

APPENDIX

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

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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.



December 6, 2019

**Testimony in Support of SCR 183:
Proposes constitutional amendment to legalize cannabis for personal, non-medical use by adults
who are age 21 years or older, subject to regulation by Cannabis Regulatory Commission**

Dear Chair Poe, Vice Chair Cryan, and members of the committee:

For eight decades, New Jerseyans have been subject to traumatic arrests and incarceration and marked with a scarlet letter for cannabis — a substance that is far safer than alcohol.¹ Those who sell and buy cannabis are at risk on the illicit market, where both parties are vulnerable to violence, and the cannabis is untested and unregulated. We are grateful to Senate President Steve Sweeney, Assembly Speaker Craig Coughlin, the bill sponsors, and the governor for their efforts to chart a more sensible and humane path forward.

The Marijuana Policy Project (MPP) supports ending cannabis prohibition in a way that repairs the damage inflicted by criminalization. That includes expungement, provisions to ensure diversity and social equity in the industry, and reinvestment in communities hard-hit by the war on cannabis. We were disappointed to learn the Senate did not have the votes to enact a comprehensive adult-use cannabis legalization bill. In light of that reality, we now view approval of SCR 183 as an essential piece of the puzzle to dismantling cannabis prohibition in New Jersey and replacing it with a comprehensive, just system of taxation and regulation.

While MPP strongly supports legalizing and regulating cannabis for adults 21 and older, voting “yes” on SCR183 requires only that lawmakers agree that New Jersey voters should be allowed to make this decision. If voters decide to move forward with legalization, the legislature would set the parameters for a regulatory structure, and the Cannabis Regulatory Commission (or its successor) would be charged with licensing and regulating the industry.

I. Cannabis prohibition has failed.

One does not have to support cannabis use to recognize that prohibition has not worked. Like the “noble experiment” of alcohol prohibition before it, cannabis prohibition has failed — and it has caused tremendous amounts of suffering.

Despite the vast sums spent on more than 35,000 cannabis arrests in New Jersey every year,² prohibition hasn’t stopped adults or youth from accessing it. Cannabis remains readily available in New Jersey and across the United States. Whereas cannabis use was relatively rare when it was first

¹ Cannabis is far less toxic, less addictive, and less harmful to the body than alcohol. For more details and citations, see www.mpp.org/marijuana-is-safer/.

² Tom Kertscher, “More arrests in the US for marijuana possession than violent crimes, 2020 hopeful Cory Booker says,” *PolitiFact*, July 11, 2019. (PolitiFact ranked the comment “true.” In 2017, the FBI’s Uniform Crime Reports reported 599,282 arrests made for possession of marijuana and 518,617 arrests for violent crimes.)

essentially prohibited nationwide in 1937,³ after decades of prohibition, about half of Americans — including Presidents Bill Clinton, George W. Bush, and Barack Obama — acknowledge having used it.⁴ In New Jersey, more than 12% of adults admit having used cannabis in the past year.⁵

Prohibition has also spectacularly failed our youth. Prior to any state legalizing adult-use cannabis sales, 40% of American high schoolers reported they had a peer who sold cannabis at school, compared with less than 1% who knew a peer selling alcohol in school.⁶ This is probably because unlike licensed liquor stores, drug dealers do not check ID. Regulating cannabis moves sales into safe, licensed retail stores where the only people selling or buying cannabis are adults, not schoolchildren.

Criminalizing the production and distribution of cannabis only serves to enrich and empower the criminal organizations controlling this lucrative underground market. Prohibition also ensures cannabis products are untested, increasing the risk of contamination with illicit pesticides, heavy metals, dangerous molds, hazardous thickening agents, or even other drugs. Only with legalization and regulation can the government control where, when, and to whom cannabis is sold. Only with legalization and regulation can the government ensure testing and labeling.

