

August 6, 2021

Kemp Chester, Acting Director
Office of National Drug Control Policy
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

RE: FR 2021-14365-Application of Equity in U.S. National Drug Control Policy

Americans for Safe Access (ASA) thanks the Office of National Drug Control Policy for organizing this request for comment on such an important issue, and respectfully submits these comments for consideration in response to Federal Register Notice 2021-14365. ASA is the nation's oldest and largest 501(c)(3) member-based medical cannabis advocacy organization with a mission to advance access to cannabis for therapeutic use and research, and we look forward to collaborating more deeply to help the administration navigate this challenging policy area.

Specifically, ASA is eager to work with ONDCP to address cannabis equity issues that patients using cannabis to treat their health face daily, ranging from social justice, patient rights and civil protections to safe, legal and affordable access to medicine. Despite a supermajority of U.S. states approving medical use of cannabis and authorizing physicians to work with patients to effectively apply cannabis medicine, patients of all races and genders – mothers, fathers, children, seniors, veterans and our families and colleagues – continue to face discrimination and a lesser standard of care under today's multi-state medical cannabis policy framework.

This discrimination is supported by the federal government's classification of cannabis as a Schedule I drug under the Controlled Substances Act (CSA), a designation that carries with it the false notion that cannabis is a drug with no medical value and a high propensity for abuse. Millions of patients living under this classification across 37 states with medical laws are at risk of employment, housing and family law discrimination for participating in state-sponsored health programs, and for using cannabis medicine where Food & Drug Administration (FDA)-approved prescription and over-the-counter remedies have failed to effectively treat their health conditions.

1. Jurisdictions at the State, local, Tribal, and territorial levels have implemented equity assessment tools to inform their policymaking or budgetary processes. What are the lessons these jurisdictions have learned from implementing or interacting with those tools?

ASA has a long and successful track record of collaborating with state and local governments, licensed cannabis businesses and community organizations to develop functional cannabis



Headquarters:
1629 K Street Northwest
Suite 300
Washington, DC 20006-1631

Toll Free: (888) 929-4367
Website: americansforsafeaccess.org
Facebook: facebook.com/safeaccessnow
Twitter: [@SafeAccess](https://twitter.com/SafeAccess)
Instagram: [americansforsafeaccess](https://www.instagram.com/americansforsafeaccess)

ASA is the largest national nonprofit organization of patients, medical cannabis providers, medical professionals, scientists and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research with over 100,000 advocates in all 50 states.

policy, and train licensed cannabis businesses to meet state health and safety requirements. Related to equity specifically, ASA participated in the equity process through City of Los Angeles in California, and was selected to provide Patient Focused Certification (PFC) services¹ to social equity licensing recipients across the city. Unfortunately, the rollout of the city's equity program is consistent with that of many other state and local governments across the country who have attempted to develop similar measures, in that the program experienced organizational challenges, and frequently subjected applicants to long delays. These delays can dramatically increase project costs for equity operators, and even force applicants to abandon the process of joining the legal market.

Given the critical nature of ensuring that Los Angeles cannabis businesses receive training to appropriately serve patients and meet critical state and local product safety and operational requirements, it is important that these processes are improved. To date it has taken over one and a half years for the city to approve ASA's training application and award the contract, and over six months to get final documents reviewed. At the time of submission of this comment letter these documents are still pending review. While the public is accustomed to the slow pace of government operations, policy and licensing approaches must be amended to improve outcomes for equity cannabis business operators and their employees across 37 states, and the patients in their communities who desperately need the services of these businesses for their health treatment.

Regarding state cannabis equity policy, states are making strides to address equity issues² pertaining to business licensing and ownership, granting resources to support business organization, and even funding criminal records expungement for past low-level cannabis offenses. However, much like the Los Angeles example, most of these state policies have been slow to develop, organize and implement, even when adopted early. As a result, many equity cannabis business operators and employees from these communities were not able to participate in the formation of the legal cannabis marketplaces authorized by states. On the related issue of health equity, none of the original state medical reform models contemplated the specific health challenges of equity communities, or sought to address them through application of cannabis medicine to their unique health challenges. ONDCP coordination with federal and state health departments to focus on solutions in this arena would be welcome.

