

MINUTES
SUBSTANCE ABUSE SERVICES COUNCIL
SEPTEMBER 24, 2014
VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS
RICHMOND, VIRGINIA

MEMBERS PRESENT:

Stephanie Arnold, *Department of Criminal Justice Services (DCJS)*
The Honorable George L. Barker, *Virginia State Senate*
Brian Campbell, *Department of Medical Assistance Services (DMAS)*
Henry Harper, *Virginia Foundation for Healthy Youth (VFHY)*
The Honorable M. Keith Hodges, *Virginia House of Delegates*
Dr. Parham Jaber, *Department of Health (VDH)*
Butch Letteer, *Department of Motor Vehicles (DMV)*
Art Mayer, *Department of Juvenile Justice (DJJ)*
Jamie MacDonald, *Virginia Association of Community Services Boards (VACSB-Prevention)*
Charlene Motley, *Commission on the Virginia Alcohol Safety Action Program (VASAP)*
Ron Pritchard, *Virginia Association of Addiction Professionals (VAAP)*
Mellie Randall, *Department of Behavioral Health and Developmental Services (DBHDS)*
Zandra Relaford, *Department of Social Services (DSS)*
Patricia Shaw, *Virginia Drug Court Association (VDCA)*
Jim Tobin, *Virginia Association of Community Services Boards (VACSB)*
William H. Williams, *Virginia Association of Community Services Boards (VACSB-SA Council)*
The Honorable Jennifer T. Wexton, *Virginia State Senate*
Eddie Wirth, *Alcoholic Beverage Control (ABC)*

GUESTS:

Malik Burnett, MD, M.B.A., Drug Policy Alliance
Shirley Ginwright, President, Fairfax County NAACP
Jeremy Grandstaff, Virginia NORML
Ed McCann, Virginia NORML
Jahan Marcu, Ph.D., Americans for Safe Access
Brenda Roberts, Legislative Aide to the Honorable Scott Taylor, *Virginia House of Delegates*
Regina Whitsett, Substance Abuse Free Environment (SAFE) of Chesterfield County
Rachelle Yeung, J.D., Marijuana Policy Project

STAFF:

Lynette Bowser, *Department of Behavioral Health and Developmental Services (DBHDS)*
Margaret Anne Lane, *Department of Behavioral Health and Developmental Services (DBHDS)*

- I. WELCOME AND INTRODUCTIONS:** The meeting was called to order by the Council Chair, William Williams. Mr. Williams welcomed the members and guests and asked all attendees to introduce themselves.

II. REVIEW & APPROVAL OF MINUTES OF JULY 30, 2014 MEETING: Minutes from the July 30, 2014 meeting were reviewed. A motion was made by Ron Pritchard, and seconded by Delegate Hodges, to approve the Minutes. The motion was carried and the Minutes were approved as written.

III. OLD BUSINESS: There was no old business.

IV. NEW BUSINESS:

PRESENTATION: “CONSIDERING MARIJUANA POLICY – PART II”

JEREMY GRANDSTAFF, INTERIM BOARD PRESIDENT, VIRGINIA NORML, stated that Virginia NORML is working to build a coalition of organizations to work on marijuana policy and legislative reform in Virginia. The goal of today’s presentation is to provide Council members with factual information. Mr. Grandstaff introduced the members of the panel.

• MALIK BURNETT, MD, M.B.A., POLICY MANAGER, OFFICE OF NATIONAL AFFAIRS, DRUG POLICY ALLIANCE

Dr. Burnett discussed the medical components of cannabis (marijuana), the history of cannabis use in medicine, methods of consumption, physiology, therapeutic uses of cannabis, and related public health implications. He noted that there are three different types of cannabis: 1) Cannabis Indica, which is predominantly used in a medical setting to provide relief for people with chronic pain; 2) Cannabis Sativa, which is the psycho-active derivative that is used for appetite stimulation and nausea relief; and 3) Cannabis Ruderalis, which is not used in medicine. Cannabinoids are the active ingredients in Cannabis. The two most familiar are tetrahydrocannabinol (THC) and cannabidiol (CBD).

