

WHITE PAPER ON CANNABIS POLICY

LESSONS FROM AROUND AMERICA

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INTRODUCTION

Few legislative and regulatory issues in the United States are as polarizing as cannabis legalization. No matter your perspective, cannabis is being legalized in many states and countries around the world for both medical and adult recreational use. In 1972, the Shafer Commission appointed by President Nixon, called for the decriminalization of Cannabis. In 2016, nine states had medical and recreational cannabis-related questions on their ballots. Currently, twenty-nine states and the District of Columbia have legalized the medical use of cannabis. Eight states and the District of Columbia have legalized cannabis for recreational use. The debate over legalization of any kind has engaged state and local governments, advocacy groups, the agriculture industry, marketers, researchers and consumers alike. The 2017 National Cannabis Summit held August 28-30 in Denver, CO, provided a structure for an objective national discussion of policies and regulatory approaches to enhance public health and safety, improve prevention and treatment, and to respond to changing cannabis policies.

TAADAS members have engaged in this debate at our monthly meetings and remain equally curious about the policy, social and medical ramifications of legalization – especially since many of the published reports seemed contradictory and confusing. TAADAS elected to send members and staff to the Summit to engage in discussion first hand and learn what we could from our colleagues. Over 350 people attended the Summit, many of which were from states who had legalized cannabis, but seeking ideas to improve existing policies.

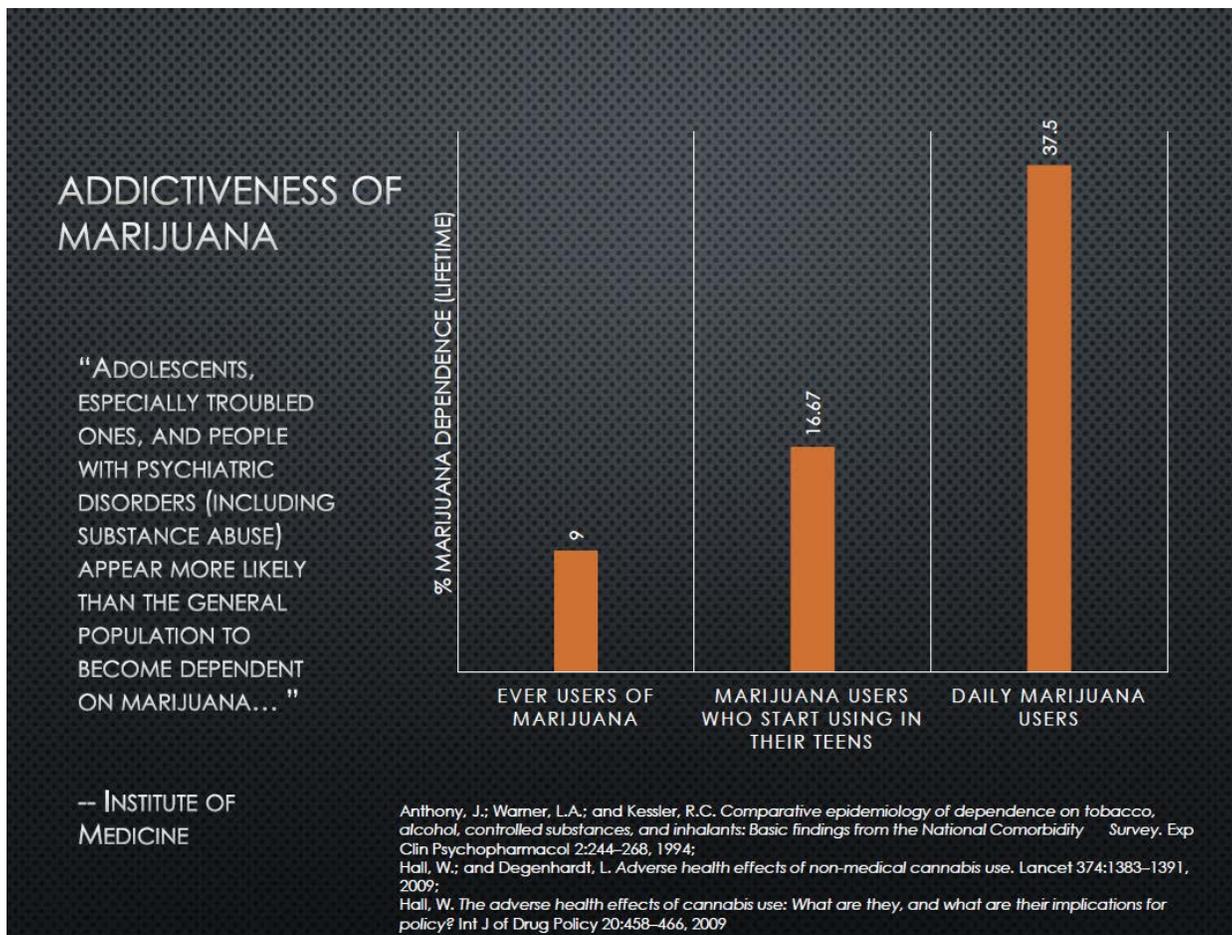
Upon return, the Summit attendees outlined three main areas of focus – prevention, treatment and regulatory policy. Our key findings from the Summit and recommendations for any future legalization for medical use in Tennessee, should it be considered, are outlined in this publication.