With state and local equity programs expanding in number, size and scope, it is important to focus on metrics to measure the utility of these programs in serving the intended beneficiaries, and identify areas of improvement to increase program performance. These tools should measure the effectiveness of programs in serving targeted populations, and track any negative externalities that may result from the policy on targeted and ancillary populations. The Small Business Administration's suite of loan and grant programs may have useful metrics for ONDCP to consider utilizing to measure the effectiveness of these programs.

ONDCP leadership is also needed in assisting states address medical cannabis policy challenges ranging from health equity, patient rights and civil protections to accessibility, cost, consistency and safety of cannabis medicine. As states pivot from limited medical cannabis frameworks to authorization of adult-use access, many patient issues remain outstanding such as employment protections, subsidies to support the cost of medicine and appropriate product testing and labeling standards to keep patients safe.³ ONDCP can help state and local governments improve policy

¹ <https://patientfocusedcertification.org/>

² <https://www.cannabisbusinesstimes.com/article/grant-funding-for-california-social-equity-program/>

³ https://www.safeaccessnow.org/adult_use_blog

and address federal barriers such as the CSA Schedule I classification of cannabis that hampers the performance of state and local policy reforms in serving patients.

Common challenges to the creation and functionality of state and local cannabis equity programs include:

- Determining state and local cannabis business licensing and employment eligibility criteria and related factors for potential business owners and employees, to include addressing challenges related to those with past cannabis-related criminal convictions, and geographically defining eligible participation zones.⁴ A related issue for state and local governments is addressing expungement of criminal records for past low-level cannabis offenses.
- Addressing state constitutional issues such as anti-affirmative action laws or related state supreme court rulings that present obstacles to forming any state or local programs designed to extend benefit to a particular class.⁵
- Extension of resources to assist equity business operators and employees is also an issue that states and local governments are exploring, and ASA encourages ONDCP to partner with the Department of Commerce and the Department of Labor, and national associations such as the Cannabis Regulators Association, National Governors Association, Council of State Governments, National Association of Counties, U.S. Conference of Mayors, National League of Cities, as well as policy experts in this arena such as the Minority Cannabis Business Association, Illinois Senior Advisor to Governor Pritzker for Cannabis Control Toi Hutchinson and Pennsylvania State Representative Chris Rabb to secure their counsel on approaches. Together this group of advisors can help ONDCP explore modifications to existing federal programs, as well as new partnerships in order to help state and local governments and equity cannabis business operators with training resources for business operation, state and local cannabis compliance, and capital support such as low or zero-interest loans to assist equity businesses with the high costs of doing business in the cannabis space.⁶
- Addressing the affordability and availability of legal cannabis medicine. The federal CSA Schedule I classification of cannabis has discouraged individual insurance providers and the Department of Veterans Affairs from providing any subsidy to help cannabis patients cover the cost of their medicine. As state and local regulatory models impose high compliance, licensing and tax costs on cannabis businesses, many of these costs are passed onto consumers to include equity patients.

Though states have developed programs to shield patients from state and local tax payments, the price of legal cannabis medicine is still too expensive for most equity patients.⁷ The availability of legal medical cannabis also continues to challenge equity communities, as most local governments in cannabis reform states have not licensed medical cannabis retailers, or have failed to license them in sufficient volume to meet the demand of patients.⁸ The high cost of legal cannabis, lack of private insurance subsidy and limited availability of legal medical retailers drives a large population of equity patients

⁴ <https://mjbizdaily.com/los-angeles-and-oakland-took-disparate-approaches-to-cannabis-social-equity/>

⁵ <https://willamette.edu/law/resources/journals/sjelj/publications/pdf/3-1/6.-brown.pdf>

⁶ <https://www.cnn.com/2021/07/01/in-billion-dollar-cannabis-market-racial-inequality-persists-despite-legalization.html>

⁷ <https://www.nbcnews.com/news/us-news/ridiculous-price-medical-marijuana-leaves-patients-scrambling-n1274085>

⁸ http://www.cahcc.com/Portals/0/ADE%20Cannabis%20Report%20_8-6-20.pdf?ver=2020-08-11-125659-360×tamp=1597175841928

to purchase medicine from illegal market providers, where patient and product safety are not guaranteed.

