MASS CANNABIS SPEAKS PRESS CONFERENCE

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MA State House Steps

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Good afternoon everyone,

I am very grateful for everyone who is here today, and on a short notice, took off from their jobs, got childcare, and prepared statements for this Massachusetts cannabis community press conference. We aimed to bring together leaders to provide positive and productive suggestions for how our Commonwealth can be a leader in legalizing cannabis in the nation. We have all the resources and academic capital to create model state in Massachusetts that balances upholding public health and safety principles, while allowing adult use cannabis industry to grow driven by science, research, data, and best practices.

My name is Dr. Marion McNabb and I am the CEO and co-founder of Cannabis Community Care and Research Network (C3RN) a cannabis research, education, and social justice company based out of Worcester, Massachusetts. C3RN is a network of cannabis academics, researchers, scientists, healthcare providers, policy makers, consumers, medical patients, advocates, and engaged citizens that believe in advancing balanced research, education, and dialogue around medical and adult-use cannabis.

I am a public health professional with nearly 20 years of training in working in low-income countries, working to use limited resources to improve health inequities. Specifically, my previous experience lies health, HIV/AIDS and youth focused sexual reproductive and rights programs, community mobilization and digital technologies for health in Africa, Haiti and other low income settings. My academic training is in public health, with a Masters' in Public Health degree from Johns Hopkins University and Doctorate of Public Health from the Boston University School of Public Health.

Today, we will hear from over 40 organizations, individuals, patients, and engaged citizens, academics, health providers, industry who are working and have worked to make this the best industry and most inclusive in the nation. We are all here to support from our areas to provide recommendations on how we can as a community continue to turn the tides of a war on drugs that has devastated the lives of millions, and still continues to do here in this great Commonwealth.

As many here know, a recent academic statement was issued stating concerns about the roll out of legal cannabis in the Commonwealth. This document came from a community of colleagues locally who serve a very important community in our Commonwealth, those faced with complex mental health and addiction issues, including addressing the opioid epidemic.

The group called the Massachusetts Prevention Alliance (MAPA) published a 16-page statement of concern regarding the roll out of the legalized cannabis industry here in Massachusetts. This statement, endorsed by 40 pediatricians, academics, mental health and addiction specialists and in Massachusetts, recommends that the state adopt a new public health framework and noted several recommendations, including ensuring youth prevention. C3RN and I am sure all others here will agree with the authors that we all want to ensure youth and those with several mental health conditions are do not have access to cannabis.

It is important to understand where these colleagues, scientists, and academics are coming from. They represent a very important aspect of our pediatric, mental health and addiction care and research system, however they do not represent the full academic and clinical community in Mass. According to my dear friend and colleague, Dr. Peter Grinspoon, there are over 28,000 MDs in MA, and the endorsers represent 0.14% of Massachusetts Doctors. Less than a quarter of the authors have demonstrated public health expertise to make such recommendations. This is not representative of the academic or clinical community of over 100 institutions of higher education, public health, and clinical excellence in Massachusetts.

It is also important to note that the studies presented in the statement are misleading, presented as “the science of cannabis”, but really represents a thin slice of 5% of the most concerning studies of cannabis from a segment of the population and infers these findings can be extrapolated at a population level through sensationalism in the media.

It is also important to note that in the US, cannabis researchers receive funding from NIDA, which is Studies traditionally focused on harm because of NIDA, haven't looked for benefit, but were intentionally designed to show harm. The U.S. Government-funded 2017 Cannabis evidence review and research agenda clearly lays out funding history, current barriers, and challenges for conducting rigorous cannabis trials.[iii] This statement also makes recommendations between the states support for providing economic opportunities for those who have been disproportionately impacted by the drug war and worsening health inequities.

These recommendations, among others in the report, are concerning as someone who has formal training in public health and health inequities, but who has also spent the last 3 years advocating for and working towards promoting and creating a balanced research agenda for the cannabis industry here in Massachusetts.