II. The War on Drugs has racist roots, and prohibition continues to be unequally enforced.

In 1971, President Richard Nixon launched the War on Drugs, which a top advisor later explained was motivated by Nixon's desire for a pretext enabling the government to harass and arrest black Americans and anti-Vietnam War activists.⁷

To this day, the enforcement of cannabis laws continues to be staggeringly unequal. The ACLU-NJ recently reviewed government data and found African Americans are three times as likely to be arrested for cannabis possession as their white counterparts in New Jersey despite using cannabis at similar rates.⁸ As a result of this disparity, African Americans are far more likely to be plagued with an arrest record and conviction for cannabis, which makes it harder to get jobs, housing, an education, professional licensing, and other opportunities.⁹

³ At the dawn of prohibition, Harry Anslinger reportedly said there were 100,000 total marijuana smokers in the U.S. Today, according to the National Survey on Drug Use and Health, about 22 million Americans admit to having used cannabis in the past month. See www.drugabuse.gov/publications/research-reports/marijuana/what-scope-marijuana-use-in-united-states.

⁴ Mary Emily O'Hara, "New Poll Finds Majority of Americans Have Smoked Marijuana," *NBC News*, April 17, 2017; Brendan Bures, "Here are 11 U.S. Presidents who smoked marijuana," *NY Daily News*, May 16, 2017.

⁵ National Survey on Drug Use and Health, "Table 72 – Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in New Jersey, by Age Group: Percentages, Annual Averages Based," February 5, 2019. See <https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables>

⁶ Columbia University, National Center on Addiction and Substance Abuse Survey, 2012.

⁷ Dan Baum, "Legalize It All," *Harper's Magazine*, April 2016. (Quoting top Nixon aide John Ehrlichman, "The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.")

⁸ "ACLU-NJ marijuana data brief finds cannabis arrests have skyrocketed since earlier report," ACLU-NJ, November 15, 2019. See <https://www.aclu-nj.org/news/2019/11/15/aclu-nj-marijuana-data-brief-finds-cannabis-arrests-have-sky>

⁹ Rebecca Vallas, "Should a Criminal Record Be a Life Sentence to Poverty?," *The Nation*, March 11, 2015. (Nearly nine in 10 employers and four in five landlords conduct background checks.) See also, the American Bar Associations' National Inventory of the Collateral Consequences of Conviction, www.americanbar.org/groups/criminal_justice/nicccf (cataloging over 45,000 federal and state statutes and regulations that impose collateral consequences on persons convicted of crimes.)

Around 99% percent of all cannabis arrests are at the state and local levels, so New Jersey enacting legalization dramatically reduces the risk of a cannabis arrest.¹⁰ Moreover, since 2013, the federal government's policy has been to not to target those complying with state cannabis regulation laws, unless a particular area of federal concern is implicated — such as sales to children or diversion to states where marijuana is illegal.¹¹

Unsurprisingly, legalizing cannabis has significantly reduced the number of searches and arrests for cannabis in those states among people of all races.

Data analyzed by the Stanford Open Policing Project found in the first two legalization states — Colorado and Washington — there have been dramatic decreases in traffic searches, which are disproportionately performed on cars with black or Latino drivers.¹² Traffic stop interactions have led to violence and even death for black Americans.¹³ The data compiled by Stanford researchers shows searches dropped by about half in Washington and Colorado since legalization. Racial disparities have decreased, but have not been eliminated.

Meanwhile, a comprehensive report issued by the Colorado Division of Criminal Justice in October 2018 found that since legalization, the “number of marijuana arrests decreased by 56% for Whites, 39% for Hispanics, and 51% for Blacks.”¹⁴ However, racial disparities remain. “The marijuana arrest rate for Blacks (233 per 100,000) was nearly double that of Whites (118 per 100,000) in 2017.”

Washington State has also seen a striking reduction in the total number of cannabis arrests and in the number of arrests of black individuals for cannabis. Before legalization, there were nine cannabis arrests per 100,000 Washington residents every year.¹⁵ That number approached zero per 100,000 residents by 2015. Unfortunately, as of 2015, Washington had seen an increase in the relative

¹⁰ Tom Angell, “Trump Administration Makes It Harder To Track Marijuana Arrests (But I Did It Anyway),” *Forbes*, September 25, 2017 (reporting on FBI Uniform Crime Reports data showing 653,249 marijuana arrests in 2016); Mark Motivans, “Federal Justice Statistics, 2015-2016,” U.S. Department of Justice, January 2019 (showing just over 4,000 marijuana arrests by the Drug Enforcement Administration in 2016); *See also* FBI Uniform Crime Reports 2003 (U.S. Government Printing Office), p. 269, Table 4.1 and p. 270, Table 29 (showing 755,186 marijuana arrests nationwide in 2002) and Compendium of Federal Justice Statistics (Bureau of Justice Statistics) p. 13, Figure 1.1 (showing 8,299 arrests for federal marijuana offenses in the 12-month period ending on September 30, 2003, which is 1.09% of the total figure).