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CANNABIS USE

Throughout the Cannabis Summit there were general findings and statistics shared from states where medical marijuana is legal. Trends and findings concerning use in these states were discussed, given each state's unique characteristics and policies. Around nine percent of Americans who use marijuana become addicted to it, according to the National Institute on Drug Abuse; for alcohol, it's 15 percent, and for heroin, it's 23 percent.



Colorado, who has one of the longest histories of legalization, shared most of the available longitudinal data. In Colorado, marijuana was decriminalized in 1975, medical marijuana use was approved in 2000 and adult use was approved in 2012. Over the years since legalization, Colorado hasn't had a much higher rate of marijuana use than the rest of the country. According to a report by the Colorado Department of Public Safety, past-month use of marijuana by adults was 12 percent nationwide in 2014, compared to 14 percent in Colorado.⁽⁹⁾ 2015 Colorado Department of Public Health & Environment findings showed similar findings with 13.6 percent of adults identifying themselves as cannabis users.

Generally:

- For legal marijuana, 80 % of the volume of use is by 20% of users
- Overall the proportion or percentage of use in the adult population has remained steady while daily use by young adults is slightly increasing
- Legal use changes the nature of the drug problem, it does not eliminate it

Various kinds of medical indication information was shared at the Summit. TAADAS will not endorse or take a position on the types of medical conditions that could be addressed with medical cannabis as those decisions are best regulated by the medical profession. Components of cannabis can be extracted (CBD) and used for medical treatment in such a way that the intoxicating properties of the cannabis (THC) is not present. To date, THC has not been found to have medical properties, though its use is being studied.

There were many strong opinions shared at the Summit regarding the use of medical cannabis for pain management, rather than using opiates. Several studies presented found pain relief from CBD was more consistent, in general and over time, than pain management with opioids. A recent study⁽²⁴⁾ found that patients using CBD to control chronic pain reported a 64 percent reduction in their use of opioids. Tolerance to CBD (requiring more medication to get the same effect) was also less of a problem with CBD than with opioids.⁽²⁶⁾ Opiate overdose can be lethal. Cannabis overdose is rare but can lead to illness, not death. It would be extremely hard to ingest an amount of cannabis that could be lethal. Someone would have to take 40,000 times the normal amount of cannabis to die. There are no recorded cannabis deaths due to overdose.⁽¹⁰⁾ High potency cannabis can lead to adverse effects like paranoia. National Academies of Science Engineering and Medicine presented in a consensus study report about cannabis in 2017⁽¹⁹⁾ that smoking cannabis does lead to bronchitis, smoking during pregnancy does lead to lower birth rates, and initiating cannabis use at an early age is a risk factor for problematic use. The National Institute of Health's (NIH) ABCD study⁽²³⁾ found that smoking one cannabis cigarette causes as many pulmonary problems as 4-10 cigarettes and found an increased risk of heart attack for smokers.

“There is increasing research that indicates cannabis is particularly useful for certain types of pain such as fibromyalgia”

Most conditions approved for medical marijuana treatment, whether with cannabis or CBD specifically, in the United States are pain based, but it is also used to treat seizures, nausea from cancer treatment, muscle spasticity in multiple sclerosis, Parkinson's disease and dementias among others. There is increasing research that indicates CBD is particularly useful for certain types of pain such as fibromyalgia. Over 90% of medical marijuana card holders in Colorado have chronic pain diagnosis.

