

Written Testimony of James A. Dumont, Esq., on behalf of Physicians for Health Communities

Re: H.612

Senate Health & Welfare Committee April 24, 2024

My name is James A. Dumont. My law office is in Bristol. Because there will not be time for me to testify, I submit this memo on behalf of Physicians for Healthy Communities to introduce the Committee to Dr. Libby Stuyt, to place her testimony in legal context, and to summarize what our other witnesses would testify about if there were time.

H.612 would authorize use of medical cards to purchase the highest potency THC cannabis and concentrates at retail recreational cannabis stores throughout Vermont.

Currently, Vermont medical marijuana cards are available to anyone 18 or older by talking over the internet with doctors or nurse practitioners in New York, Massachusetts or New Hampshire—that is, providers who are not licensed in Vermont.

Those providers need not be your actual doctor, or look at your medical records, or talk to your actual doctor. All they do is talk to you over the internet, for which they get paid. Your doctor may think this is a terrible idea, but these internet doctors don't ask and won't find out. If, based on the internet interview, they agree that you suffer from "**chronic pain**" or one of the other qualifying conditions, they sign the form and send it off to the Cannabis Control Board. One of those blank forms is Attachment 1.

Then you will be free to purchase **unlimited quantities** of high potency cannabis. Vermont law does not forbid multiple purchases at one store during one day, or many stores in one day. The only limit is on the size of each transaction. A fact sheet explaining this is Attachment 2.

Right now, this effectively unregulated issuance and use of medical cards is limited to the 5 dispensaries where you can use them. **H.612 would expand this to as many as 75 recreational retail stores**, if those stores apply for permission, pay a small additional fee, and change the layout of their stores.

Why take these risks? For no good reason. According to the CCB, the goal of this portion of H.612 is to increase the number of locations where high-potency cannabis can be purchased by persons with medical cards. This is a very bad idea.

According to the Vermont Medical Society, there is no credible medical evidence that high-potency cannabis has beneficial effect for pain or other indications. The peer-reviewed literature on the therapeutic value of cannabis has been on low-potency cannabis. Low-potency cannabis is already widely available. **According to the Vermont Medical Society, high potency cannabis is dangerous. Therefore, the Vermont Medical Society adopted a resolution condemning the uses of all high potency cannabis (dispensary or retail).**

"RESOLVED that VMS urges the Vermont Cannabis Control Board, local Cannabis Control Boards and/or the Vermont Legislature to require all cannabis grown, produced or sold whether through medical dispensaries or retail establishments, in the state be less than 15% THC cannabis as there is significant morbidity associated with its use, and as all research in the United States addressing any medical benefit of THC cannabis has been conducted on strains with potency less than or equal to

15% THC cannabis, and the risk of mental illness and addiction increases substantially with increasing THC concentrations" The complete VMS resolution is [Attachment 3](#).

H.612 would do exactly what the VMS says Vermont should not do.

Dr. Stuyt will explain to you that this bill would replicate what happened in Colorado -- a public health epidemic that resulted from widespread use of medical cards, especially among youth and young adults. After enormous harm was inflicted, Colorado overhauled the medical card system by adopting HB. 1317 to carefully limit their issuance and use, which H.612 does not propose to do.

Libby Stuyt, MD, is a Psychiatrist who for 20 years was the Medical Director of a large, well-respected, state-funded addiction treatment facility in Colorado. She will testify that high potency cannabis has no support in the peer-reviewed medical literature and is very dangerous. Cannabis, and in particular high potency cannabis, can induce psychosis and suicidality even in people with no history of mental illness. If H.612 is adopted, the expanded availability of medical cards will place Vermont in Colorado's situation before HB 1317 was adopted.

If there were time, we would also call **Laura Stack**, but you can watch her video instead. Laura Stack's child was given medical marijuana by a high school friend who used a medical marijuana card to procure high THC cannabis and then, at age 18, her son got his own medical marijuana card. He suffered addiction and psychosis, and died by suicide at age 19. Her video can be found at <https://spaces.hightail.com/space/yksDdWpWk0> . A transcript is [Attachment 8](#).

If there were time, we would also call **Representative Judy Amabile**, a member of the Colorado legislature. Her son suffered severe mental harm and addiction from high THC cannabis, so she led the effort to pass House Bill 1317. HB 1317 imposed the protections that this bill lacks. Her testimony about abuses of medical cards in Colorado, and how the legislature had to severely restrict them, can be found at <https://www.youtube.com/watch?v=PSQcCtOU2fs>,

If there were time, we would also call **Ken Finn, MD** of Colorado Springs. He is Board Certified in Physical Medicine and Rehabilitation, Pain Medication and Pain Management. He would testify that high potency cannabis is dangerous, has a high addiction potential in youth, and that he personally obtained a medical marijuana card in minutes from an online doctor. He would testify that H. 612 does not have adequate protections for teens or the public. His detailed, expert statement is [Attachment 9](#).

I also enclose as [Attachments 4 & 5](#), statements by **Colorado Attorney General Philip J. Weiser** and **Chris Rogers MD**, the medical director of child and adolescent services at the largest private psychiatric hospital in Colorado. Both statements describe the human tragedy that resulted from abuse of medical cards in Colorado, and why their use had to be sharply restricted—which H.612 does not do. Their youtube videos can be found at

<https://www.youtube.com/watch?v=XdFsU9gJbrQ>

And

https://www.youtube.com/watch?v=RPea6KtDW_A

I also submit [Attachments 6 & 7](#). These are written statements from two other witnesses we do not have time to call. Minnesotan **Heather Bacchus** explains in her statement that her teenage son went to Colorado to be able to obtain copious amount of high THC "medical" marijuana

using a medical marijuana card he could get at 18 without his parents' knowledge. He became addicted, sold high potency cannabis to other kids to support his habit, couldn't stop, and died by suicide. **Bryn Spejcher** also is submitting a statement. She was convicted earlier this year of involuntary manslaughter in California for stabbing her friend 108 times after smoking concentrated cannabis. The prosecution's expert and the defense's experts and the judge all agreed that she was suffering from cannabis-induced psychosis and had no idea what she was doing. She had no prior mental health history. The judge sentenced her to probation, with a condition requiring her to speak publicly, to people like you, about the connection between cannabis and psychosis to try to prevent this from happening to others.

