committee for all of its intelligent leadership and to the General Assembly for having stepped forward with smarter approaches to cannabis policy here in The Garden State.

Upon information and belief, the hold-up on legislative action was in the State Senate. Again, ACR840 doesn't actually accomplish anything except underscoring how The People of this great State are not in responsible Control. Being that the reticence of the State Senate can reasonably be attributed to generational differences, the General Assembly would be in an infinitely stronger political position by tabling the current bill and leading specific State Senators from freezing with an abject sense of Fear to understanding and supporting responsible approaches to cannabis policy.

Majorities across generations – except Silents – favor legalizing marijuana

% who say the use of marijuana ...



Note: Figures may not add to 100% because of rounding. No answer responses not shown.
Source: Survey of U.S. adults conducted Sept. 3-15, 2019.

PEW RESEARCH CENTER

Note that the State Constitution recognizes that, "All persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and of pursuing and obtaining safety and happiness." Prohibition failed because nobody follows the unjust law. Nobody is asking for *permission* from their government to access or use the God-given cannabis plant. They rather freely and overwhelmingly responsibly exercise the natural and unalienable right.

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Senate President Sweeney was absolutely correct when he said, "I have firmly stated before and will say again now that I do not believe you put civil rights on the ballot, period. It is the job of elected officials to ensure that everyone is provided equal protection and equal rights under the law. We should not hide from that responsibility... we should embrace it" (https://observer.com/2012/12/sweeney-pushes-back-on-same-sex-marriage-referendum/). The right to responsibly open a business is a civil right. The right to good banking is a civil right. A referendum merely kicks the can down the road. It is an unfair burden on the Cannabis Community, making Freedom a popularity contest. And the State Legislature will still need to develop a regulatory structure. There is broad agreement that we should welcome smarter approaches to cannabis policy. This referendum is not the right way to do it. Welcome a stronger push from the General Assembly to cultivate some common sense in the State Senate.

The opportunity for the State Legislature in creating safe and legal adult access is to take a forensic accounting of the current restrictive Alternative Treatment Center program and see how quickly rents, management fees, and intellectual property licensing fees of the ATCs flow out of the State. It is silly to have semi-exclusive not-for-profits helping People who are *not permitted* to help themselves. A legalization model with a broader sense of Liberty and Prosperity can recapture these values in local banking for healthy reinvestment in vibrant and growing Garden State communities. Welcome the opportunity to case-study other "regulated" industries and develop smarter approaches. Can specifically look at the culture of home brewing, the craft brewing industry, as well as the corporate chains that have come to dominate liquor stores and drug stores. Opportunity to do so much better by cultivating healthy local boutique commerce and culture that banks locally, pays skilled and educated local folks real living wages, and is actually accountable to the community served.

Thank you to this honorable Committee for all of your leadership. This proposed constitutional amendment does not give the State Legislature any power that it does not already have. Let's refocus on Policy issues. We can secure the Blessings of Liberty to plant seeds in the ground under the God-given sun this spring for personal use, while developing healthy local boutique commerce that is actually accountable to the community served.

Thankful for smarter approaches.

Very truly yours,

Justin Escher Alpert

Testimony in Support of Assembly Concurrent Resolution 840 (ACR 840)
for the New Jersey Assembly Oversight, Reform and Federal Relations Committee

Prepared by: Monica B. Taing, PharmD, RPh
December 12, 2019

Dear Chairman Danielsen, Vice-Chair Houghtaling, and Committee Members:

My name is Dr. Monica Taing, PharmD, RPh. I am a Doctor of Pharmacy and a Registered Pharmacist speaking today in support of ACR 840. I sit on the Board of Directors of Doctors for Cannabis Regulation (DFCR) and serve as the Director of Research and Clinical Education for Minorities for Medical Marijuana (M4MM). DFCR is a coalition member of New Jersey United for Marijuana Reform (NJUMR) advocating for fair and equitable marijuana legalization. DFCR's members strive neither to minimize nor to exaggerate scientific literature about the risks and benefits of cannabis use. DFCR promotes evidence-based strategies to prevent recreational marijuana use by minors and misuse by adults. M4MM's mission is to provide advocacy, outreach, research, and training as it relates to social reform, public policy, health, and clinical education.

As a clinical educator, I train medical professionals on fact-based science and research regarding cannabis and harm reduction strategies, always mindful of how best to safely counsel and monitor patients and other vulnerable populations. Through my work, I witness the widespread public health costs associated with cannabis prohibition. These issues include multifaceted public safety threats posed by the underground market, which target the most susceptible age groups, hinder clinical research opportunities, and exacerbate the burden of healthcare costs nationally.

Per the bioethical directive to *"do no harm,"* the legalization of cannabis is an effective public health harm reduction strategy. As one of the most widely used substances in the world, the illicit status of cannabis is not supported by science, as studies show that cannabis is safer than alcohol and tobacco.[1] Regulation of cannabis—like that of alcohol and tobacco—creates a legal distinction between underage and adult cannabis use, showing respect for scientific evidence and the rule of law that the flouted policy of cannabis prohibition has failed to instill in our children. Since the 1970s, effective preventive education campaigns have reduced the rates of alcohol and tobacco use by minors,[2] despite the legality of both drugs for adults. Data from the Federal Government shows that cannabis-legal states have experienced no increase in underage use,[3] and in some legalized states, the data shows a decrease in use by 12- to 17-year-olds.[4]

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[1] Lachenmeier, Dirk W. and Rehm, Jürgen. "Comparative risk assessment of alcohol, tobacco, cannabis and other illicit drugs using the margin of exposure approach." *Scientific Reports* 5. January 30, 2015. https://www.nature.com/articles/srep08126

[2] Office of Population Affairs, U.S. Department of Health and Human Services, "Tobacco Use in Adolescence." Retrieved October 26, 2019. https://www.hhs.gov/ash/oah/adolescent-development/substance-use/drugs/tobacco/index.html

[3] National Institute on Drug Abuse, National Institutes of Health, *Monitoring the Future: National Survey Results on Drug Use, 1975-2018, Key findings on adolescent drug use*, January 2019. http://www.monitoringthefuture.org//pubs/monographs/mtf-overview2018.pdf

[4] Christopher Ingraham, *Washington Post*, "Following marijuana legalization, teen drug use is down in Colorado," December 11, 2017. https://www.washingtonpost.com/news/wonk/wp/2017/12/11/following-marijuana-legalization-teen-drug-use-is-down-in-colorado/

Evidence shows that cannabis is not lethal in overdose, which is critical at a time when tens of thousands of Americans die from drug overdoses annually.[5] Criminalizing cannabis has contributed to the dangerous proliferation of synthetic cannabinoids, which are far more toxic than herbal cannabis, sometimes undetectable in drug tests, and lethal in overdose.[6] Additionally, the use of unregulated THC vaporizer pens has been associated with thousands of cases of severe lung injury and dozens of deaths in the United States over the past few months. In contrast, similar products from legal, regulated dispensaries show little if any linkage to such illnesses.[7]

Legal and regulated dispensaries check IDs to verify that purchasers are 21 or older, thus preventing underage purchases of cannabis. By contrast, illegal cannabis sellers supply cannabis of unknown potency, and untested for contamination or adulteration, to minors as well as adults.[8] Cannabis regulation benefits public health by enabling government oversight of the production, testing, distribution, and sale of cannabis.[9,10]

Cannabis regulation ensures that cannabis products are appropriately labeled with potency, product warnings, and other information, enabling adults to make informed decisions about their consumption.[11] Cannabis cultivation has led to the development of more potent strains, to the extent that illegal marijuana today is often five times stronger than it was 30 years ago. Prohibition prevents regulation of labeling, rendering consumers unable to judge the potency of marijuana, which is like drinking alcohol without knowing its strength. Thus, the increasing potency of marijuana is a medically sound argument–not for prohibition, but rather for the legalization and regulation of cannabis, to ensure that products are properly labeled with potency, ingredients and serving sizes.

Despite data showing similar usage rates, African American New Jerseyans are arrested at rates three times greater than that of white New Jerseyans.[12] One cannabis-possession arrest is made approximately every **15** minutes in New Jersey, adding up to **nearly 100** arrests per day or **nearly 35,000** arrests a year.[13] This relegation to second-class citizen status inflicts trauma and prevents societal progress for several of the most marginalized communities in New Jersey. Whether due to a cannabis-related arrest, incarceration, or criminal record, the ensuing collateral consequences impose

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[5] Center for Disease Control and Prevention. "Drug Overdose Deaths," June 27, 2019. https://www.cdc.gov/drugoverdose/data/statedeaths.html

[6] Fantegrossi, William E., et al. "Distinct pharmacology and metabolism of K2 synthetic cannabinoids compared to Δ^9-THC: Mechanism underlying greater toxicity?" *Life Sciences* (97)1. February 27, 2014. pp. 45-54.