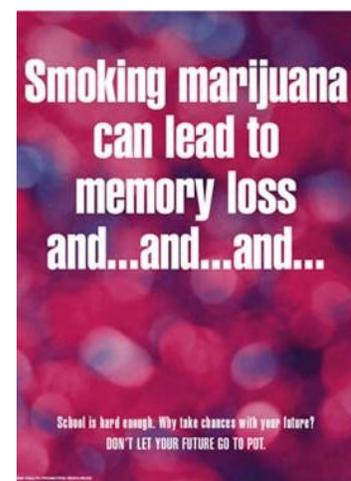
PREVENTION

With the number of states that have legalized cannabis ever increasing, whether it be for medicinal purposes or recreational use, health care professionals and policy makers must begin to look at how these changes in the law could affect adolescents and young adults from a public health perspective. Although laws have been passed and tightened on under age use and packaging, unintended use is one concern policymakers face. There is research from the state of Colorado, as well as findings from other short-term research, that have informed recommendations regarding prevention programs. The following summary was completed by a group of researchers in Colorado that were examining the potential effects of marijuana use and cognitive impairment and/or mental health disorders developed by adolescents and young adults.

Research has shown that parts of the adolescent brain are still developing well into their mid-twenties. The neural connections or ‘grey’ matter is still pruning, wiring of the brain is still in progress, the fatty tissues surrounding neurons or ‘white’ matter increase and assist with speeding up electrical impulses and stabilize connections. The prefrontal cortex is the last to mature and it involves the control of impulses and decision-making. As the prefrontal cortex is developing, adolescents often rely on the amygdala, a more reactionary, survival oriented part of the brain to help them solve problems and make decisions. It is also during adolescent years (age 9-17) that peak social and emotional development occurs. Adolescents are more at risk to develop mental health disorders such as anxiety and depression during this time of brain development.⁽⁶⁾ In the state of Colorado, close to 23% of students who started high school in 2011 did not graduate by 2015. Six percent of Colorado high school students attempted suicide in 2015 and thirty percent felt sad or hopeless almost every day for two weeks or more, one indicator of depression.⁽⁸⁾ Half of them use daily or near-daily. 2015 Healthy Kids Colorado Survey data estimate that 21 percent of Colorado high school students used marijuana within the last month. With that many adolescents and young adults using marijuana at least monthly, the potential adverse health effects are a significant public health concern.

“Research has shown that parts of the adolescent brain are still developing well into their mid-twenties”

As they were reviewing the data for their study, there were a couple of key findings to note. The strongest findings were related to reduced cognitive abilities and academic achievement, problem use or addiction to cannabis or other substances after adolescence and experiencing psychotic symptoms or diagnoses. Those that used cannabis weekly exhibited impaired learning, memory, math and reading, even 28 days after their last use. Their findings also noted that adolescents and young adults who used cannabis were more likely to experience psychotic symptoms as adults, such as hallucinations, paranoia, delusional beliefs and feeling emotionally unresponsive. Weekly use was associated with failure to graduate high school and failure to obtain a college degree.



An important note for all of these findings is that the available research evaluated the association between cannabis use and potential adverse health outcomes. This association does not prove that the cannabis use alone caused the effect.

One of the recommendations that researchers stated is that in future studies of the effects of cannabis and adolescent behavior, it will be important to improve data quality by systematically collecting information on the frequency, amount, potency and method of cannabis use in both public health surveillance and in clinical settings.

One of the most important recommendations for states to consider is the public education component on the potential effects of cannabis use and abuse. While the introduction of medical cannabis can be limited to CBD-only products, THC-infused products are available in many states. Introducing medical cannabis in any form has altered the perception of the public that all cannabis use is relatively safe, and this is particularly true for adolescents. States recommended that the education materials be designed for not only adolescents and young adults, but for parents and caregivers as well. The educational materials should be accurate and could be combined with other behavioral education that includes information on what addiction looks like. Materials should be widely available and access to treatment should be promoted. Many states that have legalized cannabis have spent large amounts of funding on public awareness campaigns and introduced evidenced-based health education curriculum into schools as prevention measures.

