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Legalization of Medical Marijuana in Minnesota: Implications for Rural Substance Treatment Centers

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Legalization of Medical Marijuana in Minnesota: Implications for Rural Substance Treatment Centers

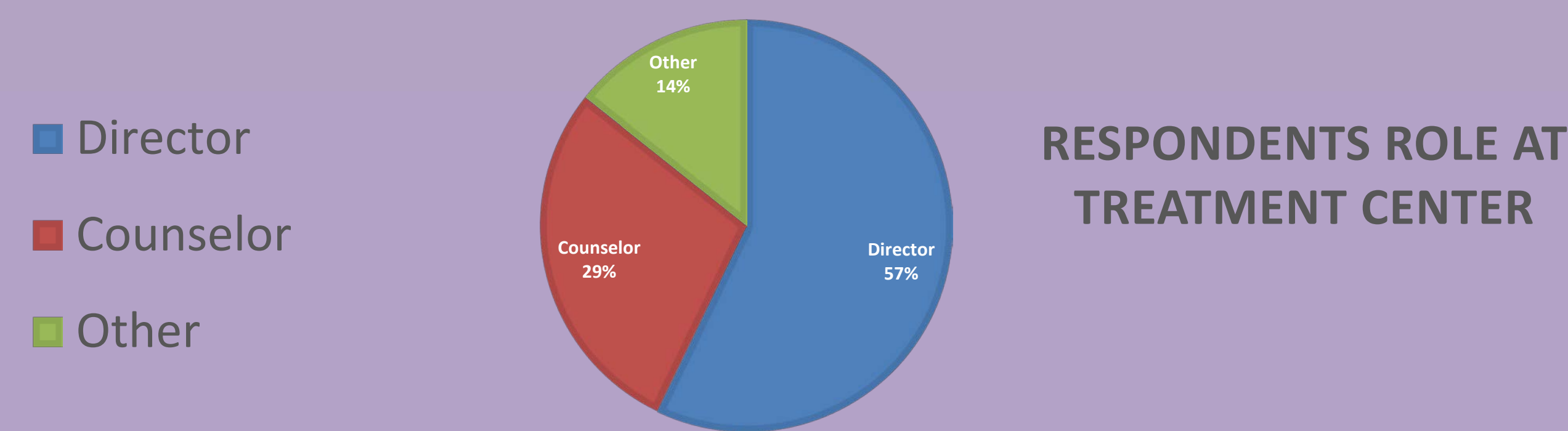
Ann Przybilla, MSW, LGSW

Statement of Purpose

The purpose of this project was to identify the anticipated impacts of legalization of medical marijuana (cannabis) in Minnesota on rural substance abuse treatment center professionals. The goal is to utilize the implications of those impacts to guide the implementation of the recently passed legislation and to provide recommendations for future policy regarding medical marijuana in Minnesota.

