STATE OF ALABAMA
OFFICE OF THE ATTORNEY GENERAL

STEVE MARSHALL
ATTORNEY GENERAL

501 WASHINGTON AVENUE
MONTGOMERY, AL 36130
(334) 242-7300
WWW.AGO.ALABAMA.GOV

January 6, 2020

Dear Senators and Representatives,

Fully cognizant of my role as the state's attorney and chief law enforcement officer, and not as one of its policymakers, I have waited for some time to wade into the debate regarding the legalization of marijuana for medical use. However, after months of careful consideration and study, and at the request of several members of the Legislature, I write to inform you that I oppose legalization.

First, I have a significant threshold concern: state laws that allow any use of marijuana, medical or recreational, are in direct conflict with duly-enacted and clearly-constitutional federal law.[1] Thus, state marijuana statutes enacted in violation of federal law are damaging to the rule of law itself—a costly precedent that I urge you to bear in mind.

Beyond this unambiguous federal-preemption problem, I am deeply troubled by the parallels that experts have identified between our current opioid crisis and the rapid entrée by many states into legalizing marijuana for medical use.[2] Shortly after I took office, Governor Ivey asked me to cochair the Alabama Opioid Overdose and Addiction Council. Months later, I initiated lawsuits on behalf of the State of Alabama against major opioid manufacturers and distributors. Through these ongoing efforts, I have spent hundreds of hours developing expertise on the pervasive effects of the opioid crisis and how it might be solved. It is from this platform, and this specific perspective, that I feel compelled to address my concerns with you regarding marijuana.

Throughout the course of our multistate, multibillion-dollar lawsuits, the driving force for me has been the fact Alabama has been harder hit by opioids than most other states. Remarkably, our state has seen one of the *highest prescription rates for opioids in the nation*. According to Blue Cross Blue Shield, their members in Alabama were *twice as likely* to be on a long-duration opioid regimen than the national average. This is relevant to the marijuana debate, given the foreboding similarities between the origins of the opioid crisis and today's aggressive campaign to legalize marijuana for medical use. Furthermore, experts have warned against the hazardous outcomes of mixing opioids with marijuana[3]—something that a state with our rate of opioid prescriptions simply cannot afford to ignore.

I will not attempt to restate for you everything that I have reviewed or discussed with national authorities, including the U.S. Surgeon General, but instead I will outline six key concerns here. To wit:

Addiction

As with opioids, marijuana is an addictive drug.[4] Marijuana is categorized as a Schedule I drug in the Federal Controlled Substances Act due, in part, to its "high potential for abuse."[5] Approximately one in ten adult users of marijuana develops an addiction.[6] In fact, there are more marijuana addicts in the United States than those addicted to cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription pain relievers—combined.[7] Furthermore, just as patients build up a tolerance to opioids over time (resulting in increased dosage), "[t]olerance and dependence . . . and desensitization of type 1 cannabinoid receptors occur with repeated exposure [to marijuana]."[8] As tolerance increases with opioids, patients require progressively higher doses to obtain the same levels of pain reduction that he or she has become accustomed to—and the same is true of marijuana.[9] Correspondingly, marijuana dosing (like opioid dosing) will have to be increased over time to produce the same result.[10] Not surprisingly, as with opioids, a distinct withdrawal syndrome caused by cessation of regular or long-term marijuana use is "well-recognized" by experts.[11] While the scientific community works to find safer alternatives to opioids, we should be loath to embrace or promote another substance that is both psychoactive and addictive.