[7] Centers for Disease Control and Prevention, "Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products," October 25, 2019. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

[8] Jaffe, Adi, "Is Marijuana a Gateway Drug?" *Psychology Today*, July 24, 2018. https://www.psychologytoday.com/us/blog/all-about-addiction/201807/is-marijuana-gateway-drug

[9] California Medical Association. "Cannabis and the Regulatory Void: Background Paper and Recommendations." 2011. https://www.cmadocs.org/Portals/CMA/files/public/CMA%20Cannabis%20White%20Paper%2010-14-11.pdf?ver=2018-06-23-142435-170

[10] Doctors for Cannabis Regulation. "Declaration of Principles," April 19, 2016. https://dfcr.org/declaration-of-principles/

[11] Orenstein, Daniel G; Glantz, Stanton A. "Regulating Cannabis Manufacturing: Applying Public Health Best Practices from Tobacco Control." *Journal of Psychoactive Drugs,* 50:1. pp. 19-32. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5878137/

[12] American Civil Liberties Union. *The War on Marijuana in Black and White*. New York, NY: June 2013. p. 17. https://www.aclu.org/report/war-marijuana-black-and-white

[13] American Civil Liberties Union New Jersey. "ACLU-NJ Marijuana Data Brief Finds Cannabis Arrests Have Skyrocketed Since Earlier Report." *ACLU-NJ*, November 15, 2019. https://www.aclu-nj.org/news/2019/11/15/aclu-nj-marijuana-data-brief-finds-cannabis-arrests-have-sky

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lifelong issues due to bureaucratic barriers. These results include being legally denied access to healthcare, financial support (such as loans or scholarships), education, employment, housing, and other avenues of access for socioeconomic improvement. Poverty, racism, educational deprivation, environmental stress, unemployment, and disrupted social support networks are all social determinants that severely reduce healthcare access in low-income communities.[14,15,16] Thus, cannabis prohibition is a public health burden for low-income communities.[17]

Today, 62% of New Jerseyans agree that now is the time to legalize and regulate adult-use cannabis.[18]

This resolution is critical for ending the criminalization of cannabis, and it is a start to rectifying the failings of prohibition. Before moving forward, it is essential to reflect on the harms that should be righted. Prioritizing robust expungement will stop derailing the lives of New Jersey citizens with old convictions. It is vital to ensure that strong social justice provisions are enacted, which prioritize those who have been most disproportionately impacted by the War on Drugs. Companion legislation should mandate the provision of critical resources that facilitate diversity, inclusivity, and equity in all aspects of ownership, management, and employment opportunities in the legal industry.

On behalf of DFCR and M4MM, thank you for your time and attention to this issue that has affected three generations of New Jerseyans. The commendable effort of Senate President Steve Sweeney, Assembly Speaker Craig Coughlin, the bill sponsors, and the governor is instrumental in implementing a sensible approach in ending cannabis prohibition.

Respectfully submitted,

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Doctors for Cannabis Regulation
601 Ewing Street, Suite C-10
Princeton, New Jersey 08540

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[14] Kaiser Family Foundation. "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." May 10, 2018. https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

[15] Mercado, Susan, et al. "Urban Poverty: An Urgent Public Health Issue." *Journal of Urban Health* 84. May 2007. pp. 7-15. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1891652/

[16] Dickman, et al. "Inequality and the health-care system in the USA." *The Lancet*. April 8, 2017. https://www.rootcausecoalition.org/wp-content/uploads/2017/04/Inequality-and-the-health-care-system-in-the-USA.pdf

[17] Horsfield, Natasha, *Punishing Poverty: How the failed 'war on drugs' harms vulnerable communities*, Health Poverty Action, 2018. https://www.healthpovertyaction.org/wp-content/uploads/2019/02/Punishing-poverty-research-report-WEB-v5.pdf

[18] Monmouth University. "Support for Legal Weed Stays High." February 18, 2019. https://www.monmouth.edu/polling-institute/reports/monmouthpoll_nj_021819/

Testimony of Chris Goldstein before The Assembly Oversight, Reform and Federal Relations Committee; and Assembly Commerce Committee

In Regards to: ACR840, A Concurrent Resolution proposing to amend Article IV, Section VII of the New Jersey Constitution related to marijuana

December 12, 2019

Witness background: *Chris Goldstein is a New Jersey resident, a regional marijuana consumer advocate, and a nationally recognized journalist. He is a former Executive Director of NORML New Jersey, a chapter of the National Organization for the Reform of Marijuana Laws, and former board member and communications director of the Coalition for Medical Mairjuana New Jersey. Chris' weekly column on cannabis policy and culture for the* Philadelphia Inquirer, *"Philly420," ran from 2012-2018. He also taught the "Marijuana in the News" class at Temple University's Journalism Department at the Klein School.*

Honorable members of the Assembly,

I am a marijuana consumer, and a New Jersey voter. There are more than 100 of us being arrested every day, simply for our association with this plant. We are still punished with all the well-known injustices of prohibition, even as the rest of the country ends this sensless discrimination against us.

Now, this legislature and voters will consider a profound exercise - amending our state Constitution - an action that should have Liberty at its core.

For nearly 50 years the National Organization for the Reform of Marijuana Laws - NORML - has represented cannabis consumers. We are the ones who will pay for regulated products. We will generate all of the billions in future tax revenue. And, there are already plenty of places to buy weed here in the Garden State.

What we require is a definitive end to prohibition, and for our rights to be fully restored.

Having covered this issue as an advocate and journalist for more than two decades, I have read **every** statewide ballot referendum related to marijuana. What we find in ACR840 is only a rather vague 'right to buy.'

I would urgently recommend changing the language in ACR840 - especially the first two sentences of what will appear on the ballot.

Current wording is a bit odd, and potentially very off-putting to voters who are well educated on this topic.

16x

CURRENT ACR840:
###Do you approve amending the Constitution to legalize a controlled **form of marijuana** called **"cannabis"**? Only adults at least 21 years of age could **use** cannabis.###

RECOMMEND:
Do you approve amending the Constitution to end marijuana prohibition? All criminal penalties for personal possession, cultivation and use will be eliminated; only adults at least 21 years of age could purchase regulated products, with a tax.

There are likely more than 1 million people in New Jersey who will consume marijuana this year. We have been promised justice. Here's how to deliver on that:
- Stop arresting us, immediately
- Remove all penalties for personal cannabis use, possession, cultivation
- Remove all statutory discrimination against consumers/patients
- Create an equitable retail industry; locals first

We have been promised relief, only to see enforcement ramp up against us. So, New Jersey's marijuana consumers certainly welcome a chance to have our voices heard at the ballot box...even having to traverse a gauntlet of police on the way.

Having surged to the polls in 2020, you can expect us to be back again...and again.

We don't want to pay a premium just to stay legal. We don't need $500 ounces of weed sold by former US Speaker of the House John Boehner with a 20 percent tax on top.

Those of us who already smoke marijuana in New Jersey want affordable, laboratory tested marijuana products. We want $100 ounces of high quality cannabis flower grown by local craft farmers. We want our current weed dealers to have a pathway to legitimacy. And after we buy regulated products we don't want to ever have to worry about THC testing at our workplace or college.

I urge you to consider changing the ballot language of ACR840 per our recommendations. NORML, through our local chapters and volunteers welcome the opportunity to work with you on this issue.

Thank you,

Chris Goldstein
Willingboro, NJ

17x

Submitted to: The New Jersey Assembly Oversight, Reform, and Federal Relations Committee / The New Jersey Assembly Commerce Committee
December 12, 2019
Testimony of Charlana McKeithen, Executive Director of Garden State NORML
In Regards to: ACR840, A Concurrent Resolution proposing to amend Article IV, Section VII of the New Jersey Constitution related to marijuana

My name is Charlana McKeithen. I'm a New Jersey resident and the Executive Director of Garden State NORML, the National Organization for the Reform of Marijuana Laws' New Jersey chapter. I am a medical patient who volunteers my time to fight for the rights of ***all*** cannabis consumers in New Jersey.

I wish to thank the members of this Committee for the opportunity to testify on behalf of cannabis legalization. This legislative action seeks to regulate and control the adult-use cannabis market, and we hope it will expand and protect the rights of consumers and our families.

NORML is the oldest marijuana consumer advocacy group in the country, with almost 50 years of experience fighting to protect responsible cannabis consumers in the US, and abroad. Here in New Jersey, 94 people are arrested for cannabis-related offenses every day, mostly for minor cannabis possession charges. This must end.

We need to stop arrests now. We need to restore the rights and clear the records of hundreds of thousands of residents. And, we need to create a truly equitable market - one that gives back to communities deeply affected by Prohibition - a market that puts small-business New Jersey locals first.

That's why we would like to see the first two sentences of the ballot language in ACR840 changed.

Please consider the following language:
Do you approve amending the Constitution to end marijuana prohibition? All criminal penalties for personal possession, cultivation and use will be eliminated; only adults at least 21 years of age could purchase regulated products, with a tax.

We at Garden State NORML are ready to go to the polls and do our part. Tens of thousands of people will likely vote for the first time, just to support marijuana reform. Now, we ask you to do your jobs, here in the Legislature. Let's deliver some real justice, together.

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Now, more than ever, there exists tremendous public support for ending our nation's nearly century-long experiment with cannabis prohibition and replacing it with a taxed and regulated adult market place.

More than six-in-ten American adults now believe that "the use of marijuana should be made legal," according to recently released nationwide polling data provided by Quinnipiac University[1].

In New Jersey specifically, 62 percent of voters now say that they support the adult use of marijuana compared to just 32 percent opposed, according to a recent poll conducted by Monmouth University[2].

Although legalizing via a ballot referendum has been popular in most states to regulate cannabis, I am here to encourage you all to consider legalizing via the legislature rather than make New Jersey residents wait another few years while continuing to live under the threat of incarceration and second-class citizenship simply due to their cannabis consumption.

But, voters do not desire replacing nearly a century of criminalization with a marijuana free-for-all. We are aware of the reality that marijuana possesses some level of risk and there exists the potential for some misuse. In fact, it is precisely because of this reality that society ought to regulate it accordingly. By contrast, advocating for marijuana's continued criminalization does nothing to offset any potential risks; it compounds them.