END



State of Vermont
Medical Cannabis Program
89 Main Street
Montpelier, Vermont 05620-7001
www.ccb.vermont.gov

[phone] 802-241-5115
[fax] 802-241-5230
[email] CCB.Med@vermont.gov

Cannabis Control Board

HEALTH CARE PROFESSIONAL VERIFICATION FORM

The purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined. It should not be considered a prescription or recommendation.

“Debilitating medical condition” means:

- A) Cancer, Multiple Sclerosis, positive status for Human Immunodeficiency Virus, Acquired Immune Deficiency Syndrome, Glaucoma, Crohn’s disease, Parkinson’s disease, and Post-traumatic stress disorder or the treatment of these conditions, if the disease or the treatment results in severe, persistent, intractable symptoms.

- B) A disease or medical condition or its treatment that is chronic, debilitating and produces and one or more of the following intractable symptoms: cachexia or wasting syndrome, chronic pain, severe nausea, or seizures.

“Health care professional” means an individual who is:

- A) Licensed to practice medicine under 26 V.S.A Chapter 23 or Chapter 33;
- B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
- C) Certified as a physician assistant under 26 V.S.A. Chapter 31; or
- D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28.

This definition includes individuals who are professionally licensed under substantially equivalent provisions in New Hampshire, Massachusetts, or New York.

An applicant without a “debilitating medical condition” is not eligible for a registry identification card.





HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant’s health care professional and signed within the past 6 months.

PATIENT INFORMATION (Please print legibly)

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Telephone Number: _____

HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

First Name: _____ M.I. _____ Last Name: _____

Office Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

HEALTH CARE PROFESSIONAL LICENSE INFORMATION:

License Number: _____

Issuing State (circle one): VT NH MA NY

LICENSURE CATEGORY

- Doctor of Medicine Osteopathic Physician Naturopathic Physician
- Physician Assistant Advanced Practice Registered Nurse

VERIFICATION OF A DEBILITATING MEDICAL CONDITION

(A) Does the patient applicant have a debilitating medical condition as defined on the Cover Sheet?

- No Yes (if “Yes”, Section B **MUST** be completed)

(B) The patient applicant I am treating or consulting has been diagnosed with (check all that apply):

- Acquired Immune Deficiency Syndrome Glaucoma
- Cancer Human Immunodeficiency Virus
- Crohn’s Disease Multiple Sclerosis
- Parkinson’s Disease Post-Traumatic Stress Disorder

A disease or medical condition or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed below. (Please fill out BOTH diagnosis and symptom subsections)

Indicate specific **diagnosis**: _____

Indicate specific **symptom** (circle all that apply): *cachexia chronic pain severe nausea seizures*



HEALTH CARE PROFESSIONAL SIGNATURE

I certify that:

- (A)** I am a health care professional:
 - A) Licensed to practice medicine under 26 V.S.A Chapter 23 or Chapter 33;
 - B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
 - C) Certified as a physician assistant under 26 V.S.A. Chapter 31; or
 - D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28; or,
 - E) Professional licensed under substantially equivalent provisions in NH, MA, or NY.

- (B)** I am in good standing with the state (VT, NH, MA, or NY) regulating my professional license, and that the facts stated on this Health Care Professional Verification Form are true and accurate to the best of my knowledge and belief.

- (C)** I understand, notwithstanding any law to the contrary, a person who knowingly provides false information on this application may be guilty of perjury and imprisoned for not more than one year or fined not more than \$1,000.00 or both. This penalty shall be in addition to any other penalties that may apply.

Health Care Professional's Signature: _____ Date: _____

MAIL, FAX, OR EMAIL COMPLETED FORMS TO:

Cannabis Control Board
Medical Cannabis Program
89 Main Street Montpelier, VT 05620-7001

Fax: 802-241-5230
Email: Ccb.med@vermont.gov

Physicians for Health Communities Fact Sheet about H.612

18-year old Vermonters can get a medical marijuana card without their parents' knowledge and can then legally purchase dangerous high-THC concentrates under current law. 7 Vermont Statutes Annotated § 953(b) (“An application by a person under 18 years of age shall be signed by both the applicant and the applicant’s parent or guardian”). The Chair of the Vermont Cannabis Control Board, consistent with the peer-reviewed medical literature, has testified that high potency cannabis products are dangerous.

The only "medical" evaluation they must obtain can be over the internet from a doctor in another state who gets paid for each approval. Under Cannabis Control Board Rule 3.2.3 and 7 VSA § 951, the only requirement for the “medical” evaluation is that the health care provider be licensed in Vermont, NY, Massachusetts or New Hampshire. The statutes and the rules do not require an in-person meeting, nor even that the provider examine the applicant’s medical records or consult with the applicant’s mental health care provider or primary care provider. It is quick and easy for anyone to go on-line and find, for a fee paid by credit card, an out-of-state physician to fill out the minimal paperwork.

Under Vermont law teens and older users with these cards can make an unlimited number of purchases of these dangerous drugs, each day. Cannabis Control Board Rule 3.5.5 provides the only sales limits. It states that “In a single transaction,” a cannabis seller cannot sell more than the potency or quantities set by law. Neither the Board’s rules nor Vermont statutes limit the number of transactions per day, or restrict a purchaser from buying from multiple dispensaries. 7 VSA §§ 952, 971.

H.612, if passed, will enlarge these sales from the existing half-dozen dispensaries to the seventy-five recreational cannabis retail stores spread across Vermont. The Cannabis Control Board currently lists six dispensaries.¹ If this bill is passed, all 75 retail stores², by making some changes in their operations and paying a small fee, will be able to become sellers to “medical” card holders.

Colorado already tried this, with disastrous results, and Colorado now requires physician meetings with all med card applicants, requires two physicians for each applicant under 21, and established a statewide registry so that patients can only purchase the amounts their doctor has authorized. <https://leg.colorado.gov/bills/hb21-1317>. Unless H.612 is amended to include Colorado’s current protections, the bill should be rejected.