As ONDCP initiates work on federal cannabis reform, ASA strongly recommends leadership to improve coordination between state and local governments, and community and patient organizations on equity policy to capture and address specific issues faced by patients who require cannabis for health treatment, as well as improve program functionality. Without such coordination, well-intentioned state programs meant to promote success for equity business operators and their staff may fall short due to lack of policy proficiency and engagement at the local level of government.

The State of California and the City of San Jose provide an excellent example of this phenomenon. While the state maintains a large grant program to extend support to local governments to help cannabis equity businesses, the city is considering a ban on the use of cannabis in multi-unit housing facilities that would most significantly affect equity tenants who rely on cannabis to treat their health conditions, and affordable housing in these facilities to meet their housing needs.⁹ The city's policy proposal fails to provide scientific evidence to support the notion that a patient using medical cannabis in a housing unit has, or can have, harmful effects on another tenant in a separate unit within the same facility. Paradoxically while state and local resources may be lent to licensing cannabis equity business owners in the city, the city is simultaneously proposing to force patients relying on the medicine cultivated, manufactured and sold by these operators to choose between maintaining their health or their housing security. People should not have to choose between maintaining their health or maintaining housing.

2. Formal consultations for the National Drug Control Strategy often involve direct relationships between ONDCP and the consulting group, organization, or subject matter expert. What are recommendations on how the agency can broaden its formal consultations to gain broader perspectives earlier in the policy development process?

Americans for Safe Access understands the need to establish relationships with key stakeholder groups, organizations, and subject matter experts as we are an information provider to patients, caregivers, healthcare professionals, regulators, lawmakers, scientists, researchers and licensed cannabis businesses. As such, the information that we provide must be accurate and presented in a manner that is understandable. As the Office considers elements of federal cannabis reform, ASA encourages it to establish relationships with organizations like ASA, the American Medical Association Cannabis Task Force, the Society of Cannabis Clinicians, Doctors for Cannabis Regulation, the Cannabis Nurses Network, Cannabis Nurses of Color, the Cannabis Nurses Network, the Association for Cannabis Health Equity and Medicine, Janice Knox, M.D., and AMVETS Chief Medical Officer Cherissa Jackson, who are working to support cannabis health access and related equity issues, and who present only information that is scientifically accurate and valid.

It is important for ONDCP to engage with ASA as Congress and the administration consider steps to reform our national cannabis laws, as the Office has traditionally approached cannabis with a view consistent with the incorrect CSA Schedule I status of cannabis, which asserts that the drug

⁹ <https://www.sanjoseca.gov/home/showpublisheddocument/75513/637625516285330000>

has a high propensity for abuse and no medicinal value. As such, many of the stakeholders the Office has traditionally consulted with share this false perception of cannabis, which is at odds with the position of 37 states, the District of Columbia, four U.S. territories, 47 countries across the globe, the United Nations and the World Health Organization. With physicians in a supermajority of states now working directly with patients to apply cannabis medicine to health conditions ranging from cancer, epilepsy or neurodegenerative disorders to chronic pain, we encourage ONDCP to expand its relationships to include organizations like those mentioned above. These are stakeholders who continue to lead efforts to educate lawmakers and regulators at all levels of government on the utility of cannabis medicine, as well as help governments navigate challenges associated with authorization of cannabis medicine.

ASA has organized an advisory committee of leading physicians, researchers, cannabis testing laboratory operators, veterans' organization leaders, health condition advocacy groups and state-licensed medical cannabis businesses to help the administration and Congress understand and address the challenges of pivoting from a patchwork of diverse and poorly-functioning state medical cannabis programs to a system of functional federally-sanctioned cannabis medicine that works for patients. The committee's work is also being correlated with the American Medical Association's Cannabis Task Force. ASA would very much like to offer this committee as a resource to ONDCP as the Office considers approaches to federal cannabis policy reforms.

3. How might research examine equity in the context of law enforcement actions against drug trafficking or transnational criminal organizations? Are there existing applicable research frameworks that might be applied to ONDCP's Grant Administration Programs or other multi-jurisdictional task forces?