At the 2017 National Cannabis Summit in Denver, two presenters spoke to the importance of policies pertaining to edible cannabis products, which have become widely popular in states that have passed both medicinal cannabis and cannabis for adult use. Their presentation spoke to why edibles require specific policies to ensure safety and to help prohibit unintended use and consequences. Some of the unintended consequences that were brought up were: delayed intoxication, THC being concentrated in only a portion of the edible, the prevention of kids, unsuspecting adults, or animals becoming sick from accidental ingestion, the ingestion of molds, pesticides or contaminants, and ingestion of spoiled or an impure product.

Some of the key takeaways from this presentation was that all edibles should be in child-resistant packaging and must contain warning labels to prevent children or unsuspecting adults from accidentally consuming products. All packages should contain ingredients, serving size and THC amounts to prevent overconsumption. Most, if not all, states have a ban on edibles that are made to resemble certain shapes that would be enticing to children, such as gummy bears/animals, edibles shaped like people, or infused into food items like cotton candy, lollipops etc.

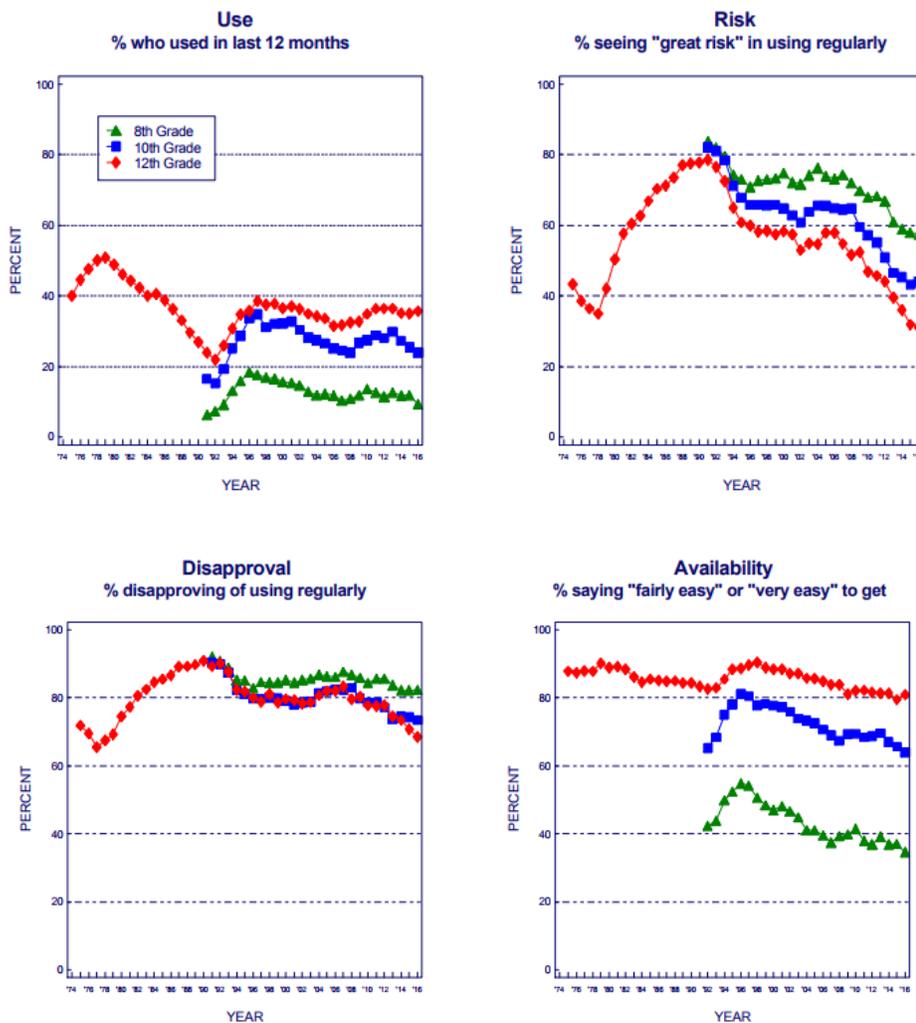
TREATMENT

As the most commonly used illicit substance in the United States,⁽⁴⁾ the percentage of Americans who reported using cannabis in the past year more than doubled between 2001-2002 and 2012-2013. The increase in Cannabis Use Disorder (met DSM V criteria for problematic use) during that time was nearly as large. Past year cannabis use rose from 4.1 percent to 9.5 percent of the U.S. adult population, while the prevalence of cannabis use disorder rose from 1.5 percent to 2.9 percent, according to national surveys conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Young adults (ages 18 – 29) were found to be at highest risk for cannabis use and Cannabis Use Disorder, with use increasing from 10.5 percent to 21.2 percent and disorder increasing from 4.4 percent to 7.5 percent over the past decade.