¹¹ James Cole, “Memorandum for all United States Attorneys,” U.S. Department of Justice, August 29, 2013. *See* <https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>. On January 4, 2018, then-U.S. Attorney General Jeff Sessions rescinded the Cole memo, but in practice we are unaware of any prosecutions that ran counter to it. As part of his confirmation process, current U.S. Attorney General Bob Barr wrote to Sen. Cory Booker, “I’m not going to go after companies that rely on the Cole Memorandum.” Justice Department practice has been consistent with that pledge. Jacqueline Thomsen, “Barr: I wouldn’t go after businesses relying on Obama-era marijuana policy,” *The Hill*, January 15, 2019. *See* <https://thehill.com/homenews/senate/425466-barr-i-wouldnt-go-after-businesses-relying-on-obama-era-marijuana-policy>

¹² Phillip Smith, “States that legalized marijuana see dramatic drop in police traffic searches,” *Alternet*, April 1, 2019. (Before legalization 1.3% of black drivers were subject to traffic searches in Colorado. After legalization, the rate was under 0.2%. Among Hispanic drivers, the rate dropped from 1% to 0.1%. Among whites, the rate of searches dropped from 0.4% to 0.1%. Thus, black drivers went from being 6.5 times as likely to be searched as whites to twice as likely, and the total likelihood of black drivers being subject to a traffic search dropped eightfold.)

¹³ Tanvi Misra, “Uncovering Disparities In Policing By Analyzing Traffic Stop Data,” *Pacific Standard*, June 7, 2018.

¹⁴ “Impacts of Marijuana Legalization in Colorado: A Report Pursuant to Senate Bill 13-283,” Colorado Department of Criminal Justice, October 2018, p. 1.

¹⁵ Caislin Firth, et al., “Did marijuana legalization in Washington State reduce racial disparities in adult marijuana arrests?,” *Substance Use and Misuse*, May 2019.

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disparities, however. There also continued to be a significant number of arrests for illegal sales. Washington's legal market was brand new at the time, with a limited supply and a number of stores that first opened in July 2014. Legal sales have increased considerably since then and largely replaced the illicit market.

While legalization has significantly reduced the number of cannabis-related searches and arrests, it has not dropped the number to zero. For example, public smoking and growing or storing large amounts of cannabis (typically to transport it to a prohibition state) remain illegal. Racial inequalities are almost uniformly present in criminal justice enforcement in the U.S., and that is unfortunately also the case with the remaining cannabis offenses post-legalization. MPP urges the legislature to impose civil — not criminal — penalties for minor offenses such as public smoking, so that individuals will not face traumatic and disruptive arrests or life-altering criminal records for those offenses, and we also support efforts to reduce racial disparities in policing.

While legalization has not eliminated disparities and arrests, it is important not to lose sight of the fact the total number of people — and the total number of African Americans — arrested for cannabis has plummeted in states that have legalized it. This means thousands of people no longer face the trauma of arrests or having their opportunities for housing, education, and employment derailed. It also saves many from deportation: more than 6,000 individuals are deported per year for cases where their most serious offense was cannabis possession,¹⁶ including many who were legally in the country and have established deep roots.¹⁷

III. A path to a better solution — regulation — has been forged by 10 states.

As it became increasingly obvious prohibition was not working and was plagued by inequality, states began to choose a more sensible approach — taxing and regulating cannabis similarly to alcohol.

Colorado and Washington voters led the way in November 2012. Since then, Alaska, Oregon, California, Maine, Massachusetts, Nevada, Michigan, and Illinois followed suit, bringing the total number of states that have replaced cannabis prohibition with regulation to 10. Meanwhile, Vermont and Washington, D.C. legalized adult possession and cultivation of cannabis, but they have not yet regulated cannabis sales. (In D.C.'s case, this is due to Congress' Harris Rider prohibiting it from spending funds to do so. In Vermont's case, the Senate has approved legalizing and regulating adult-use cannabis sales, and the House will take the bill up when they reconvene in early 2020.)