Dr. Burnett discussed the history of cannabis. The first recorded history of cannabis usage dates to 2900 BC. Cannabis has been in the U.S. Pharmacopeia since 1850. American pharmaceutical firms began selling extracts of marijuana as medicines in 1930. In 1937, the American Medical Association opposed the proposed Marijuana Tax Act and supported research on medical cannabis. The Marijuana Tax Act led to a decline in marijuana prescriptions. Due to restrictions and limited access to marijuana, it was removed from the U.S. Pharmacopeia in 1942. Subsequently, the Marijuana Tax Act became the Controlled Substances Act, which was passed in 1970. Marijuana was assigned a Scheduled I designation.

Dr. Burnett noted that there are four major methods of marijuana consumption: inhalation, oral digestion, oral-mucosal/sublingual, and topical application. With inhalation, there are two different methods: smoking and vaporization. The onset of action is 5-15 minutes and lasts a maximum of one hour. This is the preferred method for people who want relief from pain because it is the shortest time to onset of action. For oral digestion, marijuana can be infused into foods and beverages. Oral options are important for individuals (e.g., those with lung cancer) who have difficulty inhaling marijuana. The onset of action for oral digestion is 30-45 minutes and the maximum effect takes 2-3 hours. For people who want to medicate early in the day for relief throughout the day, oral consumption is the best option. In oral-mucosal/ sublingual administration, blood vessels under the tongue put cannabinoids into the blood stream quickly. The onset of action is 30 minutes to an hour, with maximum effect in 1-2 hours. The medication

can be sprayed under the tongue or used as a lozenge that is held under the tongue to get the medication into the system. With the topical method of consumption, cannabinoids are diffused through the skin by other products that are found in the cannabis plant. Topical cannabinoids are used for local pain relief (e.g., for arthritis). The onset of action is 20-30 minutes and the duration can be 1-2 hours for balms and creams or 1-2 days for transdermal patches.

Dr. Burnett reviewed the physiology of cannabis consumption. Cannabinoids are highly lipid and soluble and are stored in the fat cells of the body. This causes a person to have a positive urine drug screen for approximately 30 days after consumption. Cannabis is processed through the liver and has very few drug interactions. Some of the major side effects of cannabis include mild increase in heart rate, dry mouth, red eyes, anxiety and increased appetite. Cannabis provides relief for persons with HIV/AIDS, ALS, MS, Hepatitis C, Parkinson's, and cancer.

Dr. Burnett discussed some of the associated public health implications, including teen use, perception of risk, and ease of obtaining marijuana. Without regulation, teens have access to cannabis. With regulatory frameworks, legal access can be limited to adults over the age of 21. In addition, states that have reformed their marijuana laws have experienced a 25% decrease in deaths from prescription pain killers.

Dr. Burnett stated that the major concept that he wanted to share with Council members is the importance of maintaining the integrity of the doctor-patient relationship. Physicians with long-standing relationships with their patients will generally know what is best for those patients and will be able to make decisions that are in the best interest of their patients.

• **RACHELLE YEUNG, J.D., LEGISLATIVE ANALYST, MARIJUANA POLICY PROJECT**

Ms. Yeung discussed the legal aspects surrounding medical use of marijuana. In Virginia the possession of a single joint is currently punishable by up to 30 days in jail and a \$500 fine. In Virginia medical use of marijuana with a doctor's prescription has been legal since 1979. The law states that "no person shall be prosecuted for the possession of marijuana or tetrahydrocannabinol when that possession occurs pursuant to a valid prescription issued by a medical doctor in the course of his professional practice for treatment of cancer or glaucoma." The key word in this law is "prescription." Physicians are required to have federal licenses to prescribe controlled substances. Physicians cannot prescribe a Schedule I controlled substance because the federal government deems it to have no medical use. "Prescribing" such a substance would put physicians' licenses at risk, which is why this law was never implemented. Current medical marijuana laws use the word "recommendation" rather than "prescription." At the federal level, nothing in the law prevents states from removing state criminal penalties for the medical use of marijuana. Nothing in the U.S. Constitution or federal law prohibits states from enacting penalties that differ from federal law. In 1996 California became the first state to legalize medical marijuana. In 2002 a federal circuit court found that the First Amendment right to free speech protects a physician's ability to "recommend" medical marijuana. In 2013 the Department of Justice issued the "Cole Memo," which listed eight enforcement priorities regarding state laws regarding marijuana (both medical and recreational). The Cole Memo states that the Department of Justice will not interfere in states with "strong and effective regulatory and enforcement systems." As recently as May of this year, the House of Representatives voted 219-189 to block the DEA from spending funds to interfere with state medical marijuana programs. According to Ms. Yeung, for a marijuana law to be effective, there must be realistic access to medical marijuana, a variety of marijuana strains must be available, either smoking or