¹ <https://ccb.vermont.gov/med-dispensaries>.

² https://ccb.vermont.gov/sites/ccb/files/2024-03/Board.Meeting.February.2024_upd.pdf

Lessons from Colorado

The harms that resulted from Colorado's missteps in increasing access to medical marijuana offer important lessons for Vermont.

The Colorado Experience

- From 2009 to 2012 medical marijuana laws were loosened in Colorado allowing for greater access for medical marijuana patients and commercialization of the product.
- Eighteen-year-olds had access to medical marijuana cards, which gave them access to high-potency THC cannabis concentrates without the knowledge or consent of a parent or guardian.
- By 2021, of the kids who reported having consumed cannabis in the past 30 days, 52% said they had dabbled — vaporized a high-THC cannabis concentrate — and this number was up from 20% just four years ago, according to the bi-annual Healthy Kids Colorado Survey of over 46,000 high school students (2021).
- Colorado teens and their families began experiencing severe harms from use of the drug and Senators and State Representatives' children from both parties experienced harms. High THC was identified by pediatricians, including a House Representative as an urgent problem. <https://www.denverpost.com/2021/03/11/colorado-biggest-overhaul-marijuana-laws-thc-cap/>
- Here is a [very short but very powerful video](#) about what went wrong in Colorado, errors Vermont is poised to repeat. After many of these tragedies (including the children of legislators), the Colorado legislature overhauled how "medical card" marijuana is regulated.

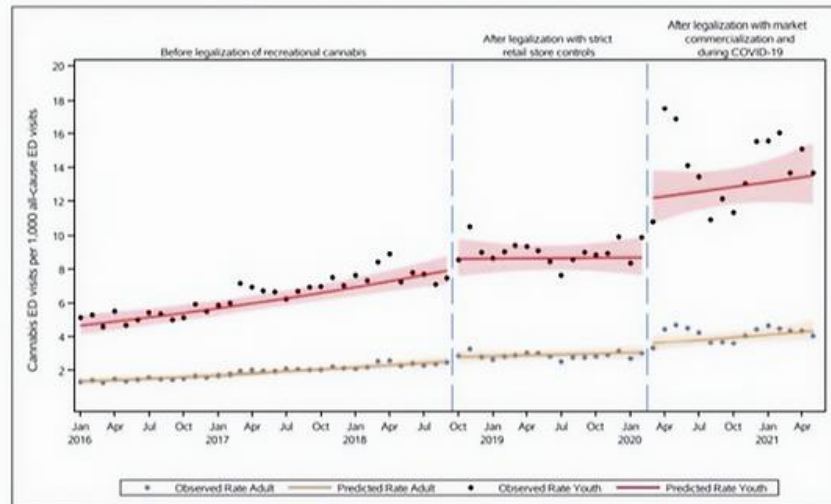


- After enormous time and resources were expended at the Colorado State House, [HB21-1317](#) was passed. Please review the safeguards Colorado put in place in this law to make their medical marijuana system safer for kids and adults.

- [Vermont Fact Sheet on H.612](#) was informed by lessons from Canada and Vermont's existing law.

Lessons from Canada

Ontario, Canada ED visits for adults and youth following loosening of strict regulations on number of retail stores

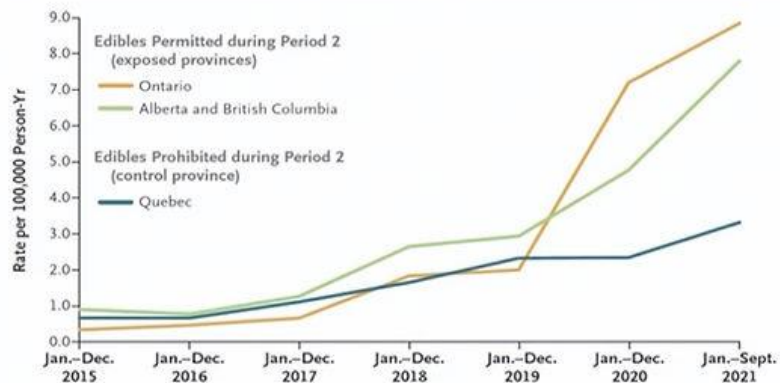


Source: Myran, D. T., Pugliese, M., Tanuseputro, P., Cantor, N., Rhodes, E., & Taljaard, M. (2022). The association between recreational cannabis legalization, commercialization and cannabis-attributable emergency department visits in Ontario, Canada: an interrupted time-series analysis. *Addiction*.

When Provinces allowed edibles and high THC concentrates child poisonings spiked.

Child poisonings did not spike provinces with THC caps (30%) and no legal edibles

Figure 1. Changes in Rates of Hospitalization for Unintentional Cannabis Poisoning in Children 0 to 9 Years of Age in Four Canadian Provinces, 2015–2021. The legalization of cannabis with restricted products began in October 2018. The legalization of edible cannabis products began in January 2020. CI denotes confidence interval.



Source: Myran et al, "Edible Cannabis Legalization and Unintentional Poisonings in Children" *NEJM* 387(8), Aug 25, 2022