Research has shown an association between cannabis use and new onset of manic symptoms in individuals without preexisting Bipolar Disorder, and that cannabis use may worsen the course of Bipolar Disorder by increasing the likelihood, severity, or duration of manic phases.⁽¹⁴⁾ In addition, there is evidence of an association between cannabis use and the development of any type of anxiety disorder, with the exception of social anxiety disorder.⁽¹⁶⁾

Continuing decreases in the perceived harmfulness and personal disapproval of regular cannabis use have continued to confounding efforts to minimize use. According to the University of Michigan Monitoring the Future study reflecting the views of 8th, 10th and 12th graders, there has been a steady decline in both measures between 1992 and 2016. This reduction in perceived harmfulness has led to a higher likelihood of the use of cannabis by this age group.⁽²⁵⁾



Source. The Monitoring the Future study, the University of Michigan.

Treatment for cannabis dependence can occur in residential programs, but typically this treatment takes place on an out-patient basis in intensive programs that meet multiple times per week. Treatment goals should be client-driven. While abstinence is preferable, particularly in states where cannabis use is illegal, some clients may only wish to decrease their use to a more manageable level in states where it is legal. Facilities with abstinence-only treatment programs as well as ones for clients wishing to minimize use should be available. While there is no single approach to treatment for Cannabis Use Disorder, there are several evidence based therapies that have been found to be effective, such as Motivational Enhancement Therapy and Cognitive-Behavioral Therapy. The addition of Contingency Management improves the effectiveness of both treatments.⁽⁵⁾ This approach may require the necessity of substance-specific groups for those in treatment for Cannabis Use Disorder. Where cannabis has been legalized, states have recognized cannabis specific programs have been needed.

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Equally important is the use of psychoeducation to provide clients substantive information concerning both the negative and positive effects of cannabis use. Thus, medical professionals, therapists and counselors should be educated on and maintain awareness of the most recent research regarding cannabis use. While additional research is indicated, several medications, Gabapentin⁽¹⁸⁾, Buspirone⁽¹⁷⁾ and N-Acetylcysteine⁽¹³⁾ have shown promise as treatment adjuncts.

Marijuana and pregnancy

The American College of Obstetricians and Gynecologists (ACOG) publishes recommendations for substance abuse treatment during pregnancy and SAMHSA has issued treatment guidelines. Because cannabis is often cited as an effective treatment for nausea, many women believe they can take it for morning sickness. In a Yahoo News/Marist Poll in April of 2017, study, 21% of Americans think using marijuana for nausea during pregnancy is appropriate. This public health issue must be addressed with educational materials to refute this belief whether cannabis is legal or not. Use of marijuana is associated with increased risk of dysfunctional labor and increased pre-term labor. THC crosses the placenta and affects a growing fetus. There is evidence that THC inhibits fetal development of the brain. One of the biggest risk factors for women using marijuana during pregnancy involves smoking the plant. Smoking is a high risk to lungs and makes it hard to breathe during pregnancy. Smoking cannabis during pregnancy is highly correlated with low birthweight babies.⁽²⁸⁾

At birth, babies affected by Cannabis use often exhibit poor feeding skills. Intoxication by the mother and or the child interferes with the eye contact needed for bonding and attending to the needs of the child. Breastfeeding is not currently recommended for mothers who’ve used cannabis during pregnancy or who may return to use postpartum. This recommendation is based on an abundance of caution, as currently there is not enough data to formulate a firm conclusion.

For women whose children are at risk due to their substance use, Children's Services included collaborative care approaches that utilize a team working with treatment providers are the most effective means to provide effective care.

In states where marijuana is legal, data indicated that 80% of women who had babies positive for marijuana at birth, resumed use after delivery. Child serving agencies and the TN Department of Children's Services would need to develop new policies for intervention in marijuana use during pregnancy and to make referrals to treatment for women if their legal use is interfering with parenting.