Marijuana prohibition drives markets underground and abdicates control of these markets to those who typically operate outside the boundaries of the law. Regulation, by contrast, allows for lawmakers to establish legal parameters regarding where, when, and how an adult cannabis market may operate. Legalization also provides oversight regarding who may legally operate in said markets and provides guidelines so that those who do can engage in best practices.

Such regulations already exist for alcohol and tobacco – two substances that are far more dangerous and costly to society than is the adult use of cannabis. (Specifically, a 2009 review published in the journal British Columbia Mental Health and Addictions estimated that health-related costs per user are eight times higher for drinkers of alcoholic beverages than they are for those who use cannabis, and are more than 40 times higher for tobacco smokers.[3]) The imposition and enforcement of tobacco and alcohol regulations, coupled with public awareness campaigns highlighting these products' risks and acknowledging the distinctions between their

[1] 1 Quinnipiac University National Poll https://poll.qu.edu/national/release-detail?ReleaseID=2432
[2] Monmouth University Poll https://www.monmouth.edu/polling-institute/reports/monmouthpoll_nj_021819/
[3] Gerald Thomas and Chris Davis. 2009. Cannabis, tobacco and alcohol use in Canada: comparing risks of harm and costs to society. Visions: BC's Mental Health and Addictions Journal 5: 11.

use versus abuse, has proven effective at reducing the public's overall consumption of these substances, especially among teens.[4]

Unfortunately, a legal environment in which marijuana is criminalized is not conducive to imposing such common sense, evidence-based practices. A pragmatic regulatory framework that allows for the legal, licensed production and retail sale of cannabis to adults, but restricts and discourages its use among young people best reduces the risks associated with the plant's use or abuse, and provides an environment whereby consumers can best learn the skills and knowledge to readily delineate between the two behaviors. That is why the majority of New Jersey voters welcome the opportunity to bring necessary and long-overdue regulatory controls to the marijuana market, and why they support lawmakers' efforts to move in this direction.

For decades, those opposed to amending cannabis criminalization warned that any significant change in marijuana policy would lead to a plethora of unintended consequences. Yet the initial experiences in the US states of Colorado and Washington, which voted to regulate adult cannabis sales in 2012, in addition to many other states' experiences regulating the production and distribution of marijuana for therapeutic purposes, has shown these fears to be misplaced. The liberalization of statewide marijuana laws is not predictive of higher crime rates[5], nor is it associated with rises in adolescent consumption patterns.[6]

For example, state survey data released by the Colorado Department of Public Health & Environment found that fewer high school students in the state consumed cannabis post-legalization.[7] Cannabis prevalence data compiled in Washington following that state's decision to legalize adult cannabis use tells a similar story. According to data compiled by Washington's Healthy Youth Survey and published in September 2015 by the Washington State Institute of Public Policy, marijuana use fell among 8th graders, 10th graders, and 12th graders in the years since marijuana became legal. Young people's self-reported access to cannabis also remained largely unchanged during this time period, although more 8th graders now report that marijuana is "hard to get."[8]

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[4] US National Institutes of Health. Cigarette and alcohol use at historic lows among teens: https://www.drugabuse.gov/news-events/news-releases/2011/12/cigarette-alcohol-use-historic-low-among-teens

[5] Science Daily. No correlation between medical marijuana legalization, crime increase: Legalization may reduce homicide, assault rates.: https://www.sciencedaily.com/releases/2014/03/140326182049.htm

[6] Lancet Psychiatry, July 2015. Medical marijuana laws and adolescent marijuana use in the USA from 1991 to 2014: results from annual, repeated cross-sectional surveys: http://thelancet.com/journals/lanpsy/article/PIIS2215-0366(15)00217-5/fulltext

[7] US News & World Report. "Pot use among Colorado teens appears to drop after legalization." https://www.usnews.com/news/articles/2014/08/07/pot-use-among-colorado-teens-appears-to-drop-after-legalization

[8] Washington State Institute for Public Policy. I-502 Evaluation Plan and Preliminary Report on Implementation. http://www.wsipp.wa.gov/ReportFile/1616/Wsipp_I-502-Evaluation-Plan-and-Preliminary-Report-on-Implementation_Report.pdf

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State and local governments can regulate cannabis in a manner that keeps cannabis out of the hands of children while simultaneously satisfying the seller, the consumer and the State — and the sky won't fall. Presently, 33 states and Washington, DC permit physicians to recommend marijuana therapy. Some of these state-sanctioned programs have now been in place for nearly two decades. Eleven states and Washington DC have legalized marijuana for adult-use, and the majority of these states have functioning regulatory systems. Washington DC and Vermont are currently working to pass similar structures. Early findings from these states are largely positive.

In particular, scientists have identified a positive association between the passage of medical marijuana laws and reduced incidences of opioid abuse. Data published in the Journal of the American Medical Association reports that the enactment of medical cannabis laws is associated with significantly lower state-level opioid overdose death rates. Specifically, statewide overdose deaths from opiate decreased by an average of 20 percent one year after legalization, 25 percent by two years, and up to 33 percent by years five and six.[9] Since that report was published in 2014, research has remained consistent in findings relating to opioid abuse and access to marijuana laws. Two 2019 studies published in the International Journal on Drug Policy[10] and the Injury Epidemiology[11] journal similarly determined that opioid abuse and mortality are reduced in jurisdictions where the population possesses access to cannabis.[12] Clinical data and also indicates that the adjunctive use of cannabis may wean patients from opiates while successfully managing their pain.[13] A study published earlier this year found that medical patients consider marijuana to be a viable alternative for opioids and other prescription medications.[14] As a result of compounding evidence, Massachusetts Sen. Elizabeth Warren has requested the US Centers for Disease Control and Prevention to evaluate "the use, uptake, and effectiveness of medical marijuana as an alternative to opioids for pain treatment in states where it is legal."[15] Regulators at the CDC have also updated their guidelines to encourage pain management specialists to no longer drug test patients for cannabis if they are undergoing opioid therapy.[16]

Today, neither science nor public opinion supports the federal government's contention that marijuana meets the criteria of a schedule I controlled substance – a classification which misconstrues the plant's abuse potential as equal to that of heroin and that it lacks the

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[9] JAMA, October 2014. Medical cannabis laws and opioid analgesic overdose mortality in the United States, 1999- 2010. http://archinte.jamanetwork.com/article.aspx?articleid=1898878

[10] https://www.ncbi.nlm.nih.gov/pubmed/31590091

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6717967/

[12] National Bureau of Economic Research. Do Medical Marijuana Laws Reduce Addictions and Deaths Related to Pain Killers? http://www.nber.org/papers/w21345

[13] I, February 2016. The effect of medicinal cannabis on pain and quality of life outcomes in chronic pain: a prospective open-label study. http://www.ncbi.nlm.nih.gov/pubmed/26889611

[14] https://www.ncbi.nlm.nih.gov/pubmed/31179810

[15] The Guardian, "Elizabeth Warren asks CDC to consider legal marijuana as alternative painkiller. https://www.theguardian.com/us-news/2016/feb/12/elizabeth-warren-medical-marijuana-painkiller-opioid-abuse

[16] The Blaze, "CDC recommends doctors stop testing patients for marijuana. http://www.theblaze.com/news/2016/03/27/cdc-recommends-doctors-stop-testing-patients-for-marijuana/

therapeutic utility that science has acknowledged. Fortunately, America's federalist system does not mandate states to be beholden to this intellectually and morally bankrupt policy. The Tenth Amendment to the U.S. Constitution provides that all "powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people," leading former Supreme Court Justice Brandeis to famously opine, "[A] state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."

It is time for New Jersey to become a leader in sensible cannabis policy. Public sentiment and common sense demand that lawmakers move forward to enact necessary and long overdue changes in state-level marijuana policies to achieve the repeal of marijuana prohibition so that the responsible, adult use of cannabis is no longer subject to arrest and criminal penalty.

On behalf of our 6,756 members in New Jersey and on behalf of the 62% of voters who support ending marijuana prohibition, we respectfully ask that you consider legalizing cannnabis via the state legislature as soon as possible, rather than make New Jersey residents wait for another few years for a legal cannabis market to be established.

In conclusion, Garden State NORML supports the ballot referendum only if legalization via the state legislature be unachievable next year. In the meantime, we encourage the New Jersey State Legislature to stop arresting and incarcerating our residents, many of whom are people of color, and work to regrade cannabis for all ages.

Thank you for considering my testimony.
Charlana McKeithen
Garden State NORML

December 12, 2019

The Rev. Alexander E. Sharp, Executive Director, Clergy for a New Drug Policy

TESTIMONY IN SUPPORT OF ACR 840 and SCR 183

Dear Chairman Poe and Chairman Danielsen, and Committee Members:

I am the Rev. Alexander Sharp, ordained in the United Church of Christ. I serve as the executive director of Clergy for a New Drug Policy. Our mission is to educate and organize clergy nationally to end the War on Drugs and seek a health not punishment response to the War on Drugs.

Over the past five years, I have worked in at least ten states working to educate clergy on the importance of legalizing cannabis as a critical step in ending this Drug War. Because we are based in Chicago, my most concentrated experience on cannabis legalization has been in Illinois. This summer we became the first state in the nation to legalize and regulate cannabis through legislative action.

I appreciate the opportunity to appear before you. I lived in New Jersey for six years after graduate school. I started my family here. My first job was with the Department of Higher Education in the administrations of Governor Richard Hughes and William Cahill.