Suicides

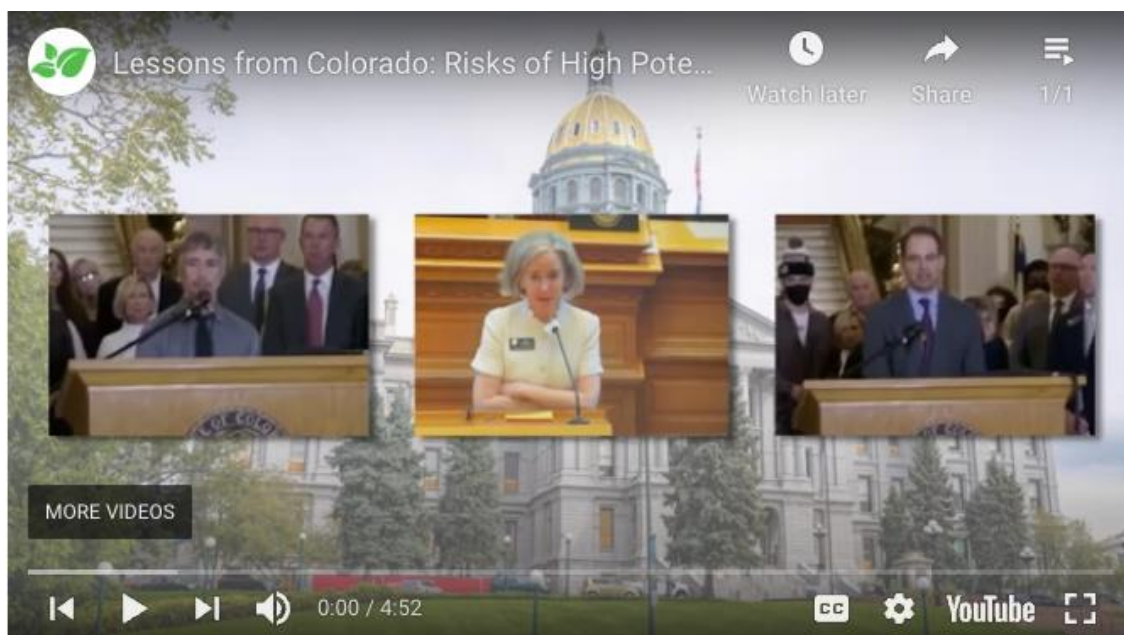
Increased suicides and mental health effects follows increased marijuana availability and potency.

[Are Marijuana Use and Suicide Linked? — A review of the data show there's cause for alarm.](#)
[MedPage Today](#) by Libby Stuyt, MD

Research Summary

Download this [comprehensive review of the research on the dangers of high-potency THC cannabis products](#). (20-page PDF)

Click the images below to open the corresponding reports from the Colorado Department of Public Health & Environment



ATTACHMENT 3

Vermont Medical Society Resolution VMS Position on Commercialized Sales of Cannabis As Adopted by VMS Board November 17, 2021

This Resolution amends and replaces the 2018 resolution Opposing a System of Commercialized Sales of Recreational Marijuana

Whereas, Vermont has the nation's highest past month cannabis use, including use of high potency (greater than 15%) THC, and use rates have significantly increased since 2013;ⁱ

Whereas, in 2020 according to the Vermont Department of Health "marijuana use is a significant public health problem in Vermont, and it is getting worse,"ⁱⁱ

Whereas cannabis use, especially of high potency greater than 15% THC, is associated with increased urgent and emergency department psychiatric visits and increased mental health disorders including psychosis;ⁱⁱⁱ

Whereas, cannabis use, especially high potency greater than 15% THC, is associated with increased urgent and emergency department non-psychiatric visits, including respiratory distress, often associated with overcrowding and overutilization of emergency room facilities;^{iv}

Whereas, non-mental health disorders, associated with or exclusively due to cannabis use, especially high potency greater than 15% THC, such as potentially life threatening and economically costly cannabis hyperemesis syndrome, a condition first described in 2004, are now seen in most large emergency rooms every day overburdening health care resources and staff;^v

Whereas, child and adult cannabis poisonings calls are increasing significantly and more than half of these calls often come from a health care facility;^{vi}

Whereas, the Centers for Disease Control and Prevention notes that these cannabis exposures can result in "extreme confusion, anxiety, paranoia, panic, fast heart rate, delusions or hallucinations, increased blood pressure, and severe nausea or vomiting;"^{vii}

Whereas, cannabis-related Emergency Department care also includes "cannabis withdrawal, and e-cigarette or vaping product use-associated lung injury (EVALI)..." and high potency greater than 15% THC or manufactured products are especially associated with serious medical outcomes;^{viii}

Whereas, evidence shows that youth ages 13-17 are about as likely to become addicted to cannabis as they are to opioids^{ix} and youth cannabis addiction is difficult to recover from as only about 10% of youth who receive treatment for cannabis use disorder/ addiction achieve abstinence one year after treatment;^x

Whereas, in Vermont there is a significant, inappropriately low perception of harm of cannabis use, including high potency greater than 15% THC, and this misperception is more prevalent than in the rest of the United States such that many Vermonters are generally unaware of the psychiatric and medical risks of cannabis use, including high potency THC cannabis;^{xi}

Whereas, Vermonters wish to be informed decision makers and Vermont physicians wish to inform the public so they are abreast of the known risks to their health of cannabis use, especially high potency greater than 15% THC use, including the risks of addiction, psychosis, suicide attempt or self-injurious behavior, low infant birth weight, painful uncontrollable vomiting, second hand smoke and impaired driving; therefore be it

RESOLVED that VMS strongly opposes the advertising, marketing and promotion of cannabis in the state of Vermont (including through the use of packaging, flavorings and placement/density of retail locations) in order to disincentivize establishments from pushing sales through fostering high use and addiction, given that 80% of product will be consumed by 20% or less of users (notably those with current or future dependence or addiction to cannabis); and

RESOLVED that VMS urges the Vermont Cannabis Control Board, local Cannabis Control Boards and/or the Vermont Legislature to require all cannabis grown, produced or sold whether through dispensaries or retail establishments in the state be less than 15% THC cannabis as there is significant morbidity associated with its use, and as all research in the United States addressing any medical benefit of THC cannabis has been conducted on strains with potency less than or equal to 15% THC cannabis, and the risk of mental illness and addiction increases substantially with increasing THC concentrations such that Netherlands declared greater than 15% THC cannabis a hard drug;^{xii} and

RESOLVED that VMS urges the Vermont Cannabis Control Board, local Cannabis Control Boards and/or the Vermont Legislature to require prominent labeling of all cannabis products with up-to-date, evidence-based warnings, which should currently include:

WARNING^{xiii}: Cannabis/THC may cause:

**1. Psychosis* 2. Impaired driving 3. Addiction 4. Suicide attempt*
5. Uncontrollable vomiting 6. Harm to fetus/nursing baby**

*This can occur in individuals with no previous history of psychosis or mental illness; and

RESOLVED that VMS urges the Vermont Cannabis Control Board, local Cannabis Control Boards and/or the Vermont Legislature to require that all written and internet advertising of cannabis display up-to-date, evidence-based warnings in typeface as large as the largest other typeface in the advertising, which should currently include:

WARNING: Cannabis/THC may cause:

**1. Psychosis* 2. Impaired driving 3. Addiction 4. Suicide attempt*
5. Uncontrollable vomiting 6. Harm to fetus/nursing baby**

*This can occur in individuals with no previous history of psychosis or mental illness; and

RESOLVED that VMS urges the Vermont Cannabis Control Board, local Cannabis Control Boards and/or the Vermont Legislature to require that all spoken advertising of cannabis include up-to-date, evidence-based warnings, which currently should include:

Warning: Cannabis/THC may cause psychosis and suicide attempts in persons with no prior mental health history, as well as uncontrollable vomiting, dangerous driving, addiction, and harm to fetuses and nursing babies.