Like all federal departments and agencies, ONDCP currently lacks sufficient expertise to approach federal medical cannabis policy reform, or address associated equity challenges affecting patients relying on cannabis medicine. The Office's programs also do not support such efforts, as the mission of federal departments and agencies pertaining to cannabis is predicated on the falsehood that cannabis has no medicinal value and a high propensity for abuse. The impact of this classification on equity patients relying on cannabis for treatment is immense, forcing many to choose between using the medicine they need to treat their health condition and maintaining housing and employment.

Acknowledging that there are 37 states, the District of Columbia, and four U.S. territories that have reformed their laws to establish medical cannabis programs in which patients in consultation with their physicians are utilizing cannabis medicine to treat their health conditions, and 18 states, the District of Columbia and two territories who have reformed their laws to permit adults 21 years or older to possess and use cannabis, ASA encourages ONDCP to consider a new approach.

Specifically, ASA encourages ONDCP to form a commission comprised of patients, caregivers, and senior physician, health and research professionals from key fields such as neurology, psychology, palliative medicine, addiction and emergency medicine, who also possess experience in treating patients with cannabis and equity patient populations. Such a commission would provide a comprehensive review of the scope of domestic and international research conducted on the application of cannabis to health conditions, as well as associated domestic and international policy reforms of countries and world organizations. The commission could also assess the status of cannabis under the Controlled Substances Act and existing jurisdictional roles and responsibilities of federal departments and agencies related to cannabis. Finally, this commission could provide recommendations to Congress and the administration on reassignment of department and agency jurisdictions and responsibilities to facilitate federally-sanctioned

cannabis medicine and research, and address associated equity issues. ONDCP can initiate this work by revisiting interagency coordination related to cannabis research that began in 2016 under the Obama Administration.

- 4. What nationally representative private health, drug or crime databases or systems might be leveraged to provide information about equitable application of U.S. drug policy and how might access to such databases improve equitable responses? Please provide specific contact information for follow-up with those in a position to authorize dataset access.**
- 5. Provide recommendations for ONDCP to involve people who use drugs, especially those not typically included in household surveys, in the development of National drug control policy.**

ONDCP has traditionally approached cannabis with a view consistent with the CSA Schedule I status of cannabis – that the drug has a high propensity for abuse but no medical value. This position is at odds with the position of 37 states, the District of Columbia, four U.S. territories, 47 countries across the globe, the United Nations and the World Health Organization. With physicians in 37 states now working directly with patients to apply cannabis medicine to health conditions ranging from cancer, epilepsy or neurodegenerative disorders to chronic pain, ONDCP should consider making a distinction between patients who are using cannabis for medicinal and adult-use purposes versus people who are abusing other legal or illegal substances whom the Office has traditionally defined as “people who use drugs”. Referring to patients that use cannabis for therapeutic purposes as “drug users” implies misuse, abuse and/or addiction similar to known drugs of abuse, such as illicit use of methamphetamine or heroin, and perpetuates stigmas around cannabis use despite 37 states having implemented medical cannabis laws and much scientific research supporting cannabis as a legitimate medical therapy.

As part of ASA’s annual State of the States Report¹⁰, which identifies gaps in state medical cannabis policies and provides state regulators with recommendations to improve their programs, medical patients are surveyed about their medical cannabis usage and access. ASA welcomes the opportunity to discuss survey options with ONDCP and, as the nation’s largest patient-based cannabis advocacy organization, our members are eager to provide answers to questions that help advance medical cannabis policies related to equity and access.

- 6. What would be your recommendations for short-term and long-term goals that ONDCP should take into account to measure progress towards equity in drug policy?**

There are many steps that ONDCP can take to help in both the short and long-term to reach and measure progress on equity in federal drug policy that ASA supports. First and foremost, non-violent cannabis offenders currently serving sentences should be released and their criminal records expunged. The rate of incarceration for non-violent offenders who are charged with cannabis-related crimes is significantly higher for equity communities, which has led to the disproportionate impact of cannabis-related criminal justice on these communities. With 37 states acknowledging the medical utility and safety of cannabis and significant scientific evidence supporting the efficacy and safety of cannabis medicine, it is not appropriate, nor has it ever been, to continue incarcerating people for possessing or using medical cannabis to treat their health.