Literature Review

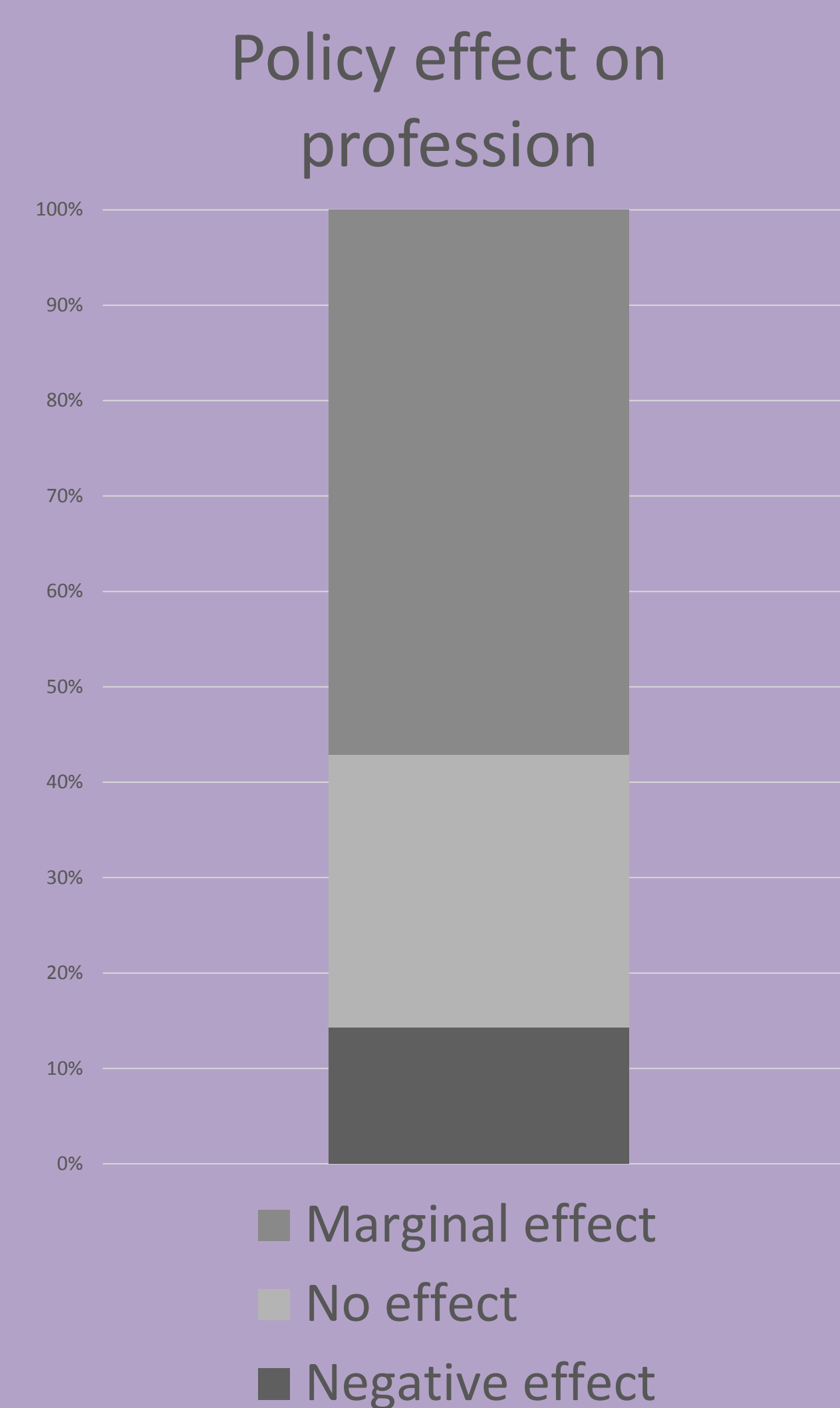
- ✓ MN is the 22nd state to allow the sale of marijuana, but with regulations and only for certain medicinal purposes for registered patients (SF 2470).
- ✓ Primary substance problem for 16.3 percent of total treatment admissions in 2012, second to alcohol (NIH, Epidemiologic Trends, 2013).
- ✓ Marijuana (a.k.a. cannabis) relieves some ailments and is a last resort option to help their children who do not get relief from other pharmaceuticals (Young, 2013).
- ✓ Synthetic forms of marijuana that are low in THC but high in cannabinoids offer relief without the “high” (Croxford, 2003).
- ✓ Marijuana is becoming a national industry. The predicted trade of marijuana is projected to be \$10.2 billion by the year 2018 (Goodman, 2013).
- ✓ In 2012, THC concentrations in marijuana averaged nearly 15 percent, compared to the 1980 potency of 4 percent (NIDA, 2012).
- ✓ In 2010, 14% of Blacks and 12% of whites reported using marijuana in the past year. However, Blacks in Minnesota are nearly eight times more likely to be arrested for marijuana possession as Whites (ACLU, 2013).
- ✓ Marijuana is more likely to be the source of treatment admission in rural areas as compared to urban areas (TEDS, figure 1).



SURVEY STUDY

An anonymous survey was emailed to 35 rural substance abuse treatment centers in Minnesota. Rural treatment centers included those located in counties not designated as parts of a Metropolitan Area by the Office of Management and Budget. Based on census information from 2010, this includes counties without a metro area containing 50,000 or more population (Office of Management and Budget, 2014). 20% of the 35 centers had at least one person who responded.

KEY FINDINGS



- **72% of respondents indicated the policy will increase an already pervasive attitude that the substance is safe and harmless, regardless of the negative consequences to the lives of those who use.**
- **Respondents did not reveal programmatic concerns such as possible higher admission rates for Cannabis Use Disorder.**

Discussion

- Overall, the policy signed into law by Gov. Dayton in 2014 is a good compromise for qualifying patients. Access to the substance will be highly regulated, which will likely decrease the chances of elevated use by youth while increasing access to those with qualifying conditions (SF 2470).
- Only liquid, oils, pills, whole plant extracts and resins of the cannabis will be allowed with this new legislation. Vaporizing of the oils or liquids is allowed but smoking is not.
- A 23-member task force will assist with the implementation of the legislation and will monitor substance abuse rates.

Recommendations

- The law does not include the design and implementation of an educational/media program describing both the aversive effects of marijuana and the potential benefits of cannabinoids for some ailments. An educational component could be very beneficial for social workers, rural substance abuse treatment providers, legislators, medical providers, parents and youth.

References

References are available from the author upon request.

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*Dedicated to the health and well-being of my family.
 Thanks for supporting me throughout this project.*

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