*This can occur in individuals with no previous history of psychosis or mental illness; and

RESOLVED that VMS urges the legislature and administration to dedicate adequate resources, including but not limited to those generated by cannabis excise taxes and addiction-related settlement funds to statewide prevention and education efforts that include: 1) public warnings for adults and youth, 2) cannabis use prevention and education at schools and in underprivileged, underserved communities, 3) afterschool activities and using tools such as timely surveys to measure risk and protective factors proven to decrease high risk behaviors among adolescents, as exemplified by the Icelandic Model and/or the Third Space Model, 4) treatment of cannabis use disorder, 5) informing state leaders, the media and the public of the increased cost and burden to our health care system caused by cannabis, especially greater than 15% THC cannabis use, including ER crowding and overburdening, cannabis addiction, psychosis, suicide attempt or self-injurious behavior, mental illness, cannabis vomiting syndrome, child poisoning, and driving injuries; and

RESOLVED that VMS will work with the legislature to clarify that the Consumer Protection Act applies to false or deceptive marketing of cannabis products and to ensure that Vermont can use the same types of consumer protection tools that have proven to be helpful in controlling tobacco addiction and harms; and

RESOLVED that this resolution including all whereas clauses be released to the public and the press to aid in increasing public education and awareness.

Additional References: See Endnote xiv^{xiv}

ⁱ National Survey on Drug Use and Health, 2010-2018 and NSDUH December 2019 Report https://mhacbo.org/media/filer_public/3e/bf/3ebf8e97-83b3-42fa-ba1d-a8e06967d830/2019_epidemiologyweb.pdf

ⁱⁱ

<https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Health%20Care/Regulation%20of%20Cannabis/W~Kelly%20Dougherty~Health%20Impacts%20of%20Marijuana~1-24-2020.pdf>

ⁱⁱⁱ Mair, et al., 2015 Drug Alcohol Dependence doi: 10.1016/j.drugalcdep.2015.06.019. MPI Report Card. San Diego, 2021.

Monte et al., Annals of Internal Medicine 2019. <https://doi.org/10.7326/M18-2809>

Wang et al., Journal of Adolescent Health 2018. <https://doi.org/10.1016/j.jadohealth.2017.12.010>

Starzer et al., 2017 The American Journal of

Psychiatry. <https://doi.org/10.1176/appi.ajp.2017.17020223> Moulin et al., 2018 Frontiers in Psychiatry (Forensic Psychiatry).

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6039574/pdf/fpsyt-09-00294.pdf>.

Di Forti et al., Lancet Psychiatry 2019. [https://doi.org/10.1016/S2215-0366\(19\)30048-3](https://doi.org/10.1016/S2215-0366(19)30048-3) (This 2019 study from Lancet Psychiatry found that their data indicated that if high-potency cannabis were no longer

available, 12.2% to 50% of cases of first-episode psychosis which often present to emergency departments could be prevented in Europe. Cities with more cannabis use like Amsterdam showed the higher 50% rate, likely in line with Vermont cannabis use rates.)

Gobbi et al., *JAMA Psychiatry* 2019. doi: 10.1001/jamapsychiatry.2018.4500.

Murray RM et al. Cannabis-associated psychosis: Neural substrate and clinical

impact. *Neuropsychopharmacology*. 2017;124:89-104. doi: 10.1016/j.neuropharm.2017.06.018

Hjorthøj C, Posselt CM, Nordentoft M. Development Over Time of the Population-Attributable Risk Fraction for Cannabis Use Disorder in Schizophrenia in Denmark. *JAMA Psychiatry*. Published online July 21, 2021. doi:10.1001/jamapsychiatry.2021.1471

^{iv} Roberts, B. *West J Emerg Med*. 2019 Jul; 20(4): 557–572.

^v Fleming JE, Lockwood S. Cannabinoid Hyperemesis Syndrome. *Fed Pract*. 2017;34(10):33-36.

Sandhu, Gurkaminder MD; et al. Prevalence of Cannabinoid Hyperemesis Syndrome and Its Financial Burden on the Health Care Industry, *American Journal of Gastroenterology*: October 2017;112:S231-S232.

^{vi} Dilley, Julie et al. *JAMA Netw Open*. 2021;4(5):e2110925. doi:10.1001/jamanetworkopen.2021.10925

^{vii} <https://ctmirror.org/2021/07/19/legalization-of-recreational-pot-brings-worries-about-risks-of-child-poisoning/>

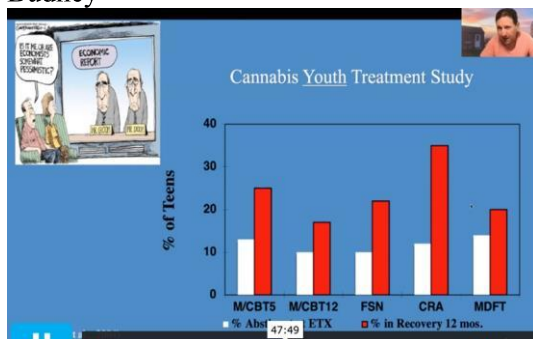
^{viii} Takakuwa KM, Schears RM. The emergency department care of the cannabis and synthetic cannabinoid patient: a narrative review. *Int J Emerg Med*. 2021 Feb 10;14(1):10. doi: 10.1186/s12245-021-00330-3. PMID: 33568074; PMCID: PMC7874647.