Let me speak first about legalization. I often stress to my clergy colleagues that "legalization" is the wrong word. What we are seeking is really "regulation and taxation" coupled with strong and realistic education. Here's what I mean. We often hear opponents of cannabis legalization warn us that cannabis today is much stronger than what our parents used to smoke. If this is true, shouldn't the best response be not prohibition, which just drives the market

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underground, but regulation, which permits those who will use cannabis to know what they are actually using?

Instead of prohibition, we need to focus on preventing abuse through regulation and education. Cigarettes are *legal*, but smoking has gone down by 50% in the last 25 years. Alcohol is *legal,* but we have made progress here as well, especially as it affects driving under the influence. Marijuana is *illegal*, and use has not gone down. What's wrong with this picture is that we have persisted in mindless prohibition.

Prohibition refuses to accept reality. Drugs are a reality in our society. Cigarettes, alcohol, and potentially addictive behaviors like gambling are with us. The issue, therefore, becomes how to prevent not use but abuse. Regulation and education are the best ways to do this.

As clergy we have a special responsibility to our young people. We need to talk with them in ways they will believe and respond to. Preaching only abstinence when it comes to marijuana, doesn't work, and that's what happens under prohibition.

When it comes to our youth, it is important to note that teen use has not increased in the states that passed legalization.

The question is frequently asked: We've got alcohol and cigarettes, but why marijuana? Do we really need another legal drug? My response: if we really believe regulation and education are the best way to shape individual moral behavior, we should legalize marijuana even if alcohol and cigarettes had never happened. In short, marijuana stands on its own merits.

Let me speak now about social justice. This is perhaps the overriding issue for clergy. You know full well the racial disparity in arrests for cannabis possession and use here and across the nation -- I don't need to cite those numbers to you. And we all know about what are

24x

euphemistically called "collateral consequences" -- loss of housing, public assistance, barriers to work. They hold tragically true everywhere I have been -- in all the New England states, Maryland, Arizona, Michigan, and my home state.

We are very hopeful about the social equity agenda that has been built into our legalization bill in Illinois. We are deeply committed to ensuring that black and brown entrepreneurs receive a significant share of licenses awarded to new companies, and have developed instruments to ensure this will happen. We have developed a broad range of licensed job categories that open positions to minorities.

I have worked in Illinois and other states with many of the advocacy groups active in New Jersey. I know that they would have preferred the passage here of legislation including social justice measures. But I am urging clergy to support the Ballot Initiative proposal before us today. While it does not bring forward social equity measures compared to the earlier legislative proposals, it moves in the right direction.

As advocates press for social equity when legalization is passed, they will not be blocked by opponents of legalization itself. And they will have at their backs the wind of a growing movement for social equity nationally and in other states.

And let us not forget that legalization itself brings no small measure of social justice. Arrests are declining in states that have legalized. The illicit market is creating legitimate jobs and not just for rich white folks. In Illinois we are seeking job training programs in our community college system.

Legalization, best understood as" regulation and education," is the best way to respond to the reality of cannabis in our society. It offers the hope that at long last we can begin to repair the damage the War on Drugs has inflicted, especially upon poor people of color, over the past almost fifty years.

25x

NJCCAP

New Jersey Council
Child & Adolescent Psychiatry

December 2, 2019

Honorable Members of the Senate and General
Assembly Committee State House
125 West State Street
Trenton NJ 08608

Dear Honorable Members of the Senate and General Assembly:

The New Jersey Psychiatric Association (NJPA) represents over 850 psychiatrists in New Jersey with expertise in multiple psychiatric subspecialties, including addiction psychiatry and child and adolescent psychiatry, and the New Jersey Council of Child and Adolescent Psychiatry (NJCCAP) represents over 200 Child and Adolescent Psychiatrists. We are writing on behalf of NJPA and NJCCAP to express our concerns regarding the harmful effects of marijuana on adolescents and ask that you consider the following scientific evidence as you review legislation that could increase access to marijuana in this vulnerable population.

The NJPA is aware that S2703 sets the age at which the conduct is made legal at 21. However, it has been demonstrated that legalization has been associated with an increased perception of safety and this in turn has been associated with an increase in marijuana use for people under 21 years of age. According to the Monitoring the Future Survey, rates of cannabis use by adolescents continue to increase. Forty-five percent of high school seniors have used cannabis, 23% are currently using and 6% use daily. These alarming trends are associated with perception. Additionally, these early rates of initiation and use of marijuana are associated with increased rates of addiction and subsequent use of other illicit drugs. Of note, about one in six individuals who begin marijuana use as adolescents develop cannabis use disorders.

The brain remains in a state of active development through the age of 25. During this critical developmental period, the young brain is more vulnerable than the mature brain to the adverse long-term effects of tetrahydrocannabinol, or THC, the active ingredient in marijuana. Cannabis use in youth is associated with reduced neural connectivity in the brain and reduced brain volumes in areas that influence memory, decision-making, impulse control, and motor functions.

Research demonstrates that these brain changes are associated with significant declines in IQ, poor school performance, increased risk of dropping out of school, decreased occupational

26x

performance and increased unemployment later in life. Increased rates of motor vehicle accidents and fatalities have also been documented as a result of driving under the influence of marijuana. Furthermore, cannabis use in adolescence is associated with increased rates and worsening symptoms of psychosis, anxiety and depression.

Dangerous effects of marijuana have also been associated with increased potency. The average potency of THC has increased from 3% in 1992 to 12% in 2010 and the potency of edibles is even higher at 62%. Use of this more potent marijuana has been associated with serious medical consequences including unrelenting vomiting, difficulty breathing, increased heart rate and severe psychotic symptoms.

Increased rates of marijuana use, initiation at a younger age, and increased drug potency are harmful to the developing brain. Marijuana use by adolescents is associated with adverse developmental, cognitive, medical, psychiatric and substance use outcomes. We respectfully urge you to oppose any legislation that will increase access of marijuana to adolescents and emerging young adults. We recommend increased public education for children, youth, and families regarding the impact of marijuana on the developing brain; increased research into the effects of marijuana related policy on child and adolescent health; and improved access to evidence-based treatments for marijuana use disorders.

Sincerely,

Wilbert Yeung, MD
NJCCAP President

Debra E. Koss, MD
NJPA President

New Jersey
Psychiatric
Association

A District Branch of the American Psychiatric Association

Position Statement on the Legalization of Marijuana

Approved by the Board of Trustees September 14, 2016

Marijuana legalization has been promoted as a public health measure to decrease drug-related crime, as a solution to the harms caused by marijuana criminalization, including incarceration, and as a significant source of tax revenue. These claims have not been validated and must be weighed against the potential negative consequences. Legalization of cannabis will reduce the public perception of its risks and increase the social acceptability of using cannabis.

NJPA opposes proposals to legalize marijuana.

There is no current scientific evidence that marijuana is in any way beneficial for the treatment of any psychiatric disorder. In contrast, there is an association between cannabis use and psychiatric disorders, and adolescents are particularly vulnerable.

Marijuana in youth lowers cognitive performance and disrupts processes for motivation. There is also evidence in both youth and adults that chronic marijuana use is associated with impaired verbal learning, memory and attention and risk for psychosis. Psychomotor function is most affected during acute intoxication, with some evidence for persistence in chronic users and after cessation of use.

Substance use disorders resulting from marijuana use are a serious and widespread health problem. Adults may incur a number of cannabis-related harms including convictions for cannabis-impaired driving, car crash fatalities and injuries involving cannabis-intoxicated drivers; and emergency department admissions for the adverse effects of ingesting cannabis products.

NJPA supports the decriminalization of marijuana, which is not the same as legalization. Decriminalization is the removal of criminal penalties for certain lesser drug law violations (usually possession for personal use). By decriminalizing possession and investing in treatment and harm reduction services, we can reduce the harms of drug misuse while improving public safety and health.

Some preliminary evidence of public health impact from jurisdictions which have already legalized marijuana (Colorado and Washington State) is concerning and should continue to be monitored. Both states, for example, report an increase in frequency of drivers in fatal car crashes who tested positive for THC. In addition, these states rank among the highest in the nation for marijuana use by youth during the past month.

REFERENCES

1. The ASAM Public Policy Statement on Marijuana, Cannabinoids and Legalization (Sept 15, 2015)
2. The APA Position Statement on Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana (July 2014).
3. The APA Position Statement on Marijuana as Medicine (December 2013)
4. ASAM White Paper on State-Level Proposals to Legalize Marijuana (July 25, 2012)
5. Roffman R. Legalization of cannabis in Washington State: how is it going? Addiction (2016)
6. Broyd SJ1, van Hell HH, Beale C, Yücel M, Solowij N. Acute and Chronic Effects of Cannabinoids on Human Cognition-A Systematic Review. Biol Psychiatry. 2016 Apr 1;79(7):557-67.

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NJCCAP

New Jersey Council
Child & Adolescent Psychiatry

New Jersey Council of Child and Adolescent Psychiatry (NJCCAP)
Policy Statement on Marijuana, Cannabinoids, and Legalization

There is a growing trend in the United States toward legalization of marijuana for both medical and recreational purposes. With this trend, there has been an increase in marijuana use and a decrease in the public perception of harm associated with marijuana use and addiction. Additionally, the potency of marijuana has increased significantly over the years along with the availability of synthetic cannabinoids and edible forms of marijuana, often ingested by children with dire consequences. There is a lack of public awareness and education around the negative effects of marijuana use and abuse that needs to be addressed. There are particular risks for children and adolescents whose brains are still developing and a lack of research addressed at further understanding the effects of marijuana on children and adolescents. Efforts in public education to alert the public concerning the adverse effects of tobacco, alcohol, and cannabis have been successful when sustained.