vaporizing marijuana must be allowed, and patients must be protected from criminal conviction. Ms. Yeung referred to the Marijuana Policy Project State-by-State Report, which compares all 24 current programs. The report is available on-line; Ms. Lane will send Council members a link to the site to review the full report.

Ms. Yeung provided an overview of state medical marijuana laws. Since 1996, 23 states and the District of Columbia have enacted medical marijuana laws. In each state, a doctor's recommendation or certification is required for a patient to qualify. In all but three states, a patient must have a specific serious medical condition or symptom to qualify. The law requires physicians to issue constitutionally protected "recommendations" rather than "prescriptions." Most states do not allow medical marijuana to be smoked in public or possessed in correctional facilities. Employers do not have to allow job-site marijuana use or allow employees to work while impaired. Most states specify that insurance is not required to cover the costs of medical marijuana. The District of Columbia and 17 states allow for state regulated dispensaries.

Ms. Yeung discussed decriminalization as another form of marijuana policy reform. Nineteen states have decriminalized marijuana, replacing criminal penalties with civil fines. According to a recent ACLU report, every 28 minutes someone in Virginia is arrested for simple possession of marijuana. African-Americans are nearly three times more likely to be arrested than white individuals. In 2010, Virginia spent \$67 million enforcing marijuana laws. A conviction or even the record of an arrest, without being found guilty of any crime, can lead to a lifetime of collateral consequences in such areas as education, financial aid, employment, professional licenses and housing. More than 107 million Americans have tried marijuana, but, due to discriminatory enforcement, these collateral consequences disproportionately affect minority communities. Nineteen states have replaced criminal penalties with fines. A 1999 report by the Institute of Medicine shows that the severity of the penalties does not affect marijuana use.

- **JAHAN MARCU, PH.D., SENIOR SCIENTIST, AMERICANS FOR SAFE ACCESS, D.C. AND RESEARCH AND DEVELOPMENT DIRECTOR, GREEN STANDARD DIAGNOSTICS**

Dr. Marcu stated that there has been a great deal of research on cannabis and cannabinoids. In 2014, for example, there were at least 1,566 studies on the topic. Most people are not familiar with the Endocannabinoid System (ECS) since the system was not discovered until the 1990s. Research articles were published by Virginia Commonwealth University in the 1970s showing specific receptor binding sites. Dr. Marcu discussed the ECS, which is an indigenous system in the body consisting of endocannabinoids, cannabinoid receptors, and enzymes for synthesis and catabolism. These systems help us to eat, sleep, relax, forget and protect. Clinical endocannabinoid deficiency syndrome is a condition with which cannabis works well. This system regulates the number of proteins, how well those proteins function, and the drugs available in your body to activate them. Dr. Marcu cited a New Zealand study that looked at the long term use and side effects of cannabis use. To be included in the study, participants had to be current users, under the age of 30, and have used cannabis a minimum of 5000 times. The study found that participants in the study were impaired in some memory tests and cognitive functions, but, in a battery of performance tests, all measureable differences went back to baseline 30 days after abstinence.

Dr. Marcu reviewed the different components of the cannabis plant and discussed the history of medical cannabis in the United States. In 1996 the first laws that allowed criminal exemptions

were passed in California. Commercial distribution of cannabis began in 2010. Dr. Marcu noted that the American Herbal Pharmacopoeia (AHP) is the standard for identifying the quality, purity and potency of the plant. The guidelines show how to make cannabis into a substance that will pass botanical safety standards in its whole plant form. The American Herbal Pharmacopoeia is used in conjunction with the American Herbal Products Association's recommendations to regulators on cultivation, manufacturing, dispensing and laboratory practices. Patient-focused certification (PFC) ensures compliance, involves physical audits, and documentation of staff training. PFC provides a non-profit, third party certification for the medical cannabis industry, ensuring that people are trained and that sites are safe. Dr. Marcu stated that cannabis, as a botanical medicine, can be grown safely just as any other agricultural product.