REGULATORY POLICY

Several presenters at the Summit stated in one way or another that 'The train has left the station, America has decided to legalize.' While this may be the case, policy makers taking an active role in where this train is headed was a determining factor in the outcome of legalization. It was clear from all the discussion that science has not caught up with policy issues regarding cannabis. Whatever process is approved for legalization needs to include a continuous review of literature that informs ongoing evaluation of the ever-changing process. Several state policy makers criticized the lack of cannabis data and called for an increase in the amount of research the Federal Government will approve. For example, they cited that there is no epidemiological data on second hand cannabis smoke.

One of the main regulatory issues often cited by policy makers in states that legalized cannabis, was that legalization changes the nature of this drug problem, it does not eliminate it. Confiscation of cannabis continues in states where it is legal and where it is not. Legal cannabis has cut down the black market. Cannabis legalization has also effected access to heroin. Drug cartels have used cash from cannabis sales to fund other smuggling. Heroin smuggling is now up and purity is up to compensate, because it is now used instead as the primary cash crop to finance other smuggling.⁽²⁷⁾

Because regulations differ so greatly from state to state and within a state (where local rules could ban sales, etc.), this also led to migration issues, 'border shopping' and confusion about using what was a legal product bought in from another state or area. Local police were often making policy on the fly as they chose to enforce or not to enforce cannabis laws and regulations. Many states described a fragmented system and a resulting need for a patchwork of rules to try to address unintended consequences. Many states tried to regulate legal cannabis in the same manner as they had regulated legal alcohol and tobacco sales, distribution and taxation but found this to be a mistake. Legalization of medical marijuana is the regulation of a drug, not the voluntary, adult use of a product.

Several states stated that they would have preferred legislation for legalization that defines what to allow rather than disallow. They believed the regulatory process is better defined when the goals of the program are defined first. It was repeatedly cited that the regulatory success of legalization depends on clearly stated goals for the program.

Several states cited their goals which included:

- Suppress the black market; reduce access to unregulated product
- Suppress use; define the recipient population
- Control dosing
- Crime reduction
- Reducing opioid use

Policy makers from Iowa cited that defining medical card holders first helped define the market. A defined market illustrated the needed supply, a distribution system, packaging, etc. that would be needed for only these users.

“Drug cartels have used cash from cannabis sales to fund other smuggling. Heroin smuggling is now up and purity is up to compensate”

Federal regulation of cannabis does exist. The initial non-commercial, mostly medical use that was allowed based on local ballot initiatives, has given way to limited regulation by the Federal Government as well as the localities and states that have legalized. The Cole Memorandum, issued by the Department of Justice, gives states guidance on Cannabis. For example, no interstate commerce is allowed in states that allow its use. No organized capital is allowed or can be filtered through Federal entities such as banks and the post office. The Cole Memorandum also directed states not to focus on marijuana enforcement except where it effects minors. ‘Seed to

sale’ tracking systems are mandated for cannabis. The cannabis industry pays a different Federal tax rate – but they do pay Federal taxes on revenue.

Defining eligible medical diagnoses was another major policy concern cited by Summit participants. Changing policy to adapt to a rapidly changing field of medical cannabis use was hard to manage for many states. Most states cited that medical prescribers should certify a qualifying diagnosis based on fairly open criteria that is under the administrative authority of a designated board or agency driven by medical science. States also cautioned that allowing medical cannabis to be used for pain management, without appropriate pain management guidelines and oversight can lead to a “cannabis epidemic’ that is similar to the current opioid epidemic many states already face.

While the risk of death by overdose is not relevant and cannabis is often cited as a better pain management tool, there are still risks with unrestricted cannabis prescription policies, especially if access to THC infused products is allowed. It has been noted that one of the issues that fueled the opioid crisis was that prescribers were not educated in pain management and addiction. This will be an issue with cannabis prescription as well, and it should be addressed in policy so that medical schools and continuing education programs cover this topic. Medical education about the prescription of cannabis has been developing primarily in states where the product is legal.

Prescribers need more data and protocols to determine the strength or dose to use, the most effective route of administration as well as what conditions are amenable to cannabis treatment. State policies that contribute to this kind of research and medical education are needed.