As Gov. Jay Inslee and Attorney General Bob Ferguson of Washington State explained:

Our state's efforts to regulate the sale of marijuana are succeeding. A few years ago, the illegal trafficking of marijuana lined the pockets of criminals everywhere. Now, in our state, illegal trafficking activity is being displaced by a closely regulated marijuana industry that pays hundreds of millions of dollars in taxes. This frees up significant law enforcement resources to protect our

¹⁶ "Secure Communities and ICE Deportation: A Failed Program?," TRAC Immigration, Syracuse University (finding 6,770 ICE deportations in FY 2013 where the most serious offense was marijuana possession and 6,447 in FY 2012).

¹⁷ *Prado v. Barr*, No. 17-72914, (9th Cir. 2019) (ruled against a woman who had lived in the U.S. since she was six months old and became a lawful permanent resident in 1980; she had a felony marijuana charge prior to legalization in California); Matt Sintsing, "Disabled veteran's husband at risk for deportation over years old marijuana charges," Radio.com, December 13, 2018 (green card holder facing deportation for simple possession of cannabis convictions).

communities in other, more pressing ways.¹⁸

In Colorado, more than \$250 million in adult-use cannabis tax revenue was collected in 2018,¹⁹ and the state has issued over 40,000 active licenses to individuals to work directly in the cannabis industry.²⁰ Meanwhile, Washington State brought in more than \$434 million in cannabis tax revenue in 2018.²¹

Cannabis tax revenue has been used to fund numerous programs improving the lives and health of the states' residents. Colorado devotes much of its cannabis tax revenue to school construction. Meanwhile, in 2018, Washington used \$262 million of its cannabis tax revenue to help pay for its share of Medicaid, which insures nearly 1.8 million low-income Washington residents. It also allocated more than \$5 million in a biennium to provide beds for youth residential treatment services and address substance use disorders.²²

IV. Legalizing and regulating cannabis replaces the illicit market with a controlled system.

More than 540,000 New Jerseyans use cannabis at least once per month.²³ Allowing legal businesses to meet that demand eliminates the vast majority of illicit market sales²⁴ and leads to safer outcomes for communities and consumers. In the underground market, both parties are vulnerable to armed robbery, and disputes cannot be solved in the courts.²⁵ In jurisdictions with prohibition, violence is sometimes employed to gain market share, further increasing the dangers.²⁶

Replacing prohibition with legalization, taxation, and sensible regulation is also far better for workers. In the underground market, workers are vulnerable to exploitation, and they risk felony convictions and prison time.²⁷ A regulated market offers important protections to workers, from health and safety

¹⁸ February 15, 2017, Letter from Gov. Inslee and AG Ferguson to U.S. Attorney General Jeff Sessions, *available at* <https://www.documentcloud.org/documents/3474339-Gov-AG-Ltr-to-Sessions-Re-Marijuana-002.html>.

¹⁹ <https://www.colorado.gov/pacific/revenue/colorado-marijuana-tax-data>

²⁰ <https://www.colorado.gov/pacific/enforcement/med-resources-and-statistics> (as of July 1, 2019)

²¹ Monthly excise tax data: <https://www.502data.com/>

Monthly sales tax data: <https://dor.wa.gov/about/statistics-reports/recreational-and-medical-marijuana-taxes>

²² Jake Whittenberg, "Where does Washington's marijuana tax money go?," *King 5 News*, August 8, 2018.

²³ See "2016-2017 National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands); Table 3 Marijuana Use in the Past Month, by Age Group and State: Estimated Numbers (in Thousands), Annual Averages," *National Survey on Drug Use and Health*. See <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeTotal2017A/NSDUHsaeTotals2017.pdf>. This is based on federal survey data, which relies on respondents admitting to something that is illegal. Thus, it is almost surely underreported.