There are many well-documented adverse effects of marijuana use such as altered brain development, cognitive impairment, decreased brain activity in areas of the brain and a significant increase in risk of developing psychotic symptoms or disorders. Those with habitual use have a greater risk of decreased academic performance, increased school dropout rates, decreased overall educational attainment and decreased workplace productivity. There are known carcinogens and toxins in marijuana and the long-term risk for developing cancer is unknown. The use of synthetic cannabinoids has led to multiple emergency room visits for paranoia, anxiety, and psychosis. The use of marijuana, particularly in adolescents increases not only the risk of addiction to marijuana, but also the risk of addiction to other substances. There have also been multiple reports of increased driving accidents and fatalities linked to driving while under the influence of marijuana.

There is little funding going toward the education, prevention or treatment of marijuana use and addiction. There is a huge amount of public funds involved in criminal penalties for marijuana use and possession that has disproportionately affected poor and minority communities. This disruption to the lives of these families has been linked to long-term social and economic destabilization. Legalization of marijuana has been proposed as a way of decreasing rates of incarceration and increasing the flow of tax revenues from the regulated sale of marijuana toward funding for education and treatment. However, there is no evidence for this and in states where marijuana has been legalized there have been concerning results such as increased emergency room visits for cannabis toxicity, psychotic reactions, and cannabis diversion to minors.

NJCCAP opposes any legislation that can increase the use of marijuana by adolescents beyond when prescribed for specified medical or research purpose.

As mental health advocates for NJ children and adolescents, **NJCCAP recommends**:

1. **Greater attention** to the public health effects of any change in the legalization of cannabis that includes--
    a. **Increased research** into the health effects of marijuana
    b. **Increased research** into the effects of marijuana-related policy changes on child and adolescent mental health
2. **Increased public education** to children and families regarding the known adverse effects of marijuana on youth
3. **Increased attention to the special issues related to children and young adults and Immediate access to evidence-based treatment** for marijuana use disorders

Approved February 15, 2017

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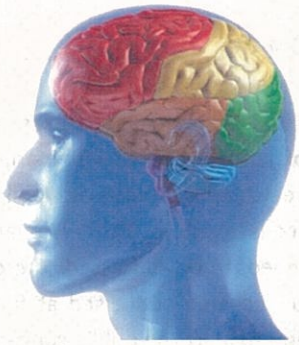
NAMI New Jersey
National Alliance on Mental Illness

Marijuana and Youth: Utilizing Science to Inform Policy



Brain development continues until the age of 25

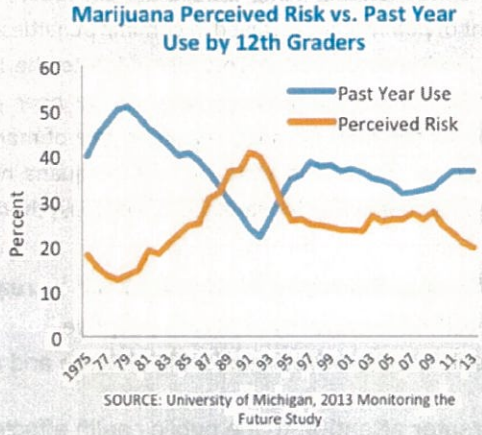
Cannabis use in youth is associated with decreased brain connections and volumes in areas involved with memory, decision-making, self-control, and motor functions.[1]

Effects of cannabis use in adolescence

- Decreased academic performance, increased drop-out rates, and decreased college enrollment and educational achievement.
- Decreased occupational performance and increased unemployment later in life.
- Increased rates of and worsening of psychotic disorders (including 2-5x increase in schizophrenia), mood, and anxiety disorders.
- Decreased IQ by 8 points on average.

Rates of Use[2]

- 45% of US high school seniors have used cannabis
- 23% of US high school seniors use currently
- 6% of US high school seniors use daily
- Decreased perceived risk is associated with increased use in youth.

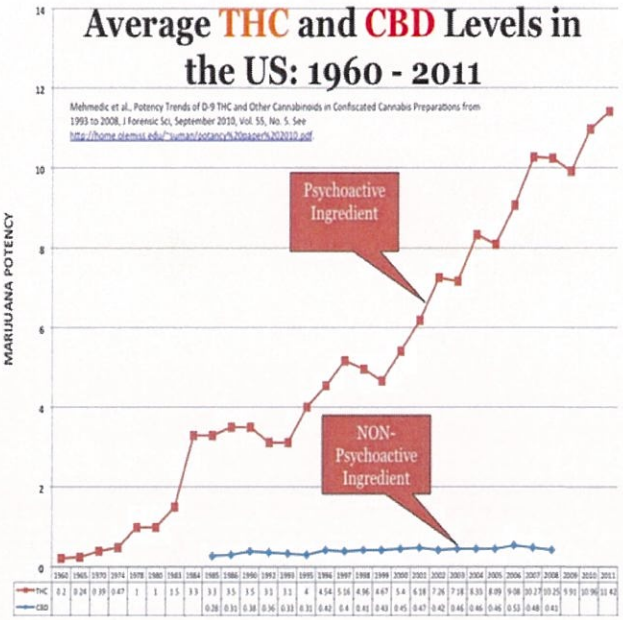


SOURCE: University of Michigan, 2013 Monitoring the Future Study

Cannabis Use and Addiction[3]

- Earlier use predicts greater risk of developing addiction to cannabis.
- People who begin using marijuana before the age of 18 are 4–7 times more likely than adults to develop a marijuana use disorder.[4]
- Youth who use cannabis are at greater risk for developing addictions to other substances including opioids.

Marijuana and Youth: Utilizing Science to Inform Policy



Marijuana Potency and Youth[5]

- Currently marijuana has higher potency (12% THC) vs. marijuana in 1990's (3%) and edibles and concentrates are even higher (62%).
- Increased potency cannabis use associated with dangerous effects including unrelenting vomiting, difficulty breathing, increased heart rate, and severe psychotic symptoms.
- Increased potency has been associated with increases in adolescent detox/rehab admissions and calls to poison control due to child marijuana ingestion and exposures (2-fold increased rate of accidental exposure in children less than 6 in states with legalized marijuana).

Recommendations

NJCCAP, NJPA and NAMI oppose any legislation that will increase access of marijuana to adolescents. We recommend the following steps be taken:

- Increased funding of educational programs for youth and their families about the effects of marijuana on youth.
- Increased funding of research into the effects of marijuana on youth and treatment strategies for marijuana addiction.
- Increased access to evidence based substance treatment programs for youth.
- Implementation of steps to prevent the distribution of marijuana and cannabis products to children and adolescents.

[1]Volkow, ND, et al. Adverse health effects of marijuana use. *N Engl J Med.* 2014 June 5; 370 (23): 2219-2227.

[2]Johnston,LD, et al. (2014). *Monitoring the Future national results on drug use: 1975-2013: Overview, Key Findings on Adolescent Drug Use.* Ann Arbor: Institute for Social Research, The University of Michigan.

[3]Hall, W, Degenhardt L. Adverse health effects of non-medical cannabis use. *Lancet.* 2009 Oct 17; 374(9698): 1383-91.

4Winters KC, Lee C-YS. Likelihood of developing an alcohol and cannabis use disorder during youth: association with recent use and age. *Drug Alcohol Depend.* 2008;92(1-3):239-247.

[5]ElSohly MA, et al. Changes in cannabis potency over the last 2 decades (1995-2014); Analysis of current data in the United States. *Biol Psychiatry.* 2016 Apr 1; 79(7):613-9.

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New Jersey Council
Child & Adolescent Psychiatry

NEW JERSEY PSYCHIATRIC ASSOCIATION 1935 DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION

NAMI New Jersey
National Alliance on Mental Illness

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MSNJ
MEDICAL SOCIETY
OF NEW JERSEY
Est. 1766

December 12, 2019

Re: Opposition to ACR-840

Dear Chairman and Members of the Assembly Oversight, Reform & Federal Relations Committee:

We urge you to oppose ACR-840 due to the major public health concerns that can result in negative impact on patients. Should the bill continue to be under consideration, we ask that you first review our recommended parameters below before moving forward with legalization.

The Medical Society of New Jersey (MSNJ) joins several groups and individuals in expressing concerns with legalization of marijuana for recreational use in New Jersey. With data available on roadway dangers, negative effects on adolescent brain development and fetal development, risk of respiratory diseases and risk of other health conditions, we are compelled to oppose the legalization of the recreation use marijuana due to public health concerns.

We point to the national American Society of Addiction Medicine for detailed information on the negative health impacts of marijuana. The New Jersey Psychiatric Association and the New Jersey Council of Child and Adolescent Psychiatry also oppose legalization of recreational marijuana, with similar public health concerns in mind. In particular, these two associations present strong evidence that marijuana should not be legally available to minors **and** young adults. Please find statements from all three associations, as well as a fact sheet on brain development, attached.

As background, MSNJ did not take an official position on the creation of the medical program, but supported safeguards, including requirement of a bona fide relationship between a patient and physician, requirement of a patient to qualify with a listed debilitating medical condition and a requirement for a review panel to consider the addition of qualifying medical conditions to the program. Similarly, we urge lawmakers to consider patient safety when considering legalization.