DISCUSSION: Panel and Council Members

Senator Wexton asked Ms. Yeung if there has been a regular process to decriminalize or approve medical marijuana in the states that have reformed their marijuana laws. Ms. Yeung replied that approving medical marijuana is usually the first step states are willing to take, considering its benefits. For some states, decriminalization is more important because of the racial disparity in law enforcement. Of the 19 states that have decriminalized marijuana, not all of them have approved medical marijuana. Ms. Yeung said, "We don't see medical marijuana as 'step one' and decriminalization as 'step two.'"

Delegate Hodges asked, in state law or in federal law, have legislators ever approved an indication for a particular drug outside of the FDA approval process. Ms. Yeung replied that neither of the two most commonly used drugs in our society, alcohol and tobacco, have FDA approval for use. Dr. Marcu replied that the predominant components of the cannabis plant are FDA approved. Dr. Burnett replied that a company that wants to make a medicine has to go through the FDA process. Physicians are not writing prescriptions; they are writing recommendations. It is not a formalized commercial product that is being put on the market so it doesn't necessarily have to go through the standard FDA approval process. Ms. Yeung stated that there is a bill on the federal level that is attempting to reschedule to a lower schedule. Dr. Marcu stated that the FDA does not regulate plants or botanicals; they regulate the labeling of them. The FDA does have a process for botanicals to become medicines. Out of the 240 that have applied in the last two decades, two have made it through that process at a cost of about \$10 billion per plant compound to get it through that process.

Delegate Hodges stated that there are two approved THC drugs on the market, one with the CBD component and one with the THC and CBD mixed component, both of which are on fast track as well as in clinical trials. He questioned why access to medical marijuana would be needed if these drugs are approved. Dr. Burnett responded that the FDA process takes approximately 5 to 10 years to complete. While he does appreciate the FDA's approval process, he is concerned that people needing relief would be waiting a long time for FDA approval. In the interim, a lot of people are needlessly suffering. Dr. Burnett expressed the opinion that there is a humanistic component to the rationale for passing medical marijuana laws and providing access to patients in need.

Mr. Pritchard asked if a patient receives the recommendation from a doctor to receive cannabis, what dosage would he recommend, and what strength and brand? Dr. Burnett responded that the reason there is a recommendation, not a prescription, is that the law requires a prescription to specify the dose and the duration that a person would use it. Given the fact that cannabis or marijuana is listed under a Schedule I designation, a recommendation cannot be written in that format because there are no established protocols for the dosage and branding of the plant. It is a trial and error process for patients when they go to a dispensary to figure out what works best for them. Dr. Burnett stated that that is the effect of prohibition and the current status of cannabis policy in the United States.

Mr. Pritchard asked who establishes dosages. Dr. Marcu responded that the Pharmacopeia is one source based on clinical trials. The standards for analysis have been established by the industry. For determining what conditions cannabis can treat, the trend is to drop conditions and to leave it up to the doctor and patient to decide. The dosaging will be determined when the standardization of cannabis continues. It is still early for doctors to recommend specific amounts because doctors still cannot tell patients where to obtain cannabis, even if there are legally operating medical dispensaries that distribute cannabis. Ms. Yeung also responded that trial and error happens with prescription medications as well. Dr. Burnett concluded that, as with prescribed medications, the doctor and patient relationship should be well-established. Doctors should know the patient's full medical history in order to make an informed decision about the benefit of recommending cannabis therapy for that patient.