Treating Opioid Addiction with Marijuana

Existing evidence does not support the claim that medical marijuana is ameliorating the opioid epidemic,[12] nor does it support the claim that access to marijuana reduces opioid-overdose deaths.[13] Though some version of these claims continue to be repeated in the media and in policy debates around the country, they have been debunked by medical research. As noted by the director of the National Institute on Drug Abuse, "scientific evidence does not support claims that marijuana helps people kick opioids."[14] Researchers from Columbia University determined that people *do not* substitute marijuana for prescription opioids.[15] New and widely reported research from Stanford University revealed that states with medical-marijuana laws experienced an *increased* rate of opioid overdose deaths by 22.7%.[16] Further, the study uncovered *no evidence* that either broader marijuana laws or more restrictive ones were associated with changes in opioid overdose mortality rates.[17] As one of the Stanford researchers told the *Washington Post* in June, "[The] big takeaway for me here is, if policymakers are pursuing cannabis legalization as a way to address the opioid crisis, it's probably going to be disappointing."[18] Notably, in late November, it was announced that the federal government would withhold federal grants to states for opioid treatment if the treatment involved marijuana because "there's zero evidence" that marijuana can treat opioid addiction.[19]

Long-Term Use

As with opioids, medical marijuana is often advertised for short-term use or for the terminally ill, yet data from across the country demonstrates that it is disproportionately "prescribed" for chronic pain—a condition that leads to long-term, even lifelong, treatment.[20] In fact, less than 5% of people in medical-marijuana programs around the country have cancer or HIV.[21] As with opioids, we do not know what the outlook is for patients who use marijuana for extended lengths of time.[22] Long-term marijuana exposure is associated with cognitive impairment, development of addiction, abnormal brain development, and symptoms of mental-health conditions.[23] Amazingly, at the inception of the

opioid crisis, no studies had been conducted involving the long-term outcomes of opioid use, nor was there evidence that opioids would improve patients' pain and function for the long term[24]—and the same is true for marijuana.[25]

Overstating Benefits, Downplaying Risks

As was true with opioids, money is driving the push to legalize marijuana and to promote its use for an ever-expanding list of conditions—the benefits of which are largely unfounded. For context, before Purdue Pharma released OxyContin in the mid-90s, opioids were used to treat severe pain over the short term with the exception of terminally-ill patients. When Purdue launched OxyContin, it sought to broaden its use to chronic pain—a more widespread condition that entails months or even years of treatment, and thus increased revenue. We have seen a similar "broadening" of the promoted uses of marijuana. Across the country, states began by legalizing marijuana for treating individuals with cancer, HIV, PTSD, and glaucoma. But now, as evidenced by the legislation introduced in our own state last year, marijuana is being pushed as appropriate for treating addiction, anxiety, schizophrenia, and sleep disorders.[26] Just as Purdue overstated the benefits of opioids while hiding the lack of evidence supporting their use and omitting or mischaracterizing the adverse effects, a cursory look at the research on marijuana reveals that many proponents appear to overstate its benefits and downplay or ignore its risks. Consider, for example, the use of marijuana for PTSD: the American Psychiatric Association has concluded that not only does marijuana fail to deliver better outcomes for those with PTSD, but it actually produces *poorer ones*.[27] Two notable studies published in the past year found it unlikely that cannabinoids are highly effective medicines for chronic, non-cancer pain;[28] moreover, an article published by the American Pain Society stated it a bit more frankly: "[s]tate policy and public opinion regarding the therapeutic role of cannabis for chronic pain . . . has rapidly outpaced the evidence."[29] Another recent study found that greater cannabis use is associated with *poorer* symptomatic outcomes in patients with wide-ranging anxiety and mood diagnoses.[30]

(In)Effective Regulation

As was true with opioids, the State of Alabama is not prepared to effectively regulate or monitor marijuana. Alabama's own opioid council has recognized, and our litigation has underscored, that the state does not have the means or personnel for collecting the kind of data necessary to aid public-health authorities (a traditional role of the Centers for Disease Control and Prevention), to assist law enforcement in keeping dangerous substances away from vulnerable populations, or to ensure that dispensed marijuana is free from contaminants (a traditional role of the U.S. Food and Drug Administration). As the state's opioid council concludes in its report, "A coordinated response to a public health crisis is aided by rapid access to current data."[31] A recent article published by the American Medical Association noted the disadvantages that states face in this context: "[S]tate-level data and surveillance systems . . . are often not as accurate or useful [as the CDC] for recognizing the magnitude of a brewing epidemic or producing reliable, real-time estimates of the impact of an ongoing epidemic."[32] For a state heavily reliant upon the vast resources of the federal government, the problem of adequate regulation and monitoring is substantially exacerbated when these resources are absent.[33]