Of particular concern is the first of six recommendations included in the statement: *"Temporarily suspend all licensing and conduct a public health impact assessment, by public health professionals, of the Social Equity Program with all the associated components to avoid worsening health inequities and disparities among vulnerable populations and communities."*

According to my colleague Dr. Sarah Trocchio, who recently received her PhD in criminal Justice, "This report does not reflect nor incorporate recent public opinion research on support for marijuana legalization or social justice provisions in the context of legalization. These are negligent absences that mischaracterize public opinion on the topic of legalization, which is especially necessary to consider given that the will of Massachusetts voters in support of a legal marijuana industry in the state. Not only did nearly 54% of voters in the state vote in support of legalization, but the majority of those individuals were residents of urban communities (see this New York Times election coverage).

Putting aside the issue that the statement's summary of the social equity programs is misguided and inaccurate, cherry-picking quotes from journalistic sources to intimate that low-income minority communities are categorically opposed to legalization is not sufficiently rigorous to warrant drawing conclusions about these nuanced criminal justice policy issues. As an expert on drug policy and race, I also find it irresponsible that this statement included far reaching positions about public policy, criminal justice reform, and structural disadvantage without consulting or referencing any scholars in those fields. Specifically, ignoring the very real impacts

of the War on Drugs, intergenerational poverty, and the historical exclusion of minorities from equal opportunities for economic advancement in the licit economy does not treat this issue with the thoughtful attention it deserves.

An intelligent conversation on these issues must start with an accurate understanding of the basic concepts and trends in drug policy and support for marijuana legalization. The statement has failed to meet those basic criteria."

We at C3RN called this press conference today because we felt the public can benefit from hearing the recommendations from others in the community, academic settings and disciplines about how we can model the industry to alleviate and reduce health inequities by thoughtfully addressing core social determinants of health that are locally defined.

Let's take Boston as an example of how we can work towards this goal:

Health inequities and disparities are a complex topic. I could not describe the intricacies of health inequities, racism in a better light than the Boston Public Health Commission. Please allow me to quote the agency describing what health inequities are directly from their website:

Figure 1. Health Equity Framework

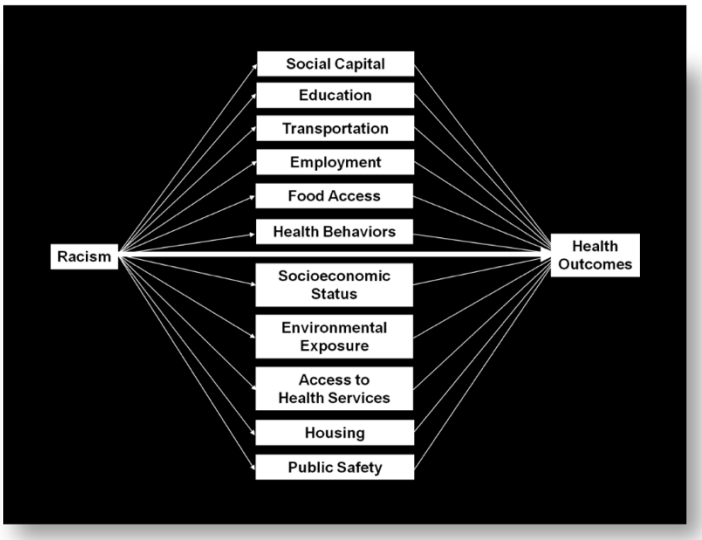

Figure 1. The Boston Public Health Commission's framework for understanding health inequities illustrates how racism has an independent influence on all the social determinants of health and that racism in and of itself has a harmful impact on health.

"Where we live, work, and play greatly shapes our health and well-being. While it's common to think first about individual behavior, genes, and health care access as most important for good health, in actuality, factors such as housing, education, environmental exposure, public safety, employment and income are also strong predictors of health and well-being. When examining

how these factors contribute to health inequities, it is important to understand how experiences within the individual and community context differ by race. In the United States, racism plays a significant role in creating and perpetuating health inequities. Social inequities, such as poverty, segregation, and lack of educational and employment opportunities have origins in discriminatory laws, policies, and practices that have historically denied people of color the right to earn income, own property, and accumulate wealth. Health promoting resources are distributed unevenly across the city of Boston and follow patterns of racial segregation and poverty concentration. As a result, on average, Boston residents who are White enjoy better health than many residents of color. These significant differences in health outcomes between residents of color and White residents are systemic, avoidable, unfair, and unjust. Other forms of oppression also contribute to different health outcomes. We must understand and address the many factors shaping our individual and collective health and provide all residents with fair access to the conditions that promote the best possible health."[iii]

According to the Health of Boston 2016-2017 report (the following bullets are directly quoted from the report):[iv] the following are areas that drive health inequities locally.