Dr. Jaberri commented that with regard to trial and error, most doctors do start with the lowest dose and go up incrementally. Even after FDA approval, there are studies that help doctors identify what dosage to use for a specific medication. He stated that he has a problem with this being a trial and error situation. From a medical standpoint, he is uncomfortable with starting this process for patients when the literature does not provide the appropriate information. Dr. Burnett stated that if a physician is going to recommend medical marijuana, there are numerous clinical education courses that can be taken to examine dosage requirements. There is a recommended range for every medication, and physicians adjust dosages based on the patient. Dr. Marcu stated that marijuana is a non-toxic material, a plant that people don't overdose on. Dr. Jaberri stated that to say that the plant is not toxic is not correct.

Ms. Motley, noting that every 28 minutes someone is arrested for marijuana, and arrest is nearly three times more likely for African-Americans, questioned if there is research that breaks this down by state, age and gender. Mr. Yeung responded that she does not know of an age and gender breakdown, but that the ACLU report does break it down by state. Virginia is in-line with the national average; there are states with higher and lower racial differentiation rates. Ms. Yeung will provide a copy of the report to Ms. Lane for distribution to Council members. Mr. Ed McCann, of Virginia NORML, also responded that the FBI data does break it down by county, city, gender, age and race. There are statistics from the Supreme Court of Virginia for convictions for all the court cases, not just arrests.

Delegate Hodges asked how an individual doing home cultivation would know how much CBD is in a particular plant. Dr. Marcu responded that in home cultivation it depends, but laboratory services do exist where samples can be submitted and tested. Delegate Hodges also asked if are

there any state laws that require physicians who recommend marijuana to document that they have exhausted existing therapies prior to recommending marijuana. Ms. Yeung responded that it varies by state. She said that many states have statutes that require the physician to recommend the use of medical marijuana only if the use of marijuana outweighs the negative effects or if the condition has not responded to other treatment.

Mr. Harper asked is there is standardization in what dispensaries charge for cannabis. Ms. Yeung responded that no state regulates the prices. It is up to the free market. Mr. Harper stated that if an individual could not afford the product, that person could potentially grow a plant themselves. Dr. Burnett stated that in Massachusetts there is a hardship provision in the law requiring dispensaries to provide cannabis to people who are at 200% below the federal poverty line at a significantly reduced rate, or on a sliding fee scale, or for free.

Mr. Pritchard expressed concern that if youth hear that medical marijuana is legal, they will only hear that that marijuana is legal and use will increase. Ms. Yeung responded that in states with medical marijuana, youth use has not gone up. Most states have additional barriers for a patient under the age of 18. Colorado legalized medical marijuana in 2000. She said that when they began regulating medical marijuana dispensaries in 2010, youth use went down the following year. Since marijuana was completely legalized for adults over 21, the black market has decreased and youth use has continued to go down in the years since legalization was passed in Colorado.

Mr. Pritchard also questioned the statement that marijuana “is not as bad as alcohol and cocaine” and if that is a prerequisite for decriminalization or legalization. Ms. Yeung responded that for her organization their ultimate goal is to see that marijuana is taxed and regulated in a manner similar to alcohol. They believe this is a good policy position because marijuana is used recreationally in a manner similar to alcohol. She said that the toxic effects of marijuana as a recreational substance are much lower than alcohol, which society accepts as a normal part of social behavior. She said that the addictive factor of marijuana is much lower than alcohol as a recreational substance, with no physical addiction found related to marijuana. Any resulting dependency is psychological dependence, and that is found in only 9% of users, contrasted with addiction rates of 15% for alcohol and 32% for tobacco.

Ms. Randall asked how the illegal market is being controlled in states where marijuana is either permitted as a medical botanical or where it has been decriminalized. Ms. Yeung responded that in Colorado, before 2010, all marijuana sold in the state was illegal because there was no regulated market. When medical cannabis became regulated, a percentage of the black market decreased. The benefits of a well-regulated commercial dispensary are that the product has been tested, the amount is consistently measured, and that there are no contaminants or other drugs that have been added to the marijuana. Demand is being met by legal suppliers. Dr. Burnett added that once the legislative process is reformed and allows for commercial distribution of marijuana, the black market does not disappear overnight. Free market forces will overcome the black market because the incentive for people to deal drugs on the black market will be eliminated. No one is going to risk criminal prosecution dealing drugs if they can do the same thing legally.