Mixing Marijuana and Prescription Drugs

As with opioids, the inability of health-care providers to track "prescriptions" for marijuana presents significant risks. Effective prescription-drug monitoring and management has been identified as a critical tool in combatting the proliferation of opioids across the country. As a result, improved and modernized prescription-drug monitoring is a central tenet of Alabama's opioid remediation plan and was the basis for a $1.1 million appropriation from the Legislature last session. Neither a patient's primary health-care provider nor the patient's marijuana "dispenser" can hope to safely or responsibly prescribe/dispense without a firm grasp on the patient's full medical and prescription history—including the prescriber, the dosage, and the supply.[34] This matters doubly because marijuana can change how a patient's prescription drugs work and can significantly and negatively affect patient outcomes.[35] To make matters worse, there is currently no uniform system that would allow providers to determine marijuana dosage.[36] Further, when marijuana is added to an existing opioid regimen and the opioid dose is not subsequently decreased, experts have determined that "it seems likely that the synergistic effects on psychomotor slowing, depressed sensorium, and delirium would lead to an increased risk of motor vehicle crashes, falls, trauma, and overdose mortality."[37] Of course, since marijuana cannot be legally "prescribed," a patient using both marijuana and opioids will not have a single prescriber to monitor the drugs' interaction.[38]

* * *

As your partner in public service, I would view it as an abdication of my duty to you, and to the public, to stay silent on this matter. While I do not question the motives or intentions of any member of the Legislature who does support legalization, the many unanswered questions and potential ramifications are undeniable. My fear is that while we fight in court for funding to remediate the opioid crisis, we will exacerbate that problem while creating a new one. We will work to provide access to recovery programs for those with opioid addiction, while the number of those who need help grows and even expands to those who develop a marijuana addiction. We will attempt to educate individuals about the long-term effects of opioid use, while endorsing the use of another dangerous drug with negative or, at best, nebulous long-term effects. We will bring in medication by the truckload to treat opioid-use disorder, but it will have no impact at all on those who turn to marijuana instead or who choose to combine the two drugs.

Before you proceed further in this debate, I humbly ask that you consider the foregoing information and the lasting consequences of legalizing "medical" marijuana in Alabama.

Respectfully submitted,

Attorney General
State of Alabama

[1] *See* Controlled Substances Act, 21 U.S.C. §§ 801–904 (2012), *construed in* Gonzales v. Raich, 545 U.S. 1 (2005).

[2] *See, e.g.*, John C. Hagan, III, *Big Tobacco, Big Opioid, Big Weed: The Successful Commercialization of Habituation and Addiction*, 115 MO. MED. 476 (2018), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC6312167/pdf/ms115_p0476.pdf [http://perma.cc/59E9-BDZX]; Shannon M. Nugent & Devan Kansagara, *Cannabis for Chronic Pain: We Simply Don't Know*, PAIN MED. (July 25, 2019), at 1, http://academic.oup.com/painmedicine/advance-article-pdf/doi/10.1093/pm/pnz168/29000923/pnz168.pdf [http://perma.cc/P53R-YBK9]; Lisa M. Ogawa, *On the Opioid Crisis and the Future of Pain Treatment: An Interview with Bertha K. Madras, PhD*, 91 YALE J. BIOLOGY & MED. 73 (2018), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5872645/pdf/yjbm_91_1_73.pdf [http://perma.cc/SB2K-EDXQ]; Luis E. Segura et al., *Association of US Medical Marijuana Laws with Nonmedical Prescription Opioid Use and Prescription Opioid Use Disorder*, JAMA NETWORK OPEN, July 17, 2019, at 1, http://jamanetwork.com/journals/jamanetworkopen/articlepdf/2738028/segura_2019_oi_190292.pdf [http://perma.cc/G42C-3UMD].