If legalization is to occur, we ask for public health measures to be taken well before products are available for sale. Product testing and consumer education and warnings should precede sales. We ask for the following parameters to protect public health, at the least:

a. Prohibit the legal sale of marijuana products to anyone younger than 25 years of age.
b. Prohibit marketing and advertising to youth, akin to the current restrictions on tobacco product advertising.
c. Require that products made available for retail sale be tested for potency and clearly labeled with THC content. Require maximum THC amounts per serving (e.g. 100 milligrams per unit) and per purchase (e.g. Colorado purchase limit: 800 milligrams).
d. Require warning labels to be placed on all marijuana and marijuana products not approved by the U.S. Food and Drug Administration (FDA) which are offered for sale in retail

MSNJ
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Est. 1766

outlets, stating, "Marijuana use increases the risk of serious problems with mental and physical health, including addiction" with notes that adverse mental and physical health effects are well documented, as well as "Marijuana should not be used by pregnant women or persons under age 25," and "Marijuana should not be used by persons prior to operating motor vehicles and heavy machinery."

e. Require that marijuana products (such as edibles and beverages) be sold only in child-proof packaging and be accompanied by the mandatory distribution of educational flyers regarding the risks of overdose and poisoning in cases of accidental ingestion by children or household pets.
f. Earmark taxes placed on marijuana and marijuana product sales, wholesale or retail, such that a majority of tax revenues are required to be devoted to public education about addiction, health effects of cannabis and synthetic cannabinoid use, prevention of initiation of cannabis and cannabinoid use by youth, or research on the health risks and potential benefits of marijuana, "natural" cannabinoids, and synthetic cannabinoids. And, direct funding to conduct research on impaired driving.
g. Limit marijuana and marijuana product sales to state-operated outlets, akin to Alcohol Beverage Control regulations existing in several states and Canadian provinces, which preserve both public access and the potential for governmental revenues linked to sales, while limiting the broad commercialization of public sale of potentially harmful but brain-rewarding products.
h. Implement public awareness campaigns highlighting the risks of marijuana use to discourage use by vulnerable populations, including adolescents and young adults, individuals with mental illness, and those with a history of addiction involving alcohol or other drugs.
i. Highlight the risks and negative impact to the lungs and respiratory system of smoking marijuana.
j. Set safety and quality standards (product testing, dispensary inspections, etc).

We request that if this bill moves forward it only does so with MSNJ's amendments included. We thank and appreciate you for your consideration of our concerns and look forward to working together on this matter.

Thank you,

Marlene M. Kalayilparampil, MHA

ASAM The Voice of Addiction Medicine

American Society of Addiction Medicine

Public Policy Statement on Marijuana, Cannabinoids and Legalization

Background

In recent years, many states have considered or enacted policies to legalize cannabis use. As of this writing, Alaska, Colorado, Oregon, and Washington and Washington, D.C. have legalized cannabis use for adults, and 23 states and Washington, D.C. have legalized cannabis for non-FDA-approved medicinal uses under state law.[1] This expansion of access to legal cannabis use has occurred partly because of the perception among the public and lawmakers that marijuana use is harmless or that the harms are not significant, especially compared to the harms associated with the use of currently legal drugs, alcohol and tobacco. Indeed, the 2014 *Monitoring the Future* survey reported a five-year decline in the perceived harm of regularly smoking marijuana, from 52.4% of high school seniors to 36.1%.[2] However, as detailed below, recent research has revealed numerous medical harms associated with cannabis use, not the least of which is the likelihood of developing addiction[a] related to cannabis use. As such, this increasing public access to legal cannabis use calls for a response from the field of addiction medicine.

Cannabis is a plant that has been used as a psychoactive recreational drug for a century in the United States and for longer in other cultures. Its use for purported medicinal benefits also has a long recorded history around the globe, and its use for medical indications has recently expanded in the United States as a non-FDA-approved medical product. Botanical cannabis is usually referred to as marijuana but it also goes by various nicknames, among them "pot" or "weed." The primary psychoactive compound in cannabis is delta-9-tetrahydrocannabinol (THC), which is a partial agonist at cannabinoid receptors in the body. The THC content in botanical marijuana sold illicitly for recreational use in America has increased from roughly 3.4% in 1993 to roughly 8.8% in 2008.[3] THC is also the active ingredient in many derivatives of cannabis, including hashish and hash oil, and it is more recently found combined with other substances in high-potency, harder-to-identify products. Other synthetic cannabinoid receptor agonists, such as JWH-018 and HU-210, have recently been gaining popularity as psychoactive substances. These synthetic substances are full agonists at cannabinoid receptors, are more potent than THC, and seem to have more intense and toxic clinical effects. They are used as alternatives to marijuana and some persons elect to use them since they can be obtained legally in many parts of the United States and are not detected by drug tests that solely analyze for THC.[4] Cannabis has been found to be the most frequently used drug in the U.S. after alcohol, tobacco and caffeine. Moreover, marijuana is the most widely used illegal drug in the United States and it is estimated that it is used by 61% of all persons suffering from a substance use disorder related to drugs other than alcohol.[5]

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[a] Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

Empirical evidence associates THC with cannabis dependence[b] (moderate to severe cannabis use disorder in *DSM-V*). In one study, 9.1% of users of cannabis developed cannabis dependence.[6] A more recent study confirmed the risk of developing cannabis dependence to be about 8%, and demonstrated that the likelihood of using alcohol, nicotine and illicit drugs is significantly higher for continuous cannabis users as well as ex-users of cannabis as compared to those who have never used cannabis.[7] The risk of developing addiction associated with cannabis use has been reported to increase to about 17% among those who start using marijuana in adolescence, and to 25-50% among those who smoke marijuana daily.[8] For example, a twin study found that individuals who used cannabis by age 17 were about twice as likely as their twin to develop cannabis abuse[c] or dependence, and 2.1 to 5.2 times as likely to use other drugs, develop alcohol dependence, or develop other drug abuse or dependence.[9] While the prevalence of past-year marijuana use among the U.S. adult population appears to have remained stable at about 4.0% from 1991-1992 to 2001-2002, the percentage of past-year marijuana smokers who displayed evidence of abuse or dependence rose from 30.2% to 35.6%; some have hypothesized that this is related to the increased concentration of THC in marijuana available in the United States in recent years.[10, 11, 12]

In addition to the risk of developing addiction, several other harmful long-term effects of marijuana use on health have been documented, including adverse psychiatric effects from its use. Specifically, the long-term effects of marijuana use include altered brain development and cognitive impairment, including impaired neural connectivity in specific brain regions, decreased activity in prefrontal regions, and reduced volumes in the hippocampus.[13] These effects have been found to be more profound in users who began marijuana use in adolescence or young adulthood.[14, 15] Other studies have found a correlation between the use of cannabis and the appearance of psychotic symptoms and the prevalence of psychotic disorders.[16] Moreover, even prenatal exposure to marijuana has been shown to be predictive of psychotic symptoms in young adulthood.[17] There is also evidence of a correlation between cannabis use and decreased academic performance, in addition to an increased likelihood of dropping out of school.[13] A review of multiple studies found consistent associations between cannabis use and lower educational attainment.[18] Another study found an association between cannabis use disorder and nonmedical use of prescription stimulants for studying, reduced class attendance and declining academic performance.[19] Along with lower educational attainment, research on employed individuals has found consistent associations between cannabis use and reduced workplace productivity.[20] Many of these studies await replication. However, collectively, these data are sufficient to suggest that children, pregnant women, and youth with still-developing brains should not use cannabis or cannabinoids due to a variety of neuropsychiatric health effects and impacts on cognitive functioning.

Cannabis is most commonly consumed through smoking, a route of drug delivery that predictably has a variety of negative effects on pulmonary function. Smoke from marijuana combustion has been shown to contain a number of carcinogens and cocarcinogens,[21] as well as many of the toxins, irritants, and carcinogens as tobacco smoke.[22] Additionally, marijuana smokers tend to inhale more deeply and hold their breath longer than cigarette smokers, which

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[b] *Marijuana dependence* is defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* as increased tolerance, compulsive use, impaired control, and continued use despite physical and psychological problems caused or exacerbated by use.

[c] *Marijuana abuse* is defined in *DSM-IV* as repeated instances of use under hazardous conditions; repeated, clinically meaningful impairment in social/occupational/educational functioning, or legal problems related to marijuana use.

leads to a greater exposure per breath to "tar" (the carcinogenic solids in smoke).[23] Regular smoking of marijuana, in the absence of tobacco, produces visible and microscopic injury to the large airways.[24]

Short-term exposure to marijuana smoking is associated with bronchodilation, while long-term marijuana smoking is associated with increased respiratory symptoms suggestive of obstructive lung disease.[25] Yet, there is no clear link between marijuana smoking and obstructive pulmonary disease,[26] such as bronchitis and emphysema, and there is no conclusive evidence of marijuana smoking-induced lower respiratory tract infection.[27] Whereas evidence is mixed concerning possible carcinogenic risks of heavy, long-term marijuana smoking,[28] epidemiological findings to date do not suggest an increased risk for the development of either lung or upper airway cancer from light or moderate use. In fact, the findings of one study that had reported increased rates of lung, upper respiratory and digestive tract cancers in users who smoked the equivalent of no more than one joint or one pipeful of hashish per day were found to be not valid once cigarette smoking and other confounders were taken into account.[29]

An increasingly popular route of administration for THC has been the incorporation of marijuana into edible products, including baked goods, candies and marijuana-infused beverages, which are readily available at retail outlets in states that have legalized cannabis use. For example, in Colorado, marijuana-infused edibles account for 45% of the legal marijuana marketplace.[30] Given their appearance and current trends in packaging and product names, edibles are often particularly attractive to young adults and even children. The absence of any quality control, consumer labeling, or predictability in dosing in edibles has led to appropriate cautionary commentaries and calls for action to protect the public health.[31] The THC content of such products has a wide range, and a given edible can contain several individual doses-worth of THC. Importantly, research has found these products are not consistently labeled; in one study, of 75 products purchased, only 17% were accurately labeled.[32] In part because consumers may be unaware of the THC content in edibles, hospital emergency departments are treating more children and adults who develop paranoia, anxiety and/or psychosis following intentional or accidental ingestion of marijuana edibles.[33,34]

There are several potential medical and public health consequences of marijuana use that require further research. Still under investigation is the potential depressive effect of THC on the immune system.[35] More research is also needed on the impact of cannabis use on driving, motor vehicle collisions, and traffic injuries and fatalities. Evidence shows that marijuana use impairs cognitive function, reaction times, divided-attention tasks, and lane tracking,[36] all of which impact driving ability. A recent National Highway Transportation Safety Administration study found no significant increase in crash risk associated with the presence of marijuana when controlling for age, gender, ethnicity and alcohol use.[37] However, several other studies have reported increased crash and culpability risks, even after adjusting for such confounders as age, sex, risky behaviors, and polypharmacy.[37] Finally, it is worth noting the observed drop in opioid overdose death rates in states where marijuana use is legal for medicinal purposes. One study found that states with "medical marijuana" laws had a 24.8 percent lower average annual opioid overdose death rate compared to states without similar laws.[38] According to the study, in 2010 alone, that translated to about 1,729 fewer deaths than expected.