Hines LA, Freeman TP, Gage SH, Zammit S, Hickman M, Cannon M, Munafo M, MacLeod J, Heron J. Association of High-Potency Cannabis Use With Mental Health and Substance Use in Adolescence. *JAMA Psychiatry*. 2020 Oct 1;77(10):1044-1051. doi: 10.1001/jamapsychiatry.2020.1035. PMID: 32459328; PMCID: PMC7254445.

Freeman TP, Winstock AR. Examining the profile of high-potency cannabis and its association with severity of cannabis dependence. *Psychol Med*. 2015 Nov;45(15):3181-9. doi: 10.1017/S0033291715001178. Epub 2015 Jul 27. PMID: 26213314; PMCID: PMC4611354

^{ix} Volkow ND, Han B, Einstein EB, Compton WM. Prevalence of Substance Use Disorders by Time Since First Substance Use Among Young People in the US. *JAMA Pediatr*. 2021;175(6):640–643. doi:10.1001/jamapediatrics.2020.6981

^x VDH “Consequences Of Cannabis Use and Legalization on Youth”, September 9, 2021, Dr. Alan Budney



^{xi} Source: National Survey on Drug Use and Health, 2017-2018 and NSDUH Dec 2019 Report

<https://legislature.vermont.gov/Documents/2020/WorkGroups/House%20Health%20Care/Regulation%20of%20Cannabis/W~Kelly%20Dougherty~Health%20Impacts%20of%20Marijuana~1-24-2020.pdf>

^{xii} Stuyt, Elizabeth. “The Problem with the Current High Potency THC Marijuana from the Perspective of an Addiction Psychiatrist.” *Missouri medicine* vol. 115,6 (2018): 482-486.

^{xiii} *Reference #1: Colorado Child and Adolescent Psychiatric Society Sourced Letter, 9/27/2021*
Reference #2 <https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-marijuana-use-and-developing-brain/index.html>

Reference #3 [Monitoring_Health_Concerns_Report_FINAL Colorado State Report 2016-2.pdf](#)
^{xiv}

ADDITIONAL REFERENCES:

1. [Colorado Child & Adolescent Psychiatric Society Letter from 9/27/2021](#)
2. <https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-marijuana-use-and-developing-brain/index.html>
3. [Monitoring Health Concerns Report FINAL Colorado State Report 2016-2.pdf](#)
4. [Compilation of Current Research on Mental Health and High Potency THC](#)

ATTACHMENTS:

REFERENCE #1:

[Colorado Child & Adolescent Psychiatric Society](#) PO Box 27723 Denver, CO 80227 303.692.8783
CCAPS.office@gmail.com

September 27, 2021

RE: HB21-1317 “Tangible Educational Resources

Marijuana Enforcement Division Members:

HB21-1317 “Regulating Marijuana Concentrates” requires the state licensing authority to produce a “tangible educational resource” regarding the use of regulated marijuana concentrate. Section 44-10- 202 (8) further instructs this tangible educational resource shall include risks and precautions. We appreciate and support the inclusion of cannabis hyperemesis syndrome, cannabis use disorder, and other listed risks and precautions. However, they should not be categorized as occurring only in those with previous psychiatric history and other risk factors as cannabis use disorder most commonly occurs in individuals with no previous psychiatric history.¹ Similarly, cannabinoid hyperemesis syndrome is currently understood to be a physiologic response to chronic cannabis use that is independent of mental health.² Additional known risks of high-potency cannabis use include **cannabis-induced psychosis** and **suicide attempt or self-harm**.³ In the most current draft of the tangible educational resource provided by MED for review, cannabis-induced psychosis is listed as a risk only for those with previous psychiatric conditions, which is not accurate, and suicide attempt is excluded.

As it reads, the resource embeds the risk of psychosis only in individuals with psychiatric history and with “other risk factors.” This is not an accurate representation of what we know about the risk. Cannabis-induced psychosis can occur in individuals with no known psychiatric history, no known family history of psychosis, and no previous psychotic episodes. We are also concerned that the wording “psychotic symptoms and/or psychotic disorder” appears to minimize or soften the language, which is ineffective when conveying risk to consumers and patients. Cannabis-induced psychosis is a recognized medical condition attributed to cannabis use. While considered rare, chronic and treatment- refractory cases of cannabis-induced psychosis have occurred in Coloradans, primarily under the age of 25 years-old. Given the seriousness of this potential risk, a bold, direct statement is ethically required. For psychosis, we

propose the following: **WARNING: Risk of cannabis-induced psychosis and/or psychotic symptoms. This can occur in individuals with no previous history of psychosis.**

CDPHE materials do not limit risk of psychosis to only individuals with previous psychiatric or family history. In the 2020 report from CDPHE titled *THC Concentration in Colorado Marijuana: Health Effects and Public Health Concerns*, CDPHE makes the following stand-alone statement regarding psychosis: “We found MODERATE evidence that individuals who use marijuana with THC concentration >10% are more likely than non-users to be diagnosed with a psychotic disorder, such as schizophrenia.”⁴ Later, in summary of the evidence reviewed, CDPHE writes, “Current literature shows that adults who use

1 See <https://www.mdpi.com/2077-0383/10/1/15>.

2 See <https://link.springer.com/article/10.1007%2Fs13181-016-0595-z>.

3 See <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2723657>

4 See <https://www.thenmi.org/wp-content/uploads/2020/08/THC-Concentration-in-Colorado-Marijuana-CDPHE-8.3>

marijuana classified as containing high concentrations of THC (>10% THC) are more likely than non-marijuana-users to be diagnosed with a psychotic disorder, such as schizophrenia. In a 2015 study by Di Forti et al., individuals who reported using marijuana products with higher THC concentration (average 12.9% THC) had greater odds of developing first episode psychosis compared to those who never use marijuana products.” These statements do not contain the qualification that they only apply to individuals with previous psychiatric or family history.