- *"In 2015, a higher percentage of Black and Latino residents reported that they felt they were stopped by the police just because of their race or ethnic background compared with White residents."*

- *"After adjusting for differences in age, race/ ethnicity, and sex, those who felt they were stopped by the police just because of their race or ethnic background were more likely to report persistent anxiety and persistent sadness compared with those who did not feel they were stopped by the police for these reasons."*

- *In 2015, 56% of Boston adult residents felt their neighborhood was either somewhat safe or not safe. — The percentage of residents who felt their neighborhood was unsafe was higher for Black (70%) and Latino (69%) adults compared with White adults (51%).*

- *Between 2006 and 2015, the Boston resident homicide rate decreased by 37%. However, for 2011-2015, the Black (18.7 deaths per 100,000 residents) and Latino (8.3) homicide rates were approximately 14 times and 6 times the rate of White residents (1.4), respectively.*

- *In 2016, alcohol was cited most often as a primary, secondary, or tertiary drug of misuse among unique-person treatment admissions in Boston, with a rate of 71.3 admissions per 10,000 residents ages 12 and older. — Between 2012 and 2016, drug-specific unique-person treatment admissions rates decreased by 25% for alcohol, 29% for cocaine, 17% for marijuana, and 26% for prescription drugs. — There was no change in the rate of heroin treatment admissions.*

- *In 2015, the rate of hospital patient encounters involving substance mis-use related unintentional overdoses/poisonings was 26.6 encounters per 10,000 residents ages 12 and older. — From 2011 to 2015, the rate increased by 13%. — The rate for drug-related unintentional overdoses/poisonings increased by 40%, while the rate for alcohol-related overdoses/poisonings decreased by 68%.*

- *In 2015, the substance misuse mortality rate in Boston was 39.8 deaths per 100,000 residents ages 12 and older. From 2011 to 2015, the rate increased 54% for Boston overall. — Rates also increased by 83% for Black residents, 73% for Latino residents, and 42% for White residents during this same time period.*

- *In 2015, the premature mortality rate for Black residents (267.5 deaths per 100,000 residents under age 65) was 31% higher than the rate for White residents (204.1). The rates for Asian (81.1) and for Latino (172.8) residents were 60% and 15% lower, respectively, compared with the rate for White residents.*

- *In 2015, unintentional opioid overdoses accounted for 71% of deaths due to accidents for residents under age 65 and would rank third if explicitly specified within the ranking scheme.*

- *In 2015, the rate of unintentional overdose mortality due to fentanyl use alone or in combination with other drugs was 16.2 deaths per 100,000 residents ages 12 and older compared with 1.1 in 2011. From 2011 to 2015, the rate increased more than 40 times."*

Investing in these communities with cannabis has the opportunity to provide economic inflow, jobs, education, and address security fears – all factors that are considered social determinants

of health. We are seeing property values increase, schools being funded, and neighborhoods being safer because of the increased security tied to cannabis businesses. You don't see that level of security on a liquor store in these neighborhoods. I have been to several city meetings here locally where neighboring businesses were thrilled to have a new business invest in the security and clean-up of their areas. Instead of fear mongering, we should take a balance public health approach to these complex topics.

We all here today agree that youth should not have access to cannabis.
Last year, The CCC launched the Cannabis Control Commission Launches "More About Marijuana" Campaign, Urges Parents to Discuss Risks of Underage Use with Kids FOR IMMEDIATE RELEASE: August 9, 2018. We now see billboards with CCC public health campaign messages (developed with the Mass DPH) that highlights youth prevention are placed around Massachusetts and on social media. Labeling requirements are strict, edible limits are low, and educational materials for prevention have been develop and distributed by the CCC.