Ms. Randall stated that in reference to the patient-physician relationship, there is the risk of unscrupulous doctors writing official recommendations and making a lot of money. This is a risk Virginia might incur with approval of medical marijuana. Dr. Burnett stated that there will be people who will try to abuse any system that is developed. There are policy solutions to mitigate those factors, such as accessing or monitoring the number of recommendations any one physician writes. Ms. Yeung responded that checks and balances on physicians can also be implemented either at the statutory or regulatory level. In D.C. and Maryland, each physician who is going to recommend medical marijuana must register with the Medical Marijuana Commission, the oversight agency. Physicians must register each of their patients and they have to report how many times they issue a written recommendation to the patient.

Ms. Relaford asked about the cost of a low level prescription through a legal source, compared to a black market source. She asked if marijuana usage in Colorado is covered by federal medical insurance. Ms. Yeung responded that marijuana usage is not covered by any federal medical insurance. Currently in Colorado, the legal medical market is lower than the illegal adult use market. When recreational stores were opened in Colorado, they matched their prices to prices on the black market. It is a lot cheaper for those who can register as medical patients, and it is tax free because it is a medicine. In Colorado, there is 25% more tax on recreational marijuana compared with medical component.

Dr. Jaber commented that for marijuana to be used as a medicine it needs to be proven to be both effective and safe. In the absence of literature and supporting data, he questioned why this has to be done now. He believes it is too soon. He suggested alternatives, such as changing the scheduling, doing more research, and doing clinical research that is disease-dependent. From a public health prospective, potential harm needs to be identified. Dr. Burnett responded that from a public health standpoint, physicians prescribe many medications that have gone through the FDA process with significantly worse side effects. Marijuana has been around for thousands of years, millions of people have used it, and no ill effects have been noted. From a broader public health stand point, he does not see risks to approving medical marijuana or to allowing physicians to provide a recommendation for an alternative therapy after exploring all the other therapeutic options that are available within the traditional framework of medicine in an established physician-patient relationship. He does support further research. There have been numerous attempts both at the federal and the local level to reform laws, although there are vested interests who want to maintain the status quo and slow down the process. The compassion argument has weight because during the delay, there are people who are suffering.

Senator Barker commented that he has constituents who have taken legally prescribed medications for certain purposes, physical or behavioral health issues, but have had side effects. There are many instances where some legally prescribed drugs have effects upon depression and mental health issues, sometimes resulting in suicides. He questioned if there are linkages to some of these things with medical marijuana and he suggests that this should be taken into consideration. He stated that approval should include a specific dose and a specific strength and should be adjusted through trial and error, rather than remain open-ended. Dr. Burnett responded that in discussing mental health and marijuana, there are a lot of studies looking at the issue from many perspectives. There is research that suggests that people who have a propensity toward mental health problems who use marijuana will see those problems exacerbated. There is also

research that suggests that people with mental health disorders use marijuana to help them cope with those mental health disorders. He noted that there are a number of factors that go into what brings about mental health disorders: genetic predisposition, environmental factors, and a number of other circumstances that could include drug use.

Delegate Hodges commented that he has read that 2% of the total population of Colorado has been recommended marijuana. He is concerned that once marijuana can be recommended by physicians, it might lead to a situation parallel to pain pill mills. Dr. Marcu stated that Americans consume more drugs and supplements than most other nations. In the United States, 40% of the population is taking at least one prescription drug. Delegate Hodges commented that prescription medications are the most cost effective way to treat diseases. He questioned why 2% of the population in Colorado would be recommended marijuana when there are prescription drugs on the market that are as effective or more effective than medical marijuana. He does not believe it is a path that should be pursued and that the FDA process should be used. Dr. Marcu responded that drugs that don't work for all patients should be replaced. Drugs are approved because they are effective in 50% of the people studied. Dr. Marcu believes that, in personalized medicine, people are finding something that may work better for them than what they have been prescribed.