Initially many states allowed ‘home grows’ of plants to allow patients access to medical cannabis. This practice was largely sanctioned to allow patients needing these medications access where medical use products were not being manufactured, were not readily available and were too expensive to be accessible. With a growing medical cannabis industry, this is much less of an issue. Access to CBD only products are now available and are more accessible. Where home grows are allowed, the number of permissible plants has often been lowered and new tracking mechanisms for plants have been implemented. Every state who would consider home grows, cited the need to regulate and inspect the plants, ensure that pesticide use was regulated and to regularly review the ongoing need for medical use, among other issues.

The types of cannabis products, many containing THC, that are manufactured has ballooned in states and countries that have allowed medical use. The use of any ‘edible’ product, such as cookies, candies, etc. which are often needed for elderly patients with dementia or cancer, for example, needs to be balanced with policies that ensure they are clearly labeled as medicine and not marketed or packaged in ways that are appealing to children. Child resistant packaging was seen as a necessity. Products have included gummy-type candies, which most states are eliminating or highly regulating as they are too enticing for children. Where products are manufactured for use by children, policies to clearly label them or similar products as medicine were seen as critical.



Several states talked about mandating advertising and messaging that stressed things like, "These are not your grannies’ brownies." Edibles often have to be refrigerated and have a ‘sell by’ date that results in the need for policies to destroy ‘unfit to sell’ items.

Some of the other broad areas of regulation and policy that were discussed included:

Pros and Cons of defining an existing agency or new one to be the chief regulator

- Define clear regulations that are accessible (web based)
- Mandate record keeping and retention
- Compliance checks at every level
- Video and signage requirements for dispensaries, farms and distributors

Define state and local licensing; letting localities ban sales

- Include regulation of local zoning – number of shops; hours of operation
- State taxes and local taxes; fees

Eligibility to be a grower, distributor or prescriber

- Minimum residency requirement
- Background checks and process for surprise inspections
- Limited number of producers creates an opportunity for monopoly; graft
- Limited number of producers can be easier to inspect and regulate

Define 'dose'

- Potency by type of cannabis product
- Quality control with a clear 'no sampling' policy
- Labs for quality control are separate companies from farmers, distributors, etc.

Pesticide

- EPA rules are lacking for cannabis; states must issue regulations
- Pesticides for plants becomes concentrated when making oils and extracts
- Rules for workers who are exposed to pesticides

Advertising

- Information campaigns that are evidence-based
- Clear 'not for kids' labeling and messaging; no cartoon characters
- 1st amendment complaints and lawsuits have been filed re: limits on advertising

Other legal regulation issues such as:

- Public housing regulations; public intoxication issues; operating under the influence regulations and determinations; dispensing in schools; and use of law enforcement stings with prescribers, especially for underage patients;

Most states mentioned that implementing medical cannabis took more time and infrastructure than originally anticipated. It was typical for dispensaries to take 2 years to begin operating and it also took time for farms, medical education, the regulatory framework and agencies to develop, as well as many other areas of the process to launch.

Policies regarding the economic impact were discussed. Social norms were affected by cannabis use which impacted how people socialized, shopped and used transportation, for example. The economic impact of the cannabis industry in states is magnified because the industry is so siloed and isolated from other areas of the economy. The industry is completely contained in that state. Generally, this industry is supported by private capital investments, but state and local banks, unregulated by Federal agencies, have invested in the market. While state and local tax revenue from cannabis has remained high in many states, as the industry has expanded, manufacturing costs have been reduced and prices for cannabis product have gone down – along with the resulting tax revenue. This was particularly true in Colorado.

A key area of agreement between the states attending the Summit was the need for a diverse group to be engaged in policy development. The widely varying expertise needed to work on implementation surprised many law makers and state officials. Specialists with experience in agriculture, marketing, prevention, dispensing, packaging, environmental protection, addiction, legal issues and regulation in addition to prescribers and medical educators were all needed. States regularly cited the need to include public health agencies in policy development and data review. States also worked with poison control centers for data and review.

Medicaid and Medicare payment for medical cannabis is being debated at the Federal level, as its use is seen as a means to lower the costs of prescriptions. A report published in Health Affairs⁽¹²⁾ found that if all states had legalized medical marijuana in 2014, Medicaid could have saved \$1 billion in spending on prescriptions.