²⁴ "Market Size Demand for Marijuana in Colorado Market 2017," Colorado Marijuana Enforcement Division, August 2018. ("Colorado's preexisting illicit marijuana market for residents and visitors has been fully absorbed into the regulated market.") However, as long as some states prohibit cannabis, that demand will fuel illicit production and sales. In addition, a variety of policy choices in states that legalize influences how swiftly and completely sales transition to a legal market. For a quicker and more complete transition, regulators should expeditiously license enough businesses of all types to meet demand. Unduly onerous regulations and excessive taxes should be avoided to ensure illicit market cannabis is not cheaper. To avoid large pockets of prohibition, states should allow delivery statewide and incentivize localities to allow sales.

²⁵ See "Keansburg man found guilty of murder in marijuana robbery," *New Jersey 101.5*, October 23, 2019; Kathleen Hopkins, "Keypot pot deal murder: 'I didn't mean for any of this to happen' defendant says," *Asbury Park Press*, October 17, 2019; "NJ man, 22, joins girlfriend in prison for killing weed dealer," *New Jersey 101.5*, April 4, 2019; "Family of police informant who was murdered, dismembered agrees to \$1M settlement," *WJBK*, October 4, 2017.

²⁶ See Dan Werb, et al., "Effect of drug law enforcement on drug market violence: A systematic review," *International Journal of Drug Policy*, March 2011.

²⁷ See Shoshana Walter, "In secretive marijuana industry, whispers of abuse and trafficking," *The Center for Investigative Reporting*, September 8, 2016.

regulations to unemployment insurance and social security and all the advantages of working in a legal industry instead of the sometimes-dangerous criminal market.

Finally, prohibition guarantees cannabis won't undergo quality control testing, resulting in possible contamination by pesticides, fertilizers, molds, bacteria, or the lacing of cannabis with other drugs, unnecessarily putting consumers at risk. A regulatory system can include requirements for testing to ensure quality control, including by ensuring cannabis and cannabis-infused products are accurately labeled for potency.

The recent incidences of severe lung ailments related to vaping underscores the need for effective public health regulations — regulations which are only possible in the context of legalization. As of mid-October, Colorado, a legalization state, had seen only nine reported illnesses and no reports of fatalities. Meanwhile in neighboring, less populous Utah — where marijuana is not legal — there were over eight times the illnesses Colorado had, with 76 reported illnesses and one fatality.²⁸ The far better safety profile of regulated products was underscored when CannaSafe, a California-based testing laboratory, recently tested illegal and legal vape cartridges. It found that 13 of the 15 illegal vape cartridges included vitamin E acetate²⁹ — an additive the CDC recently identified as the likely cause of the illnesses.³⁰ None of the legal products CannaSafe tested included vitamin E acetate.

V. Legalizing cannabis improves the fairness and efficiency of the criminal justice system.

The unequal way in which cannabis prohibition is enforced — coupled with its nature as a victimless crime — erodes trust between police and communities at a time when such trust is sorely lacking. As Washington, D.C.'s former police chief bluntly put it: "All these [marijuana] arrests do is make people hate us."³¹ In addition to being valuable in itself, positive police/community relationships improve public safety. A Department of Justice study found that trusting relationships with the local community was one of the most important factors in whether police were effective in solving violent crimes.³²

Ending prohibition also frees up police time and resources that are currently wasted in prosecuting adults for cannabis offenses, allowing those resources to be focused on solving crimes with victims. A study published in *Police Quarterly* found that clearance rates (the percent of reported crimes resulting in arrests) increased significantly post-legalization in Washington and Colorado, while remaining basically unchanged in other states.³³ Burglary and motor vehicle theft clearance rates "increased dramatically" while violent crime clearance rates also increased.

VI. The legislature should also swiftly adopt decriminalization and expungement.

Unfortunately, without the votes for a statutory approach, legalization will have to wait until November 2020. That means between now and Election Day an estimated 31,571 New Jerseyans will have their lives turned upside down by cannabis possession arrests. Thousands more will be denied jobs, employment, professional licenses, housing, entry to educational institutions, and financial assistance on the basis of prior convictions, or will not pursue those opportunities because they expect

²⁸ Ean Seeb, Special Advisor on Cannabis to Gov. Jared Polis. Email communication. November 1, 2019.