In the previous drafts of the tangible education resource, risk of suicide attempt was also listed. However, in the current draft, this risk has been removed. Research studies consistently show that an active substance use disorder, including cannabis use disorder, increases the odds of attempting suicide among adolescents and adults. As with cannabis-induced psychosis, risk of suicide can exist in individuals with no previous psychiatric history and no family psychiatric history. We propose adding the following:

WARNING: Risk of suicide attempt or self-injurious behavior.

The current MED draft of risks and precautions mischaracterizes some of the statements as only applicable to individuals with psychiatric history or other risk factors and excludes suicide attempts. Coloradans want to make educated decisions regarding their healthcare and recreational behaviors and MED should make every effort to support Coloradans’ ability to do so by presenting accurate educational resources. We recommend the tangible educational resource read:

WARNING: Marijuana Concentrate may cause:

1. **Cannabis-induced psychosis and/or psychotic symptoms.** This can occur in individuals with no previous history of psychosis.
2. Mental Health Symptoms/Problems.
3. Cannabis hyperemesis syndrome (CHS).
4. Cannabis use disorder.
5. **Suicide attempt or self-injurious behavior.**

REFERENCE #4:

[Compilation of Current Research on Mental Health and High Potency THC](#) by Dr. Elizabeth Stuyt

1. Young-adult compared to adolescent onset of regular cannabis use:

A 20-year prospective cohort study of later consequences

Chan GCK et al. *Drug and Alcohol Review* (2021) DOI: 10.1111/dar.13239

By the mid-30s, both young-adult and adolescent-onset regular users were more likely than minimal/non-users (63.5%) to have used other illicit drugs (odds ratio [OR] > 20.4), be a high-risk alcohol drinker (OR > 3.7), smoked daily (OR > 7.2) and less likely to be in relationships (OR < 0.4). As the prevalence of the young-adult-onset group was nearly double of the adolescent-onset group, it accounted for a higher proportion of adverse consequences

than the adolescent-onset group. Cannabis users who began regular use in their teens had poorer later life outcomes than non-using peers. The larger group who began regular cannabis use after leaving high school accounted for most cannabis-related harms in adulthood. Given the legalisation of cannabis use in an increasing number of jurisdictions, we should increasingly expect harms from cannabis use to lie in those commencing use in young adulthood.

2. Association of High-Potency Cannabis Use With Mental Health and Substance Use in Adolescence

Hines LA et al. *JAMA Psychiatry* 2020;77(10):1044-1051.

In this cohort study of 1087 participants who reported cannabis use in the previous year, after adjusting for frequency of cannabis use and early adolescent mental health, use of high-potency cannabis was associated with a significant increase in the frequency of cannabis use, likelihood of cannabis problems, and likelihood of anxiety disorder. Those using high-potency cannabis had a small increase in the likelihood of psychotic experiences; however, this risk was attenuated after adjustment for frequency of cannabis use. Risks for cannabis use problems and anxiety disorders are higher among those reporting use of high-potency cannabis; provision of public health messaging regarding the importance of reducing both frequency of cannabis use and the potency of the drug, as well as limiting the availability of high-potency cannabis,

may be effective for reducing these risks.

3. Association Between Recreational Marijuana Legalization in the United States and Changes in Marijuana Use and Cannabis Use Disorder From 2008 to 2016 Cerda M et al. *JAMA Psychiatry*. 2020;77(2):165-171.

This study's findings suggest that although marijuana legalization advanced social justice goals, the small post-RML increase in risk for CUD among respondents aged 12 to 17 years and increased frequent use and CUD among adults 26 years or older in this study are a potential public health concern. To undertake prevention efforts, further studies are warranted to assess how these increases occur and to identify subpopulations that may be especially vulnerable.

4. The Effects of Cannabis Use on the Development of Adolescents and Young Adults

Hall W et al. *Annu. Rev. Dev. Psychol.* 2020. 2:461–83

This review summarizes evidence on the effects of cannabis use on the development

of adolescents and young adults. It draws on epidemiological studies, neuroimaging studies, case-control studies, and twin and Mendelian randomization studies. The acute risks include psychiatric symptoms associated with the use of high THC (tetrahydrocannabinol) products and motor vehicle accidents. Daily cannabis use during adolescence is associated with cannabis dependence and poor cognitive function, which may affect educational attainment and occupational choice. Daily use of highly potent cannabis is associated with more severe psychological symptoms, such as psychoses, mania, and suicidality.

5. Trends in Cannabis Treatment Admissions in Adolescents/Young Adults: Analysis of TEDS-A 1992 to 2016

Standeven LR et al. *J Addict Medicine* 2020

Treatment admissions for cannabis among adolescents/YAs rose 3-fold from 1992 (49,996) to 1996 (125,858). The majority of referrals came from the criminal justice system (56%). Cannabis is increasingly the sole substance of use, with polysubstance use decreasing from 89% in 1992 to 59% in 2016. While alcohol-related treatment admissions were most common in 1992, admissions for treatment of cannabis use (followed by heroin and alcohol) were highest (38%) by 2016. Being an adolescent (odds ratio [OR] 3.1, 95% confidence interval [CI] 3.1–3.2), non-Hispanic black (OR 6.2, 95% CI 6.2–6.3), male (female OR 0.6, 95% CI 0.6–0.6) with co occurring alcohol use (OR 25.9, 95% CI 25.7–26.1) was associated with admission for treatment of primary cannabis use as compared with other substances.

6. Evaluation of THC-Related Neuropsychiatric Symptoms Among Adults Aged 50 Years and Older A Systematic Review and Metaregression Analysis

**Velayudhan et al. *JAMA Network Open*. 2021;4(2):e2035913.
doi:10.1001/jamanetworkopen.2020.35913**

We used metaregression analyses to examine any association between THC dose and self-reported neuropsychiatric adverse events (AEs) using data from double masked, randomized clinical trials (RCTs) investigating CBMs in people aged 50 years or older. Higher THC dose was associated with a higher incidence of thinking or perception disorder and dizziness or light-headedness. Self-reported thinking or perception disorders reflect alterations in thinking and perception typically described under psychotic symptoms and suggest that older adults may also be at risk of psychotomimetic effects from THC.