Many of the social costs of cannabis use have been widely debated, but the one social issue that has been the most widely discussed is legal cannabis' effect on homelessness. Colorado has been singled out as a chief example of this issue as they have allowed adult recreational use and initially, fairly unrestricted use for medical purposes. With a yearly growth rate of 1.85% in 2016, Colorado is the second fastest-growing state in the USA. Colorado's economic growth rate is 5th in the nation. With the population and the cannabis industry growing so quickly, the number of homeless grew as well.

However, research shows that Colorado homelessness was primarily caused by the cost of rent doubling. Housing was in high demand and there was a higher cost of living because of the new cannabis industry.^(11, 26)

The impact of medically prescribed cannabis in work settings was discussed. Drug free workplace policies generally cover the use of a prescribed product that can be intoxicating or can affect someone's ability to perform work tasks. Aside from Federal workplaces, policy makers agreed that existing guidelines for drug free work places were adequate to address medical cannabis. Forbidding use of any intoxicating substance during work hours was something many employers added to their employee manuals in order to address both medical and recreational use of cannabis. CBD use would not cause intoxication or create any type of a positive result on a drug screen.

Penalties for unsanctioned cannabis distribution at any level of the process needed to be defined in criminal statutes in states where cannabis is legal and many surrounding states had chosen to enhance such penalties as well. Growers with a continuous pattern of diversion are typically subject to increased scrutiny before ultimately having their sales license revoked for continued infractions. Any home-grows for medicinal use still had to register their plants and could have their medical card to allow home grows revoked where there was a practice of diversion. All these licensure reviews were subject to due process provisions. Stronger penalties for illicit marijuana sales to minors were strongly endorsed by many states.

SUMMARY

TAADAS does not condone medical cannabis or seek to limit it. Legislative approval of access to medical cannabis can lead to many unintended consequences. Ensuring that any medical use by adolescents, whose brains are developing, is limited whenever possible to non-intoxicating extracts, such as CBD, is critical to protect the healthy brain development in adolescents.

TAADAS member agencies and practitioners see the impact of the opioid epidemic daily, as well as the impact of overdoses in our communities. Reducing the use of opioids by implementing pain management strategies with cannabis will address overdose deaths. However, using appropriate extracts, such as CBD, to control pain in lieu of the use of opioids would need to be initiated only with strict guidelines for use in pain management and would need to be developed well in advance of any legal use. Guidelines for any other medical use would need to be developed well in advance of any legalization as well.

Several states attending the National Cannabis Summit in 2017 recommended that along with setting goals for any legalization of cannabis, policy makers should establish clear goals for the use of any revenue generated with the regulation of cannabis. Legislating where any new revenue will be invested was key to ensuring a smooth, responsive and responsible implementation process. Earmarking some of the revenue for addiction treatment was a goal that was cited as well as using the revenue for prevention programs.

After the conclusion of the Summit, in December of 2017, the World Health Organization (WHO) issued a statement that cannabidiol (CBD), a component in medical marijuana, does not have a risk for abuse. The WHO suggests that CBD could be useful in treating medical conditions and recommends that it not be regulated by the government.

Any medical cannabis use will need to have a cohesive and evidence-based marketing strategy to ensure citizens are aware of appropriate medical use, its intent and regulations. Such messaging must precede implementation by a significant period of time to address well established misconceptions. A significant lead time will also ensure that potential patients are prescreened and approved appropriately by physicians that have been well trained on its use and according to well-developed protocols.

RECOMMENDATIONS

TAADAS recommends the following, if medical cannabis is legalized:

1. Standards for cannabis prescription for any medical issue should be developed prior to implementation, but in particular for pain management; medical use should be limited to CBD products whenever clinically appropriate
2. A strong medical prescriber and clinician education program be enacted, including ongoing continued education
3. Determine clear and well-defined goals for any medical cannabis program prior to any implementation process
4. Any process for the determining implementation and regulations be multi-disciplinary and community based with a broad range of stakeholder participation
5. Prevention and educational messaging should be developed and implemented well before any implementation; include messaging targeting pregnant women
6. Standards for packaging and for any approved product items should take into consideration how they could be perceived by and used by children and adolescents
7. Criminal penalties for sales to minors be reviewed and strengthened where appropriate
8. Revenue from medical cannabis regulation and taxation should be set aside for addiction treatment and prevention programs
9. Funding for cannabis specific treatment and prevention programs should be enacted

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