This emerging industry, still under development of regulations and youth prevention interventions, as a commonwealth we have the opportunity to be a unique public health development use case and pilot model state of excellence.

Risks our youth are facing
As public health professionals, it is important to understand the severity of risk of cannabis (which is a documented non-lethal plant)[v] compared to the other health risks our young people face in Massachusetts. The authors cherry picked severe cases of cannabis causing psychosis in a segment of the population. However, there are a WIDE range of studies that have to be considered.

From my perspective, the more important issue is understanding the most common conditions our young people face in Massachusetts, and what is the greatest risk for them? That is where we should be putting our public health dollars and energy.

Massachusetts youth and adults are facing one of the worst epidemics in our lifetime, the opioid epidemic.

According to NIDA:

> *"Massachusetts ranked among the top ten states with the highest rates of drug overdose deaths involving opioids. In 2017, there were 1,913 drug overdose deaths involving opioids in Massachusetts—a rate of 28.2 deaths per 100,000 persons, which is twofold higher than the national rate of 14.6 deaths per 100,000 persons. The greatest increase in opioid deaths was seen in cases involving synthetic opioids (mainly fentanyl): a rise from 67 deaths in 2012 to 1,649 deaths in 2017 (Figure 1). Deaths involving prescription opioids totaled 321 in 2017 and have remained steady since 2015. Heroin involved deaths decreased 25 percent over the past 2-years with a total of 466 deaths in 2017."*[vi]

In 2018, researchers from the Boston University School of Medicine and Massachusetts Department of Public Health analyzed data on adolescents in Massachusetts, ages 11 to 17, who experienced an opioid-related nonfatal overdose between 2012 and 2014. Among all non-fatal overdoses, occurring in 195 adolescents versus 22,311 adults, adolescent girls were more likely to experience an opioid-related nonfatal overdose - the opposite in adults. Additionally, adolescents only 8% received adequate treatment compared to 29% of adults. The authors speculated low numbers because many people now have access to opioid overdose reversal drugs outside of a health care setting."[vii], [viii], [ix]

I recommend that everyone who is listening to this red a recent article by Donna Murch in the Boston Review published on April 10, 2019. It provides an elegant explanation of racial history in Boston, redlining, and the history of racism, the war on drugs and the opioid crisis here locally. One quote sums it all up:

"In the united states, prohibition of illicit drugs and the mass marketing of licit pharmaceuticals fits in a larger framework of Racial capitalism and deregulation that are deeply intertwined and mutually reinforcing. The opioid crisis would not have been possible without the racial regimes that have long structured both illicit and licit modes of consumption."[x]

We are at a crossroads in history now. We can now see, that our youth face health concerns and addiction risks that are pressing public health concerns for our young people. Its time now to focus less on hysteria and repetitive tactics to encourage fear mongering. We have the opportunity to change history here, not repeat it.

Call to Action:

1. Support expediting the social equity and economic empowerment programs and thoughtfully engage public health professionals trained in health inequities, criminal justice, and other relevant academic expertise.
2. Implement collaborative and balanced public health prevention, education, and awareness programs, both for prevention of youth access together with reducing the stigma around its use for adults and medical patients.
3. Continue to develop the robust ethical research guidance at the CCC, academic partnerships, and balanced research agenda that was set in motion for cannabis in Massachusetts, that utilizes recommendations from the **2017 National Academies systematic literature review on cannabis recommendations** as a research foundation for future collaborative academic inquiry.
4. Support the ongoing research work in youth prevention and social equity tracking at the CCC will propel Massachusetts as a leader in the nation and world.

We are in yet another moment in time where can sit on the sidelines and watch, or we can choose to be an active participant in the creation. we as a community have the ability to continue to create a model for the nation, in all facets of the industry. Massachusetts has the intellectual capital, innovative drive, and demonstrated tenure as a leader in many fields of technology and innovation to not make this new industry right.

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