¹⁰ <https://www.safeaccessnow.org/sos>

ONDCP should also begin working internally with federal departments and agencies to lead a comprehensive review of federal cannabis policies as they exist currently, how those policies affect the health of equity communities, and how changes to the federal scheduling of cannabis under the CSA and corollary reassignments of departments and agencies would improve health outcomes for equity populations. From the Office of Personnel Management and the Department of Housing and Urban development to the Department of Veterans Affairs, Health & Human Services and the Department of Commerce, reforms must be made to facilitate a pathway to federally-sanctioned cannabis medicine and address federal policies that are disproportionately impacting the health equity communities. For example, ONDCP can work with the Office of Personnel Management to ensure that federal hiring laws no longer disqualify qualified applicants for cannabis use, or impose punitive actions against employees for use of cannabis.

If the federal government wants smart, capable and dedicated staff to carry forward the important work of the American people, it must acknowledge that many of these potential employees and contractors hail from one of 37 states with medical cannabis policies firmly in place. Qualified cannabis patients applying for federal work are like any other federal employee relying on some form of federally-sanctioned medicine to treat their health conditions, with the only exception being that this administration is choosing to discriminate against them in hiring. How can an administration so focused on removing systemic equity fail so monumentally in extending employment equity to qualified applicants based on the type of medicine they are using to treat their health?

Similarly, ONDCP can work closely with the National Institutes of Standards and Technology to reconcile the diversity of state approaches to medical cannabis product testing and labeling standards.¹¹ These varying standards coupled with federal prohibitions on cannabis patients traveling across state lines with their medicine challenge the safety and consistency of medicine, as well as increase medical expenses.¹²

Another key federal department with whom ONDCP should begin working to address equity issues associated with federal cannabis policy is the Department of Housing and Urban Development (HUD). HUDs mission to extend housing support to equity communities is compromised by the CSA Schedule I nature of cannabis. And with millions facing the loss of housing security and economic instability stemming from the COVID pandemic, it is critical that HUD work to remove discriminatory policies pertaining to cannabis and housing.

According to U.S. census data, there are nearly 4.6 million Americans who rely on federal support for housing. However, because federal law still classifies cannabis as a Schedule I substance under the CSA, any of the 4.6 million Americans who rely on federal support for housing, and who are also medical cannabis patients, are at risk of eviction even if they live in one of the 37 states where medical cannabis is legal. As a result, many of our nation's medical cannabis patients must choose daily between meeting their health and housing needs.

Currently, the largest population receiving federal housing support are seniors. A 2020 JAMA Internal Medicine research letter revealed that senior medical cannabis use doubled between 2015 and 2018, making seniors the fastest growing demographic of medical cannabis patients. Acknowledging this trend, the American Association of Retired Persons (AARP) publicly

¹¹ www.the-scientist.com/bio-business/the-wild-west-of-cannabis-testing-67175

¹² www.safeaccessnow.org/americans_for_safe_access_unveils_medical_cannabis_patient_s_guide_for_u_s_travel

expressed support in 2019 for the group's 38 million members to be able to use medical cannabis in consultation with their doctors if they live in states with legal medical cannabis access.¹³

While many seniors who live in federally-subsidized housing experience health challenges that benefit from medical cannabis treatment, such as chronic pain, insomnia, neuropathy and anxiety, current federal law places these seniors at risk of loss of housing if they legally possess or use medical cannabis where they live. No one should have to choose between using the medicine they need to treat their health and housing security.

Veterans living in one of 37 medical cannabis reform states also desperately need the leadership of ONDCP in working with the Department of Veterans Affairs (VA), as they face a confusing system of federal and state laws related to physician engagement and affordable access. For example, veterans who rely on the VA as their primary healthcare provider are unable to receive medical cannabis recommendations from their doctors, even if they live in a state with a medical cannabis program. And, veterans who use medical cannabis to treat their condition must also pay for this medication out-of-pocket with no financial support or subsidy from the VA.