[3] *See, e.g.*, Andrew H. Rogers et al., *Opioid and Cannabis Co-Use Among Adults with Chronic Pain: Relations to Substance Misuse, Mental Health, and Pain Experience*, 13 J. ADDICTION MED. 297 (2019), http://journals.lww.com/journaladdictionmedicine/fulltext/10.1097/ADM.0000000000000493 [http://perma.cc/N2SQ-LLFH]; Paul J. Larkin, Jr. & Bertha K. Madras, *Opioids, Overdoses, and Cannabis: Is Marijuana an Effective Therapeutic Response to the Opioid Abuse Epidemic?*, 17 GEO. J.L. & PUB. POL'Y 555 (2019), http://www.law.georgetown.edu/public-policy-journal/wp-content/uploads/sites/23/2019/09/17-2-Larkin-Madras.pdf [http://perma.cc/N3NE-3RAS].

[4] *Is It Possible for Someone to Become Addicted to Marijuana?*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 7, 2018), http://www.cdc.gov/marijuana/faqs/marijuana-addiction.html [http://perma.cc/S8WU-6S9Z].

[5] *Drug Scheduling*, U.S. DRUG ENF'T ADMIN., http://www.dea.gov/drug-scheduling [http://perma.cc/C7BV-SFC6] (last visited Nov. 19, 2019).

[6] *Is It Possible for Someone to Become Addicted to Marijuana?*, *supra* note 4.

[7] *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH 32–41 (2019), http://store.samhsa.gov/system/files/nsduhffr2018.pdf [http://perma.cc/DCZ7-QM8G].

[8] Deepak Cyril D'Souza & Mohini Ranganathan, *Medical Marijuana: Is the Cart Before the Horse?*, 313 JAMA 2431, 2431 (2015), http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2015.6407 [http://perma.cc/7N2M-TP3G].

[9] *See id.*; *see also* William C. Becker & Jeanette M. Tetrault, *Medical Marijuana in Patients Prescribed Opioids: A Cloud of Uncertainty*, 91 MAYO CLINIC PROC. 830, 831 (2016), http://www.mayoclinicproceedings.org/article/S0025-6196(16)30116-1/pdf [http://perma.cc/E5V8-3HNJ].

[10] D'Souza & Ranganathan, *supra* note 8, at 2431.

[11] *See id.*; *see also* Udo Bonnet & Ulrich W. Preuss, *The Cannabis Withdrawal Syndrome: Current Insights*, 8 SUBSTANCE ABUSE & REHABILITATION 9, (2017), http://www.dovepress.com/getfile.php?fileID=36222 [http://perma.cc/C3CA-EYG7].

[12] *See, e.g.*, D'Souza & Ranganathan, *supra* note 8, at 2432; Kenneth Finn, *Why Marijuana Will Not Fix the Opioid Epidemic*, 115 MO. MED. 191, 192 (2018), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC6140166/pdf/ms115_p0191.pdf [http://perma.cc/F8RW-GKA8] ("Although there are patients who have successfully weaned off of their opioids and use marijuana instead, the evidence that marijuana will replace opioids is simply not there."); Larkin & Madras, *supra* note 3, at 571–72 ("[T]he studies performed to date do not support the conclusion that we should rely on marijuana to solve our opioid overdose epidemic. Instead, growing evidence is supportive of the opposite conclusion."); Ogawa, *supra* note 2, at 76 ("When you look at the root causes of the current opioid crisis there are many—at least 30 contributors. One of the first contributors was poor science, we had no long-term outcomes on the use of opioids for chronic pain. None. . . . We had nothing published on safety and efficacy after years and years of opioid administration. We have precisely the same problem with marijuana with regards to long[-]term use for pain management.").