²⁹ <https://www.nbcnews.com/health/vaping/tests-show-bootleg-marijuana-vapes-tainted-hydrogen-cyanide-n1059356>

³⁰ <https://www.nytimes.com/2019/11/08/health/vaping-illness-cdc.html>

³¹ McCarton Ackerman, "D.C. Police Chief Supports Marijuana Legalization," *The Fix*, March 4, 2015.

³² See "Getting Away with Murder," *The Economist*, July 4, 2015.

³³ "Positive policing changes after cannabis legalization: Clearance rates improve for burglaries, vehicle thefts," *Science Daily*, July 24, 2018.

their cannabis conviction will slam the door on opportunity. We encourage the legislature not to allow that to happen.

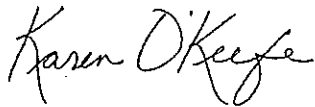
Please approve decriminalization and expungement legislation as swiftly as possible — in addition to SCR183 — to stop needlessly derailing thousands of lives.

VII. Conclusion

Thank you for your time and attention to this important issue. We urge the legislature to approve SCR183 to allow New Jersey voters to decide whether to replace cannabis prohibition with legalization, regulation, and taxation for adults 21 and older. We also urge the legislature to pass comprehensive implementation legislation to ensure equitable post-prohibition cannabis laws, including by swiftly enacting decriminalization and expungement.

If you have any questions or need any additional information, I would be happy to help and can be reached at the email address or phone number below.

Sincerely,



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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

^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

^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 doses 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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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.

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December 12, 2019

Re: Opposition to SCR-183

Dear Chairwoman and Members of the Senate Commerce 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

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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,

A handwritten signature in black ink, appearing to read "Marlene M. Kalayilparampil", written over a horizontal line.



Marlene M. Kalayilparampil, MHA

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Medical cannabis access




 Wed 11/27, 8:42 AM
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November 26, 2019

Dear Legislator,

Looking at the Resolution that proposes a constitutional amendment to legalize cannabis for personal, non-medical use by adults 21 years and older, subject to regulation by Cannabis Regulatory Commission, it's hard to know how to support it for those that would like home cultivation of cannabis to be part of the state's legalization plan.

According to the latest Rutgers Eagleton poll in 2018 showed:

"On the positive side, 64 percent believe the legalization of cannabis will help the state's economy, and 57 percent believe it will help areas in the state with high arrest records for marijuana. Moreover, state residents believe individuals should be able to cultivate marijuana for their own use: far more (60percent) are opposed to banning private residences from growing marijuana than favor such a ban (33percent)."

<http://eagletonpoll.rutgers.edu/NJ-marijuana-October2018/>

If provisions for it are not planned as part of the legalization legislation behind the constitutional amendment, they should be, as it means a true equitable legalization that the people want.

As a medical cannabis advocate, I must implore you, especially in the face of legalization, that you introduce and get the legislature to pass a bill for home cultivation for patients and caregivers.

I am thankful for the legislators' great work and the passage of the Jake Honig Compassionate Use Medical Cannabis Act (CUMCA). It's helping expand access to the program and with provisions for small-business, jobs, and job and family protections for patients, but it was passed as the most comprehensive in the country, yet lacked basic fundamental home cultivation access.

Fourteen sitting senators in the legislature have already voted in favor of a medical cannabis program with provisions for home cultivation in 2009 and some patients have waited a decade for this access and want to know why it was removed. That it was done in an era when top leaders didn't take cannabis medicine seriously and others took it too seriously, it's easy to see then, but hard to understand how this attitude still stands today. Why was it removed in 2009?

https://www.njleg.state.nj.us/2008/Bills/S0500/119_S2.HTM

I am thankful for Senator Vitale's work in looking to have the State Health Benefits Program, the State Health Education Program and The Catastrophic Illness in Children Relief Fund to help cover the cost of medical cannabis as this would help affordability, but this is not a guaranteed avenue of relief and would be taking money out of needed coffers for overpriced product.

If we are looking for pathways to support reduced-priced access, why are we still denying this common solution even after it was something fourteen current senators voted in favor of?

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was an ultra-limited pilot program that even he agreed was overly restrictive.