20 million veterans living in the U.S. experience chronic pain, traumatic brain injuries and post-traumatic stress disorder at a higher rate than the general population,¹⁴ and typical treatment offered for these conditions relies on opioids. Two decades of a continually increasing opioid epidemic have illustrated the addictive and devastating effects of this illusory remedy, and 2021 saw the highest annual increase in opioid overdose deaths ever recorded.¹⁵ According to a 2019 National Institutes of Health (NIH) study veterans are twice as likely to die from an opioid overdose.¹⁶

Meanwhile, research continues to demonstrate the value of cannabis as a medicine in treating neurological challenges and physical pain issues. The results of the first FDA-regulated study on cannabis treatment for veteran post-traumatic stress disorder (PTSD) conducted by the Multidisciplinary Association for Psychedelic Studies (MAPS) were released in March of this year, revealing the effectiveness of cannabis in treating this condition without many of the harmful side effects of opioid use.¹⁷

Beyond advancements in research, there is also wide support among veterans for federally-sanctioned access to cannabis and education of VA physicians on cannabis as a medicine. Results of a 2017 American Legion study revealed that over 90 percent of veterans support medical cannabis research, with 80 percent surveyed also supporting allowing VA doctors to prescribe cannabis to veterans.¹⁸ In this same survey, 22 percent of veterans said that they were already using medical cannabis to treat chronic pain, PTSD, spasticity, agitation and to improve sleep quality.

In addition to VA physician consultations on cannabis from cannabis-educated physicians, the Veterans Administration must also tackle the issue of affordability of medicine. The high price of cannabis continues to be one of the greatest barriers to access reported by patients across the country. Like all medical cannabis patients, veterans who use medical cannabis to treat their condition must also pay for this medication out-of-pocket with no financial support or subsidy from

¹³ www.forbes.com/sites/abbierosner/2019/09/05/aarp-takes-medical-marijuana-mainstream/?sh=6027b244312c

¹⁴ www.radio.com/connectingvets/articles/veterans-could-use-medical-marijuana-va-help-bill

¹⁵ www.commonwealthfund.org/blog/2021/spike-drug-overdose-deaths-during-covid-19-pandemic-and-policy-options-move-forward

¹⁶ pubmed.ncbi.nlm.nih.gov/21407033/

¹⁷ <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0246990>

¹⁸ www.legion.org/veteranshealthcare/239814/survey-shows-veteran-households-support-research-medical-cannabis

the VA. The cost of medicine can vary wildly depending on the state and city in which the patient lives, with monthly costs ranging from hundreds to thousands of dollars. With promising research advancing, abundant legal state access available, and 1 in 5 military veterans making the choice to use cannabis for treatment, it is time for ONDCP to help the VA, HUD, OPM and all other federal departments and agencies amend their approaches to cannabis medicine. The patients who rely on and come into contact with federal departments and agencies should not receive discriminatory treatment or punishment because they need cannabis to treat their health.

Conclusion

ASA is encouraged by this request for comment that ONDCP is prepared to lead federal cannabis policy reforms that addresses the failures of the War on Drugs and its impact on equity communities. As the Office embarks on this ambitious agenda ASA encourages partnership with our association and partners referenced in this comment letter to also ensure that federal policies that are imposing harm on cannabis patients are reformed. From patients right and civil protections affecting employment, housing, child custody, pediatric access and affordability, consistency and safety of cannabis medicine policies across federal departments and agencies must be updated. Until these policies are uniformly reconciled with state and local governments across the country, equity communities and cannabis patients will be negatively and disproportionately affected by them at a substantial cost to taxpayers.¹⁹

Sincerely,



Dustin McDonald, Interim Policy Director
Americans for Safe Access



Heather Despres, Patient Focused Certification Program Director,
Americans for Safe Access

¹⁹ https://drugpolicy.org/issues/drug-war-statistics?ms=5B1_22GoogleSEM&utm_source=GoogleSEM&utm_medium=cpc&utm_campaign=SEM&cid=7011K000001SFcBQAW&gclid=CjwKCAjwmK6lBhBqEiwAocMc8haF-D5GCVwhTOxZvSgzDJ2VnnUzAQhHapVEkcYQ516fK1Vz9dbbshoCLdAQAvD_BwE