Marijuana contains at least 85 distinct cannabinoids,[39] several of which are being investigated for their potential therapeutic value. To date, the FDA has approved two pharmaceutical products for human use which contain active ingredients that are present or similar to those present in botanical marijuana: Marinol® and Cesamet®. Marinol®, a Schedule III drug whose active ingredient is a synthetic version of THC, is approved for the treatment of chemotherapy-

induced nausea and vomiting as well as anorexia associated with AIDS and increased intraocular pressure in cases of glaucoma.[40] Cesamet®, a Schedule II drug, contains the synthetic cannabinoid nabilone and is approved for the treatment of nausea and vomiting associated with chemotherapy.[41] Other cannabis-derived or cannabis-like drugs are being developed and have been approved for use in other countries. One example is Sativex®, a fast-acting non-synthetic oral-mucosal cannabinoid spray containing 50% THC and 50% cannabidiol, which is available in Canada, New Zealand, the United Kingdom, and several European countries to treat spasticity in multiple sclerosis (MS).[42] Cannabidiol (CBD), a non-psychoactive cannabinoid, is one of the main known active ingredients in marijuana besides THC that may have desirable medicinal effects.[43] CBD has been shown to have antipsychotic effects,[44] as well as anticonvulsant, neuroprotective and anti-inflammatory effects.[45] The medical literature contains only small and methodologically limited studies of CBD in human epilepsy, the results of which have been inconclusive; there is a clear need for further investigation into its potential in epilepsy and other neuropsychiatric disorders.[46] Pharmaceutical grade cannabidiol is being investigated, along with genetically modified strains of botanical marijuana which contain almost exclusively cannabidiol and essentially no THC,[47] and regulatory reform to facilitate research into the potential efficacy and safety of cannabidiol for possible medical uses has been proposed.[48] To date, 15 states have legalized limited access to marijuana products with low THC/high CBD content for medicinal purposes,[49] sometimes in response to reports in the popular media of benefits for neuropsychiatric conditions that are not yet substantiated by well-designed medical research studies.

Herbal marijuana is also increasingly sought out for its purported medicinal effects. However, unlike the above-mentioned regulated pharmaceuticals, which have been tested for safety and efficacy, the potency, purity, and effective does of herbal marijuana and cannabis-infused edible products are unknown. A recent review of cannabinoids for medical use has called into question the efficacy of these types of products, finding only moderate-quality evidence to support the use of cannabinoids for the treatment of chronic pain and spasticity, and only low-quality evidence suggesting cannabinoids were associated with improvements in chemotherapy-related nausea and vomiting, weight gain in HIV, sleep disorders and Tourette syndrome.[50] The review also confirmed cannabinoids were associated with an increased risk of short-term adverse events. Given the uncertain evidence to support the safety and efficacy of cannabis and cannabinoid-products in the treatment of medical conditions, ASAM and a number of other professional medical societies have advised that all cannabis-based medicinal products, like all other medicinal products, should be approved by FDA. And given the current state of medical evidence, the American Medical Association has gone so far as to advise that marijuana and cannabis-containing products such as edibles should be required to be labeled with the statement: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."[51]

These various responses of professional and research entities to expanding knowledge of the health and public health aspects of marijuana and other cannabinoid use, and to the need for expanded knowledge via increased research, have developed in a larger sociological and political context in which approximately half of Americans support legalization. ASAM recognizes that an important factor in the changes in public attitudes about legalization, as well as philosophical positions held by physicians on such matters, is the perception that the current drug control policy which emphasizes criminalization ("The War on Drugs") hasn't been effective, has expanded incarceration in our nation in non-salutary ways, and is biased against minority citizens. There are indeed public health aspects of criminalization, but these are beyond the scope of this policy statement.

One of the suggested solutions to the problems of criminalization is legalization. In its extreme, legalization includes legal commercialization, with for-profit entities manufacturing, distributing, marketing, and wholesaling cannabis and psychoactive cannabis products for retail sale. The image of major corporations entering "the business" of marijuana is disturbing in its similarity to the presence of major corporations in the promotion and sale of tobacco products. Quite different from a policy of legalization is a policy of decriminalization, in which possession and personal use of cannabis and cannabis products is not tied to criminal penalties. One version of decriminalization has criminal penalties for possession and personal use reduced to lesser offenses such as misdemeanors; but this still results in those convicted of possession having criminal records which can lead to lifelong discrimination against them. Another version of decriminalization would reduce penalties for possession and use to civil offenses only (non-criminal citations, "tickets," or fines), which could be linked to contingencies that would promote public health, such as mandatory clinical assessments, health education related to substance use and substance use disorders, and referral to addiction treatment when indicated. Common models of decriminalization retain criminal penalties for distribution or importation. The nation of Portugal has drawn attention for its drug policy reforms which strive to emphasize public health, including early identification of cases of addiction and referral to clinical interventions in lieu of criminal sanctions. Comparable models for drug policy reform can mandate follow-through with required clinical assessments and escalating civil penalties for individuals who fail to comply with medical recommendations or who become habitual offenders of civil regulations addressing cannabis possession and use. ASAM's intention in developing the current policy statement is to assist health care professionals and the general public, as well as policy makers and the media, to better appreciate current evidence about the biology and health aspects of the use of cannabis, cannabis products, and synthetic cannabinoids. The overall response of American society to cannabis use is undeniably relevant to the medical and public health communities as they address the health aspects of human use of such products.

In light of the evolving legal landscape surrounding cannabis in the United States, which is giving rise to increased availability and use of cannabis and cannabis products, ASAM's viewpoint is that it is imperative that Americans promote and adopt public policies that protect public health and safety as well as protect the integrity of our nation's pharmaceutical approval process, which is grounded in well-designed and executed clinical research. Currently, the legalization of cannabis in some states but not others provides a unique opportunity for a thorough investigation into the societal and public health impact of broader cannabis use. Such research is critical to inform other jurisdictions in how they can best protect and promote public health as they consider the legal status of marijuana use.

Recommendations:

A. Policy Recommendations

1. **ASAM supports the "decriminalization" of marijuana**, which would reduce penalties for marijuana possession for personal use to civil offenses linked to contingencies, such as mandated referral to clinical assessment, educational activities, and, when indicated, formal treatment for addiction or other substance-related disorders.
2. **ASAM does not support the legalization of marijuana and recommends that jurisdictions that have not acted to legalize marijuana be most cautious** and

not adopt a policy of legalization until more can be learned from the "natural experiments" now underway in jurisdictions that have legalized marijuana.

3. **ASAM recommends that jurisdictions that have already legalized marijuana or that may act to legalize it in the future implement the following public health and safety measures to minimize potential harms to vulnerable populations.** ASAM encourages addiction medicine physicians to champion the implementation of these safeguards in all jurisdictions where marijuana has been legalized or may be legalized in the future.
    a. Prohibit the legal sale of marijuana products to anyone younger than 25 years of age.
    b. Prohibit marketing and advertising to youth, akin to the current restrictions on tobacco product advertising.
    c. Require that products made available for retail sale be tested for potency and clearly labeled with THC content.
    d. Require rotating warning labels to be placed on all marijuana and marijuana products not approved by the U.S. Food and Drug Administration (FDA) which are offered for sale in retail outlets, stating, "Marijuana use increases the risk of serious problems with mental and physical health, including addiction," or "Marijuana should not be used by pregnant women or persons under age 25," or "Marijuana should not be used by persons prior to operating motor vehicles and heavy machinery."
    e. Require that marijuana products (such as edibles and beverages) be sold only in child-proof packaging and be accompanied by the mandatory distribution of educational flyers regarding the risks of overdose and poisoning in cases of accidental ingestion by children or household pets.
    f. Earmark taxes placed on marijuana and marijuana product sales, wholesale or retail, such that a majority of tax revenues are required to be devoted to public education about addiction, prevention of addiction, health effects of cannabis and synthetic cannabinoid use, prevention of initiation of cannabis and cannabinoid use by youth, addiction treatment, or research on the health risks and potential benefits of marijuana, "natural" cannabinoids, and synthetic cannabinoids.
    g. Limit marijuana and marijuana product sales to state-operated outlets, akin to Alcohol Beverage Control regulations existing in several states and Canadian provinces, which preserve both public access and the potential for governmental revenues linked to sales, while limiting the broad commercialization of public sale of potentially harmful but brain-rewarding products.
    h. Implement public awareness campaigns which highlight the risks of marijuana use to discourage vulnerable populations, including youth (i.e., adolescents and young adults), individuals with mental illness, and those with a history of addiction involving alcohol or other drugs, from using marijuana products.