I've discussed with Department of Health, NJ Medical Marijuana Program Assistant Commissioner, Jeff Brown about using the micro-licensing provision as a way to create patient co-ops but given these co-ops would be regulated per S20, with things such as security, tracking, packaging, testing and acquiring a location, it becomes quite costly and nullifies the cost savings patients are looking for alternatively with home cultivation. It's also important to mention that compliance with local laws may make this difficult for those who have the ability to secure these things but can't travel. Further, patients would be in competition for licenses with businesses that may have more experience and lose out on the opportunity altogether.

Although it may help some, it is not honestly seen as a replacement for the need and desire for home cultivation for patients.

A robust Alternative Treatment Center (ATC) system is needed but the cost of expansion should not be put on sick people needing it for medicine. Patients should not have to bear the burden of corporate expansion especially when we're talking about a botanical herb many can grow themselves.

Although there are provisions in S20 (CUMCA) to supply medicinal cannabis at a reasonable or reduced price and even at no charge to those who've demonstrated financial hardship, that will take time for the Cannabis Regulatory Commission (CRC) to establish and given the number of patients that this may include, may not be sustainable for licensees, especially smaller licensee types.

It becomes more unsustainable when considering those with a terminal diagnosis have an unlimited supply recommendation. Being recommended more cannabis per month is great but if one couldn't afford their monthly allotment before, it's likely they cannot afford a larger recommended amount now.

Even if they could afford it, the current ATCs including newly proposed ATCs may not be able to keep up with demand and it will take time to establish more producers and produce more product. Currently, there are shortages and ATC imposed limitations on what patients can get. If there is an issue with quality, which is common, this problem becomes further exacerbated and will make costs more unsustainable for producers and patients.

Patients deserve consistency in supply and that means all the access they can safely get. This is especially concerning when we are using cannabis to help combat the opioid epidemic. Many patients are pushed onto the medical cannabis program after having opioids removed but without having an adequate, affordable supply of cannabis available for their conditions. That is an unfair, dangerous position that causes unnecessary suffering.

These delays can be and have been a death sentence for some. These are lives in your hands, and they cannot live with the legislature continuing to lead in fear on this.

Patients first and foremost have to take their health into their own hands and home cultivation literally lets them do that. It is an empowering, self-preserving act that helps give patients some control over their conditions and can be therapeutic in itself. It has been modernized to be affordable, efficient and safe and actually helps eliminate use of the illicit market.

It's not just about accessibility and affordability but about protecting a natural right to life. Other important reasons for these provisions are for specific strain availability, transparency of production and for access to the whole plant. Cannabis leaves and roots which are considered waste in the industry, can provide an abundance of medicinally beneficial raw cannabinoids that can be juiced and are a bonus for some that grow.

S20 (CUMCA) law distinctly recognizes medicinal cannabis users because of their necessity. The law recognizes that patients are priority when it comes to accessing cannabis. Not legally recognizing this access criminalizes patients and deems their homegrown cannabis an illicit, dangerous substance, that police will confiscate, even if the patient got the seed from an ATC.

Patients caught growing their own plants can be sentenced up to 5-20 years in prison for cultivating their own

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financially and medically for those that are just trying to access affordable medicine. Further we leave patients exposed to punishment by federal and local laws.

Looking at Colorado, it took roughly five years and with legalization to get cannabis prices close to competing with home cultivation costs, which are currently about a quarter of current New Jersey ATC prices. In the case of legalization, which may only be a year away in New Jersey, there will be even more shortages from anticipation and then the adult use market. I believe this is why every legalized state allows medical patients or their caregivers to grow their own medicine.

<https://www.coloradoan.com/story/money/business/2018/06/21/legal-weed-cheaper-colorado-than-its-ever-been-due-increased-supply/722513002/>

Each state is unique in their experience with this and it seems those with the most avenues of access are the best for patients. In New Jersey, home cultivation is the one thing that is left missing from making it truly the most comprehensive program. I guarantee if the Department of Health were to poll registered patients on the matter, you would find a majority of want this access.