[13] Chelsea L. Shover et al., *Association Between Medical Cannabis Laws and Opioid Overdose Mortality Has Reversed over Time*, 116 Proc. NAT'L ACAD. SCI. 12624, 12624 (2019), http://www.pnas.org/content/pnas/116/26/12624.full.pdf [http://perma.cc/L5D2-WSKE] ("[T]he claim that enacting medical cannabis laws will reduce opioid overdose death should be met with skepticism.").

[14] Ken Alltucker, *Marijuana as a Cure for Opioid Use? Nation's Top Drug Scientist Says She's Skeptical*, USA TODAY (Mar. 20, 2019), http://www.usatoday.com/story/news/health/2019/03/20/weed-marijuana-cannabis-opioid-addiction-withdrawal-nida-nora-volkow/3221792002/ [http://perma.cc/6LCU-5C43].

[15] Segura et al., *supra* note 2, at 8.

[16] Shover et al., *supra* note 13, at 12625.

[17] *Id.*

[18] Lenny Bernstein, *A Cautionary Tale About Medical Marijuana and Opioid Deaths*, WASH. POST (June 10, 2019), http://www.washingtonpost.com/health/a-cautionary-tale-about-medical-marijuana-and-opioid-deaths/2019/06/10/b8e1c924-8b97-11e9-adf3-f70f78c156e8_story.html [http://perma.cc/5SM7-EFJY].

[19] Carla K. Johnson, *Federal Addiction Treatment Dollars Off-Limits for Marijuana*, ASSOCIATED PRESS (Nov. 22, 2019), http://apnews.com/b0cbbb745a9a2dd7883539d238bab8b4 [http://perma.cc/WJ9F-X29R].

[20] Dennis P. Scanlon & Christopher S. Hollenbeak, *Preventing the Next Crisis: Six Critical Questions About the Opioid Epidemic That Need Answers*, 25 AM. J. MANAGED CARE SUPPLEMENT S234, S236 (2019), http://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_A904_05_2019_OpioidEpidemic_Commentary_01.pdf [http://perma.cc/L6XH-9443] ("The CDC . . . issued its first guidelines on prescribing opioids in 2016, making it clear that opioids are not typically indicated for long-term use associated with chronic pain that is not related to cancer or palliative, end-of-life care."); Kevin F. Boehnke et al., *Qualifying Conditions of Medical Cannabis License Holders in the United States*, 38 HEALTH AFF. 295, 298 (2019), http://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05266 [http://perma.cc/R2NH-58SC].

[21] KEVIN A. SABET, REEFER SANITY: SEVEN GREAT MYTHS ABOUT MARIJUANA 46 (rev. ed. 2018).

[22] Bertha K. Madras, professor of psychobiology at Harvard Medical School and a member of the President's Commission on Combating Drug Addiction and the Opioid Crisis, has excellently encapsulated the lack of robust research on marijuana and the foreboding similarities between this state of the science and the causes of the opioid crisis:

> The recent National Academies of Sciences, Engineering, and Medicine report summarized what over 15 meta-analyses have already concluded. The vast majority of the medical indications for whole plant marijuana embedded in state regulations have no rigorous scientific basis whatsoever. And for the few randomized controlled trials that have been conducted for chronic neuropathic pain, none have been extended beyond a few weeks and the majority of subjects were experienced marijuana users. It's also important to note that a THC (tetrahydrocannabinol)/CBD (cannabidiol) mixture failed in Phase III clinical trials for cancer pain. In many ways the recent history of the marijuana movement is recapitulating the history of the opiophilia movement that has led to our current national crisis.
>
> When you look at the root causes of the current opioid crisis there are many—at least 30 contributors. One of the first contributors was poor science, we had no long-term outcomes on the use of opioids for chronic pain. None. Nothing published that went beyond a few months. We had nothing published on safety and efficacy after years and years of opioid administration. We have precisely the same problem with marijuana with regards to long-term use for pain management. We have nothing in terms of randomized controlled trials conducted for long periods and a safety-efficacy profile to include quality of life measures after extended use of the various concoctions designated as medical marijuana. Some of the abstracts I have seen of preliminary data show that people are smoking marijuana 3 to 8 times daily which means that for most of the time they are awake, they are cognitively compromised. So, at this point it is very difficult to endorse a psychoactive, addictive, psychotomimetic plant extract as an alternative without good evidence. We should not go down the same path that we did with opioids which was to accept poor-quality science claiming that they were safe for the long term and non-addictive for pain patients. Think of the many factors that fueled the opioid crisis and the compelling parallels with marijuana. During the development of the opioid movement, vast sums of money were spent to promote their unsubstantiated use for many pain conditions, side-by-side comparisons with safer drugs were not performed, doses were not evidence-based, and they were promoted as safe and not addictive without solid evidence for safety and efficacy for chronic medical conditions. Opioid advocates received attention but prudent opponents were ignored or vilified as drug warriors; addiction, diversion and other adverse consequences were not anticipated or even ignored. Illicit opioid analogs flooded the nation, medical education lagged far behind the crisis, and government regulations failed to protect the public. Quite similar to today's marijuana movement, wouldn't you agree? We are at the same stage with marijuana and we have to be as cautious.

Ogawa, *supra* note 2, at 76–77.

[23] Becker & Tetrault, *supra* note 9, at 830.

[24] *See supra* note 22.

[25] *Id.*; Nugent & Kansagara, *supra* note 2, at 1.

[26] For example, legislation—entitled the Compassion, Access, Research, and Expansion (CARE) Act—was introduced in both houses of the Alabama Legislature during the 2019 Regular Session, seeking to legalize marijuana for an expansive list of *thirty-two* "qualifying conditions," ranging from cancer to irritable bowel syndrome, as well as "[a]ny additional conditions approved by the [Alabama Medical Cannabis Commission] by rule" (i.e., requiring no additional legislative action). *See* H.R. 243, 2019 Leg., Reg. Sess. (Ala. 2019) (as introduced, Mar. 20, 2019) , http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2019RS/PrintFiles/HB243-int.pdf [http://perma.cc/Y5VF-MVVZ]; S. 236, 2019 Leg., Reg. Sess. (Ala. 2019) (as introduced, Apr. 4, 2019) , http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2019RS/PrintFiles/SB236-int.pdf [http://perma.cc/LZ9M-U7A7]. The Alabama Senate passed a modified version of the CARE Act, which included a less-expansive list of "qualifying conditions, yet retained the "[a]ny additional conditions" clause. *See* S. 236, 2019 Leg., Reg. Sess. (Ala. 2019) (as passed by Senate, May 9, 2019), http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2019RS/PrintFiles/SB236-eng.pdf [http://perma.cc/UHP6-UBKC].

[27] AM. PSYCHIATRIC ASS'N, RESOURCE DOCUMENT ON APA OPPOSITION TO THE USE OF CANNABIS FOR PTSD (2019), http://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/Resource-Document-2019-APA-Opposition-to-the-Use-of-Cannabis-for-PTSD.pdf [http://perma.cc/NVU9-5FLR].

[28] Gabrielle Campbell et al., *Effect of Cannabis Use in People with Chronic Non-cancer Pain Prescribed Opioids: Findings from a 4-Year Prospective Cohort Study*, 3 LANCET PUB. HEALTH e341, e341 (2018), http://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(18)30110-5.pdf [http://perma.cc/42Y3-HHC8] ("Cannabis use was common in people with chronic non-cancer pain who had been prescribed opioids, but we found no evidence that cannabis use improved patient outcomes. People who used cannabis had greater pain and lower self-efficacy in managing pain, and there was no evidence that cannabis use reduced pain severity or interference or exerted an opioid-sparing effect."); Emily Stockings et al., *Cannabis and Cannabinoids for the Treatment of People with Chronic Noncancer Pain Conditions: A Systematic Review and Meta-Analysis of Controlled and Observational Studies*, 159 PAIN 1932, 1951 (2018), http://journals.lww.com/pain/fulltext/10.1097/j.pain.0000000000001293 [http://perma.cc/8MAK-FRQL].