4. **ASAM supports the use of cannabinoids and cannabis for medicinal purposes only when governed by appropriate safety and monitoring regulations, such as those established by the FDA research and post-marketing surveillance processes.**
    a. ASAM supports the medicinal use of pharmaceuticals that contain cannabinoids that have gone through the FDA-approval process.
    b. ASAM asserts that cannabis, cannabis-based products, and cannabis delivery devices should be subject to the same safety and efficacy standards that are applicable to other prescription medications and medical devices.[52] Such products should not be distributed or otherwise provided to patients unless and until they have received marketing approval from the FDA.
    c. In general, any product purported to be medicine should have the appearance of medicine, such as a pill, capsule or wafer, and should not appear to be candy or food.
    d. Physicians who recommend marijuana use to patients should do so within the context of a patient-physician relationship that includes the creation of a medical record, and follow-up visits to assess the results of physician-recommended clinical interventions so that treatment plans can be amended, as indicated.
    e. ASAM rejects smoking as a means of drug delivery.
5. **ASAM does not support the legalization of synthetic cannabinoid receptor agonists.** ASAM supports the establishment of legal controls on the manufacture and sale of synthetic cannabinoid receptor agonist compounds within the framework of controlled substances laws for other highly addictive compounds.

B. Clinical Recommendations

1. **ASAM recommends that addiction medicine physicians and other clinicians educate their patients about the known medical risks of marijuana use,** including the use of and accidental exposure to edible products, and the risks of use of synthetic cannabinoid receptor agonists.
2. **ASAM recommends a significant expansion of opportunities for youth with cannabis use disorder to receive medically necessary treatment** as well as for youth to receive appropriate clinical preventive services related to cannabis use, and that private and public insurance coverage be available for youth to be able to access such services.
3. **ASAM supports the consensus of most addiction professionals that clinicians should counsel persons suffering from addiction about the need for abstinence from marijuana and synthetic cannabinoids and the role of cannabis and cannabinoid use in precipitating relapse,** even if the original drug involved in their addiction is a substance other than marijuana.

4. **ASAM supports the expanded establishment of clinical entities such as Student Assistance Programs in middle schools, high schools, and post-secondary schools, including professional schools,** which offer health promotion approaches and support services to persons, especially youth, who have been identified as having cannabis or cannabinoid use disorder or other unhealthy use of such substances.
5. **ASAM recommends that medical professional societies educate the public, the media, and public policy makers that there is no such thing as a legal "prescription" for marijuana and that laws enacted to date provide for physicians to authorize "permits" for use and possession and nothing more.**

C. Professionalism Recommendations

1. **ASAM asserts that in states where physicians are placed in the gate-keeping role of authorizing marijuana use permits, professional licensure authorities should take steps to ensure that physicians who choose to discuss the medical use of cannabis and cannabis-based products with patients:**
    a. Are able to have good-faith discussions with patients without conversations on such topics between clinicians and patients being considered illegal or unprofessional acts.
    b. Adhere to the established professional tenets of proper patient care, including
        i. History-taking and good faith examination of the patient;
        ii. Development of a treatment plan with clinical objectives;
        iii. Provision of informed consent, including discussion of potential adverse drug effects from use;
        iv. Periodic review of the treatment's efficacy;
        v. Consultation, as necessary, with other clinical colleagues; and
        vi. Proper record keeping that supports the clinical decision to recommend the use of cannabis.
    c. Have a *bona fide* patient-physician relationship with the patient, i.e., should establish an ongoing relationship with the patient as a treating physician when there is not a pre-existing relationship, and should offer recommendations regarding the use of marijuana within the context of other indicated treatment for the patient's condition; they should not offer themselves to the public as solely a permit-authorizing individual;
    d. Ensure that the issuance of "recommendations" is not a disproportionately large aspect of their practice;
    e. Have adequate training in identifying addiction and unhealthy substance use.

D. Research Recommendations

1. **ASAM supports research on marijuana, the various cannabinoids present in marijuana, and synthetic cannabinoid agonists and**

antagonists, including both basic science and applied clinical studies, as well as the development of pharmaceutical-grade cannabinoids. The mechanisms of action of marijuana and its constituent compounds, its effect on the human body, its addictive properties, and any appropriate medical applications should be investigated, and the results made known for clinical and policy applications. Research should be expanded on functional impairments associated with use of cannabis and related substances including effects on driving, how to distinguish impaired driving due to cannabinoids from impaired driving due to other factors, and effects on educational and occupational performance.

   a. Research should receive increased funding and appropriate access to marijuana for study.
      i. ASAM recognizes that research into the medical benefits of marijuana is not within the remit of the National Institute on Drug Abuse (NIDA) and encourages other NIH institutes to sponsor additional research on the potential medicinal properties of cannabis and cannabinoids related to specific disease states.
      ii. ASAM supports the expansion of NIH-approved research sites to grow different strains of marijuana with varying composition and concentration of specific cannabinoids. Thus, ASAM believes NIH should be able to grant multiple contracts to grow marijuana for research purposes.

2. **ASAM recommends that the federal and state governments establish robust health surveillance related to marijuana use.** The data should be made available to public health and health policy researchers to understand the public health impact of marijuana use as well as the relative effectiveness of different policy levers to discourage use among vulnerable populations, especially adolescents and young adults, persons with mental illness, and persons with pre-existing substance use disorders.

Adopted by the ASAM Board of Directors September 21, 2015.

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Dear Honorable Assembly members,

My name is Sanjay Chaudhari and I am a NJ medical cannabis (marijuana) patient in addition to being a Rutgers certified master gardener, environmentalist, economist, founder and horticultural consultant at Sweet Virginia Soil llc and the founder of the Cannabis Wars Alliance. I am very much in support of the ballot initiative to legalize cannabis in New Jersey and starting to end the damage caused to our society and citizens by the 82+ years of the failed Cannabis Wars in New Jersey and America. The Cannabis Wars Alliance is working to end cannabis prohibition and identify the politicians that are opposed to ending cannabis prohibition. We are actively working to see that they are not re-elected because New Jersey doesn't not need any more antiquated relics of the past in office that have lost touch with the needs of their constituents and the people of New Jersey and America.

The Cannabis Wars Alliance and Sweet Virginia Soil llc held a #MarchForHomeGrow November 25, 2019 that was well attended by over 100+ patients and supporters. Many could not attend because of work, physical limitations, and the stigmas that still exist to be a supporter or even patient of this plant, but they will be voting during the next election cycle. We will vote for those that support ending prohibition and those that support patients being allowed the Dignity to grow and explore their own cannabis medicine.

We recently met with the Governor's office about supporting a stand-alone patient home grow bill and they are prepared to work with any assemblyman's office and senators' office to get this important piece of legislation primed. I would implore a passionate legislator to work with us to prime this bill and return the dignity of home grow that CUMMA patients should have had in 2009.

Every citizen can brew 200 gallons of beer per year in America and New Jersey. We need laws to be consistent and if we can all brew a life destroying intoxicant then we must all be able to grow a lifesaving plant organically as well.

Over 30 million citizens have been negatively impacted by cannabis prohibition in America. This is another American tragedy and civil war that you have the ability to help end in New Jersey.

Currently there are only six corporations that are allowed to cultivate and none of them are producing cannabis organically. Patients are forced to buy inferior cannabis medicine that is chemically produced and that pollutes our environment and protected watersheds. Legalization must not continue in this exploitative manner as CUMMA has existed.

Legalization must not be about corporatization and profitization. It must be about correcting a mistake that should not have happened and acknowledging that the government has been wrong and negligent and liable for over 8 decades of destruction of primarily minority, urban communities.

Every human has an endocannabinoid system and cannabis prohibition has been infringing on our human rights to access a substance that our bodies have been designed to intake and needs to heal itself. It is not the role of our government to be a healthcare cartel nor should it ever be.

If any legislator would like to work with the Cannabis Wars Alliance to prime a stand-alone patient home grow bill please have your aides email me: Sanjay@SweetVirginiaSoil.com sanjayrchaudhari@yahoo.com . We have the support of some of the vary program doctors for patients to be able to home grow.

Our goal is to have a stand-alone CUMMA patient home grow bill passed before the ballot initiative vote on election day. Over 10,000 patients have died since the inception of CUMMA. Most died struggling to afford adequate cannabis medicine. Many died without the strains that would have served their medical needs the best as the stores grow that which is most profitable and not necessarily what is the best medicine. Many died struggling to pay their mortgage and have enough cannabis to die with dignity. Many died waiting for our legislators to finally care about them and their needs. I have many friends that are dying right now, waiting for their dignity to grow and explore the 5,000+ varieties of cannabis that may help them live life more beautifully in their final days.

As legislators you cannot change your inaction of the past but you can control your voting moving forward and what bills you prime and support. Life is hard. Life is sad and often ugly. Life is fragile and too often ended in New Jersey and America by the pill and by the gun. Let those on the brink of homicide put down their guns and pick up a joint. Let us live more beautifully while we are privileged to walk the earth. Let us walk with less pain and sorrow. Let us walk with our children. Let us walk with God and the flower of the plant she put on Earth to heal us and help us to love each other again. Please, let us grow weed.

44x