V. PUBLIC COMMENT

- **REGINA WHITSETT, EXECUTIVE DIRECTOR, SUBSTANCE ABUSE FREE ENVIRONMENT (SAFE) OF CHESTERFIELD COUNTY**

Ms. Whitsett asked if any of the presenters had data on the average age of a medical marijuana card holder in Colorado. Dr. Marcu responded that the national average age is 44, and Ms. Yeung responded that in Colorado the average age is 54. Ms. Whitsett commented that not only are families with sick children going to Colorado to get medical care, but that there has been a 75% increase in the homeless shelter population in Colorado due to people going there to smoke pot legally. Ms. Yeung commented that the homeless youth rate has gone down since the legalization of marijuana. Ms. Whitsett commented that the cost is about \$400 an ounce if you buy it from the recreational store versus \$200 if you buy it on the black market. She indicated that many people are still buying on the black market, even though the promise was that legalization was going to eliminate the drug cartel and the black market. Persons over 21 can use a medical marijuana card at a recreational store; she believes that youth will continue to buy from drug dealers.

Dr. Marcu commented that people prefer to purchase cannabis from a legal provider because, although it costs more, it is standardized product and process. With a legal dispensary, a person can return a defective product and report them to the Department of Health. Dr. Burnett commented that the legal sale of marijuana in Colorado just started at the beginning of this year, and that the black market is not going to disappear immediately, it will take some time for prices to settle out. Stores incur a tremendous amount of start-up costs that they need to recoup. Over time, the price of legal cannabis is expected to plummet. It has dropped at least 40% since the beginning of this year when stores originally opened. He believes that the price point of legalized cannabis will ultimately drop below the black market price, which will eliminate black market sales.

- **ED McCANN, POLICY DIRECTOR, VIRGINIA NORML**

Mr. McCann noted that discussion is revolving around medical cannabis in Virginia. Virginia has already recognized the medical benefits of cannabis, specifically for glaucoma and cancer, but the Commonwealth has not implemented that policy. There is a law regarding distribution by pharmacies, which requires dispensing only by prescription. NORML's intent is to fix that law so that the medical benefits can be realized for the greatest number of people for whom it can be effective by allowing this law to be implemented with controlled regulations, similar to regulations for legally recreational substances like tobacco and alcohol.

- **SHIRLEY GINWRIGHT, PRESIDENT, FAIRFAX COUNTY NAACP**

Ms. Ginwright addressed the issue of decriminalization because of concern about the disproportionate number of minorities incarcerated due to possession of small amounts of marijuana. She noted that there have been several incidents in which students could have lost their PELL grants if they had been convicted of possessing marijuana. Since students with drug charges are not able to obtain financial aid, many are not able to attend college. Ms. Ginwright supports decriminalization; she believes that possession should be subject to a fine, not to a drug charge which will destroy a person's life.

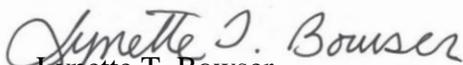
Council Chair Williams thanked the members of the public for their comments. He also thanked the panelists for their presentations and asked if they had any final remarks.

Dr. Marcu stated that drug diversion is a rampant problem with opiates, but there are electronic systems in place that can limit the amount that people can purchase. There are mechanisms that have been shown to be effective in reducing diversion and in tracking use. Dr. Burnett stated that there is always a discussion of whether or not now is the right time to pursue these questions. Since there are many people who are actively seeking alternative health solutions, it is hoped that the Council will consider the needs of those individuals in their deliberations and recommendations. Ms. Yeung thanked the Council members for their very thoughtful questions and stated that she would like to continue this dialogue with legislators and their constituents. Mr. Williams stated that the Council should review and discuss the information provided in the four presentations offered during the July 30th meeting, as well as the three presentations offered during today's meeting, in order to prepare a letter to the Governor and the General Assembly stating Council's recommendations concerning this issue. Ms. Lane noted that all seven of the panelists' PowerPoint presentations will be posted to the Council's website. Ms. Randall suggested preparation of a range of recommendations for the Council to consider. Ron Pritchard and Jamie McDonald volunteered to assist Ms. Randall. At Council's request, Ms. Lane will arrange a meeting of the full Council in early December to discuss and decide the Council's recommendations in order to complete preparation of the letter.

VI. ADJOURNMENT:

There being no further business, the meeting was adjourned.

Respectfully submitted,


Lynette T. Bowser