[29] Nugent & Kansagara, *supra* note 2, at 1.

[30] George Mammen et al., *Association of Cannabis with Long-Term Clinical Symptoms in Anxiety and Mood Disorders: A Systematic Review of Prospective Studies*, 79 J. CLINICAL PSYCHIATRY e1, e10 (2018), http://www.psychiatrist.com/JCP/article/Pages/2018/v79/17r11839.aspx [http://perma.cc/29ZM-GXRG].

[31] ALA. OPIOID OVERDOSE & ADDICTION COUNCIL, 2018 ANNUAL REPORT 8 (2018), http://mh.alabama.gov/wp-content/uploads/2019/02/FINAL-Alabama-Opioid-Overdose-and-Addiction-Council-Report-to-Governor-2018-Read-only.pdf [http://perma.cc/WR4B-NB53].

[32] Scanlon & Hollenbeak, *supra* note 20, at S236–37.

[33] *See generally id.* at S235 ("Although state governments are responsible for certain areas, such as medical professional licensure and the regulation of health insurance within the state's borders, other responsibilities related to the opioid epidemic fall to the federal government to organize and regulate on behalf of all states."); *see also* Larkin & Madras, *supra* note 3, at 593 ("For more than fifty years, American law, policy, medicine, and society have accepted the need for the medical and scientific professionals at the FDA to decide what is a drug, whether that drug is safe and effective, and, if so, how to regulate its use. We should leave those responsibilities to the FDA, rather than create a new-fangled exception for marijuana in the mistaken attempt to bring the opioid overdose crisis to a close.").

[34] *See, e.g.*, Rebecca L. Haffajee et al., *Mandatory Use of Prescription Drug Monitoring Programs*, 313 JAMA 891, 891 (2015), http://jama.jamanetwork.com/article.aspx?doi=10.1001/jama.2014.18514 [http://perma.cc/5J8Q-CX7K] ("Clear benefits can derive from increased prescriber participation in PDMPs. When prescribers query the database for a patient's prescription history, they have access to information about the dose, supply, and prescriber of scheduled drugs the patient has filled. With knowledge of this information, practitioners can communicate with patients about their histories, avoid polypharmacy, and refrain from supplying opioids to those who 'doctor shop' while comfortably prescribing to those who do not."); Larkin & Madras, *supra* note 3, at 577 ("Also missing from a rational discussion

of using marijuana to treat pain is consideration of the complexity of the spectrum of patients in pain and their likelihood of abusing painkillers. Those facts must be considered in any serious debate over liberalizing marijuana use for medical purposes.").

[35] *What Are the Effects of Mixing Marijuana with Alcohol, Tobacco, or Prescription Drugs?*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 7, 2018), http://www.cdc.gov/marijuana/faqs/mixing-marijuana-with-alcohol-tobacco-drugs.html [http://perma.cc/VT4K-47UW].

[36] Becker & Tetrault, *supra* note 9, at 830; *Is Marijuana Medicine?*, CENTERS FOR DISEASE CONTROL & PREVENTION (Mar. 7, 2018), http://www.cdc.gov/marijuana/faqs/is-marijuana-medicine.html [http://perma.cc/8BN9-9Z5A] ("Another problem with marijuana as a medicine is that the ingredients aren't exactly the same from plant to plant. There's no way to know what kind and how much of a chemical you're getting.").

[37] *Id.* at 831.

[38] *Id.*