There are a good amount of requests for support for home cultivation to the Department of Health.

https://www.nj.gov/health/medicalmarijuana/documents/RuleAdoption_May2019.pdf

This provision has been endorsed by many advocates for medical cannabis across the country and in this state, including Vice President of Government Affairs of Acreage Holdings, Mike Etten. You can read his position here:

https://www.linkedin.com/pulse/home-grow-cannabis-threat-our-industry-nick-etten/?fbclid=IwAR1hNjnEDfE0GW6otsH4bq-Jv1jr-Kmgs5LlpeqNwKz3_k65ADo8Yhz74IA

I have compiled a list of current laws in states that have legal provisions for medical cannabis home cultivation for you to consider our you could use the language from S119 allowing patients six plants.

https://www.njleg.state.nj.us/2008/Bills/S0500/119_R2.HTM

Eighteen states allow for medical cannabis home cultivation including, the eleven plus Washington, DC that have legalized cannabis for adult use. Although a few states have their own statutes, generally most allow for six plants. Under legalization, Illinois decriminalized home cultivation of adult-use cannabis up to 5 plants with an imposed fine up to \$200 and allows for patients to do so legally.

With six plants for registered patients and caregivers, there is little room for diversion and it would not be a disruption to physicians' recommendations but rather an enhancement. In the case of law enforcement, if we legally recognize and register patients for lawful possession of cannabis, we can legally recognize and register lawful cultivation of cannabis.

According to Marijuana Policy Project, home cultivation hasn't been a problem, no state has repealed home cultivation, and there has never been a serious push to do so.

<https://www.mpp.org/issues/legalization/the-case-for-allowing-home-cultivation/>

Arizona, Florida, Pennsylvania, and New York's current legalization bills all allow for home cultivation.

Arizona is by constitutional amendment legalization ballot measure.

[https://ballotpedia.org/Arizona_Marijuana_Legalization_Initiative_\(2020\)](https://ballotpedia.org/Arizona_Marijuana_Legalization_Initiative_(2020))

Florida allows for six plants per household, with no more than three mature.

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Pennsylvania allows for 10 plants.

<https://www.senatorleach.com/wp-content/uploads/2019/10/sb350.pdf>

New York's allows for 6 plants.

<https://www.nysenate.gov/legislation/bills/2019/a1617/amendment/a>

Given that it is recognized by industry and legislators, including Commerce and Economic Development and Financial Institutions and Insurance Committees Assemblyman Freiman, that patients cultivating their own medicine will not have a dramatic effect on demand from ATCs, patient/caregiver cannabis cultivation, is something all legislators can get behind.

Home cultivation is one of the most equitable provisions in cannabis legalization for social justice. Massachusetts' Cannabis Control Commissioner, Shaleen Title, has it listed as number one.

<https://www.linkedin.com/pulse/top-ten-equity-must-haves-any-legalization-bill-shaleen-title/?fbclid=IwAR2UtlwAKoitKadCkCDn4qyUCwXCxT8JHggMQVsCbnbbKQ3LBG4Xs1-HXHw>

Obviously, legislators that have championed expanded access can support this. Even legislators who are anti-legalization and prefer decriminalization can support these patients' rights.

NJ RAMP's Bishop Jethro James told me there isn't anything wrong with patients growing a few plants for themselves. This also includes those for religious rights. The Bible and many other religious texts include cannabis into a healing, sacramental herb and food.

It should be easy for those who lean more Libertarian or conservative, as this is an act of self-sufficiency for those in need.

One cannot say they support affordable access, looking to programs, plans, and insurance to help, recognizing the need for affordable access and accessibility, and continue to look the other way on home cultivation. It is a cruel double standard that people should not have to suffer from especially in times of legalization and when it's what patients want.

Lastly, S20 (CUMCA) passed with the purpose of making medicinal cannabis more accessible and affordable to those who need it, but since its passage it seems the proposed cost savings in requiring fewer visits for recommendation is still thwarted by some doctors charging the same they previously were just for fewer visits. This is something legislators should also consider when discussing patient savings.

I would like to meet with you to discuss this further and help answer these questions patients have. I would appreciate any input you have so if you could arrange a meeting with me, I would appreciate it.

Thank you for your time and consideration.

Sincerely,

Jo Anne Zito
Coalition for Medical Marijuana-New Jersey, Inc.