MENTAL HEALTH
LEGISLATIVE NETWORK

January 18, 2023

Members of the Judiciary Finance and Civil Law Committee:

On behalf of the Mental Health Legislative Network (MHLN) we are writing to share our concerns with HF 100. The MHLN is made up of over 40 organizations representing advocates, professionals, and providers with broad perspective and expertise on the needs of our mental health system and the people who are directly impacted by mental health legislation. We recognize that HF 100 does a lot to address concerns that we have voiced over the several years that this bill has developed, and we're grateful for your time and attention to continue to make this the safest legislation possible for Minnesotans with mental illnesses.

Interaction with human services systems: HF 100 gives the Office of Cannabis Management significant duties in studying, recommending funding, and distributing grants for substance use disorder (SUD) and mental health treatment. While we appreciate that the bill clearly prioritizes these issues, we do not think the office is the best body to carry out these duties. The creation of the Substance Use Advisory Council may be beneficial in continuing to build these essential treatment and support systems, but the placement of the council in the newly created chapter 342 is confusing. We would encourage clear separation between cannabis related regulations and human services laws that have impacts far beyond the use of cannabis. We recommend that provisions for increased assessment and treatment for the SUD and mental health communities should be in the bill, but that any of those duties and any advisory councils should be the jurisdiction of the Department of Human Services (DHS).

More specifically, we have concerns about the "study on the state's mental health system and substance use disorder treatment system" required in article 1, section 4. The intent of collecting this data is ambiguous and some of the data may be difficult to acquire, for example "whether the admission or order was for a mental illness or substance use disorder; and, to the extent known, the substance of abuse that resulted in the admission or order." Collecting the rates at which people access services is only one piece of improving that access. This data does not capture important issues that the SUD and mental health communities are already working on, such as did the person have insurance and what kind? How many people tried to access care but were unable and why? We feel that this study is beyond the scope of the Office of Cannabis Management, and again recommend that data collection and studies be the jurisdiction of the departments of health and human services. Additionally, we recommend that those departments are required to engage the community in what data they collect and why.

Potency: We recommend that cannabis products have a limit on the potency of intoxicating elements that a person may purchase and that legislators work with mental health and cannabis professionals to set safe limits based on the types of products.

Mental health representation on Cannabis Advisory Council: We recommend that the Commissioner of DHS be added to the council as well as at least one mental health professional.

Minimum age: It is well established now that the adolescent brain continues to develop well into the early 20s and to the age of 25. Research has shown that cannabis use in young people can cause disproportionately

adverse effects compared to a fully formed brain. We recommend that the minimum age for cannabis use be 25.

Consistency for health care practitioners: Article 1, sections 21-44 regulate the many types of licenses that may be obtained for cannabis businesses. We found inconsistencies in the prohibitions on health care practitioners in owning, operating, or investing in a business with *certain* cannabis-related licenses. It is confusing that a health care practitioner may not be associated with cultivator, manufacturer, or retail licenses, but there is no limitation on a health care practitioner operating a microbusiness which may cultivate, manufacture, and sell cannabis products. Furthermore, the definition of a health care practitioner excludes SUD and mental health treatment providers. If it is believed that participation in the growing or distribution would be a conflict of interest for these healthcare providers, then they should be disallowed at a business of any size and the definition of practitioners should be expanded.

Labeling and warnings: We recommend that the requirements for labeling and information in article 1, section 57 should be expanded. At the very least, warnings regarding the impact on neonatal development for pregnant women and on brain development for those under 25 should be required, not merely suggested. We recommend that the information in subdivision 6 about impairment effects and driving should also be required to be posted. Evidence from the use of warning labels for tobacco products has demonstrated that such warnings play an important role in prevention. We also recommend that information about storing cannabis in a house with children should be available to everyone, not only through home visiting programs.

Education: We fully support the requirements for educational programs in the bill. In addition to the provisions for youth and pregnant people we recommend that information and education about the risks of psychosis associated with cannabis should be developed and approved by mental health and medical professionals. Research has shown a link between people at a higher risk for psychosis and the use of cannabis for worsening illnesses. In addition to public knowledge about these risks, we believe this information should be explicitly reviewed by health care practitioners and patients who seek to participate in the medical cannabis registry. Beyond psychosis, we recommend that patients and practitioners who are considering medical cannabis should be given at least the option and accessibility to consult with a mental health professional on their personal situations and treatment options.

Investment in First Episode Psychosis programs: As mentioned above, a clear link between people at-risk for psychosis and cannabis use has been established in research. As general use of cannabis increases in our state we must expect and prepare for illnesses involving psychosis to increase. We must invest to expand our First Episode Psychosis programs. These programs are essential supports for individuals and families who are encountering these illnesses for the first time, and early intervention is specifically important for the future managing of psychotic illnesses.

Other data collection: In addition to the data collection required by the Department of Health in article 6, section 7, we would like stakeholders to expand the data collected for different purposes. Some states have collected information about the number of children who have been admitted to the ER for cannabis consumption, we would recommend that the same data be collected in Minnesota.

Office of Social Equity: The MHLN supports the creation of this program and the effort to ensure that communities of color and people negatively impacted by the war on drugs can share in the economic benefits of cannabis legalization.

Decriminalization: Finally, we are in full support of the provisions in the bill to allow for expungement of cannabis-related crimes. We appreciate the proactive provisions in the bill to inform people about expungement opportunities. This is one good step in addressing the disparities in our legal system against Black, Indigenous, and people of color communities, as well as people with mental illnesses and substance use disorders.

Thank you again for your attention to these concerns. We are happy to offer representatives and experts from the MHLN to work on specific language for amendments.

Sincerely,

Sue Abderholden, MPH
Executive Director, NAMI Minnesota
Co-Chair, Mental Health Legislative Network

Shannah Mulvihill, MA
Executive Director, Mental Health Minnesota
Co-Chair, Mental Health Legislative Network

The following organizations are members of the Mental Health Legislative Network:

ACCORD
Allina Health System
Amherst H. Wilder Foundation
Avivo
AspireMN
Barbara Schneider Foundation
Catholic Charities Twin Cities
Central Minnesota Mental Health Center
Children's Minnesota
East Metro Crisis Alliance
Epilepsy Foundation of Minnesota
Fraser
Guild
Hennepin Healthcare
Lutheran Social Service of Minnesota
Mental Health Minnesota
Mental Health Providers Association of Minnesota
Mental Health Resources
Mid-Minnesota Legal Assistance/Minnesota Disability Law Center
MARRCH - Minnesota Association of Resources for Recovery and Chemical Health
Minnesota Association of Black Psychologists
Minnesota Association for Children's Mental Health
Minnesota Association for Marriage and Family Therapy
Minnesota Association of Community Mental Health Programs
Minnesota Behavioral Health Network
MN Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Prenatal to Three Coalition
Minnesota Psychiatric Society
Minnesota Psychological Association
Minnesota School Social Workers Association
Minnesota Social Service Association
NAMI Minnesota
National Association of Social Workers, Minnesota Chapter Nurse-Family Partnership
NUWAY
Nystrom
People Incorporated
Pregnancy Postpartum Support Minnesota
RISE, Inc.
State Advisory Council on Mental Health Subcommittee on Children's Mental Health
Touchstone Mental Health
Vail Place
Washburn Center for Children
Wellness in the Woods