7. Association of Cannabis Use With Self-harm and Mortality Risk Among Youths With Mood Disorders

Fontenella CA et al. *JAMA Pediatrics* 2020 doi:10.1001/jamapediatrics.2020.5494

A study of 204,780 (aged 10-24 years) Medicaid-enrolled youths with mood disorders found that the presence of cannabis use disorder was significantly associated with an increased risk of nonfatal self-harm, all-cause mortality, and death by unintentional overdose and homicide. Meaning Cannabis use disorder is common among adolescents and young adults with mood disorders and is associated with an elevated risk of self-harm, overall mortality, and death by unintentional overdose and homicide in this already vulnerable population.

8. Comorbid Cannabis Use Disorder with Major Depression and Generalized Anxiety Disorder: A Systematic Review with Meta-analysis of Nationally Representative Epidemiological Surveys

Onaemo VN et al. *Journal of Affective Disorders* 2021;281:467-475

In summary, our study findings provide further evidence on the strength of comorbid association of CUD with MD and CUD with GAD in the general population. The rates of comorbid MD and GAD is three times higher among those with CUD. This evidence should help guide clinical management of patients with comorbid CUD and mental health illness, which has often been associated with inadequate treatment, poor prognosis, and high levels of health service utilization (Hasin et al., 2016; Kessler, 2004). A thorough understanding of the way and reasons CUD co-occur with GAD and MD may provide effective prevention and treatment guidelines that focus on integrated shared-care approaches and/or psychosocial treatment in parallel systems (Horsfall et al., 2009; Mills et al., 2012; Tiet and Mausbach, 2007), as well as mitigate barriers

in clinical management of patients with a comorbid diagnosis (Mills et al., 2012). Given the increasing prominence of cannabis use along with ongoing changes in cannabis legalization in legalization in many countries (Statistics Canada, 2019; Hawley et al., 2020), it is imperative to mitigate the serious health-related harms of CUD, such as increased risk of comorbid anxiety or depression (Patton et al., 2002); high risk of myocardial infarction, stroke, and transient ischemic attacks (Thomas et al., 2014); increased ER visits and fatal car accident (Brady and Li, 2014)); and crime (Schauer et al., 2016). There is a great need for stronger evidence-based policy interventions that include, public health education about potential

harms and responsible use (Murray et al., 2007); increased clinicians training about treatment prognosis; more

health care funding due to increase service utilization of comorbidity; and reduce social stigmatization of individuals who seek treatment.

9. Understanding Opioid Use Disorder (OUD) using tree-based classifiers

Wadekar AS. Drug and Alcohol Dependence 2020

<https://doi.org/10.1016/j.drugalcdep.2020.107839>

The proposed machine learning approach predicts adults at risk for OUD with remarkable accuracy. **The dominant predictor of OUD is first use of marijuana before the age of 18 years.** Socioeconomic and demographic groups affected by such early initiation are also identified. The machine learning models are capable of finding a “needle in a haystack”, given the low number of observations with OUD. Finally, it is shown how a combination of different machine learning methods can be used to comprehensively and synergistically predict Opioid Use Disorder in adults.

10. Examining Associations Between Licensed and Unlicensed Outlet Density and Cannabis Outcomes From Pre Opening to Postopening of Recreational Cannabis Outlets

Pedersen ER et al. American Journal of Addiction 2020 DOI: 10.1111/ajad.13132

This study expands beyond studies of outlet prevalence to find that, after controlling

for outcomes 1 year prior, licensed and unlicensed outlets were associated with young adults' cannabis outcomes. The current study is among the first to find associations between cannabis use outcomes and density of cannabis outlets among young adults using data from two time points: pre opening and post opening of recreational cannabis retailers. Findings can inform policies around the density and placement of cannabis outlets.

11. Mapping cannabis potency in medical and recreational programs in the United States

Cash MC et al. PLOS ONE 2020 <https://doi.org/10.1371/journal.pone.0230167>

A total of 8,505 cannabis products across 653 dispensaries were sampled.

Despite the clear differences between medicinal and recreational uses of cannabis, the average THC concentration advertised online in medicinal programs was similar (19.2% \pm 6.2) to recreational programs (21.5% \pm 6.0) when compared between states with different programs, or between medicinal and recreational programs within the same states (CO or WA). Lower CBD concentrations accompanied higher THC products. The majority of products, regardless of medicinal or recreational programs, were advertised to have >15% THC

(70.3% - 91.4% of products). These stated concentrations seem unsuitable for medicinal purposes, particularly for patients with chronic neuropathic pain. Therefore, this information could induce the misconception that high potency cannabis is safe to treat pain. This data is consistent with reports in which THC and CBD in products from legal dispensaries or in nationwide products from the illegal market were actually measured, which indicates that patients consuming these products may be at risk of acute intoxication or long-term side effects. Our study offers grounds to develop policies that help prevent misconceptions toward cannabis and reduce risks in pain patients.

12. Risk of Persistence and Progression of Use of 5 Cannabis Products After Experimentation Among Adolescents

Barrington-Trimis JL et al. JAMA Network Open. 2020;3(1):e1919792

In this cohort study of 2685 adolescents with no history of heavy cannabis use, after accounting for polyuse of multiple products, the association of baseline experimental use with persistent use and

progression of use of that product during a 12-month follow-up period was significantly stronger for cannabis concentrate than for other cannabis products. The rate of persistence and progression after experimentation among adolescents may be amplified with the use of cannabis concentrate compared with other cannabis products.

13. Knowledge of Tetrahydrocannabinol and Cannabidiol Levels Among Cannabis Consumers in the United States and Canada

Hammond D, Goodman S. Cannabis and Cannabinoid Research 2020 DOI: 10.1089/can.2020.0092

Few consumers knew and were able to report the numeric THC or CBD levels of their usual cannabis products. For example, only 10% of dried herb consumers reported the THC level, approximately 30% of whom reported implausible values. A greater proportion of consumers reported a descriptive THC:CBD ratio of their usual product, ranging from 50.9% of edible users to 78.2% of orally ingested oil users. Consumers were substantially more likely to report

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products high in THC versus low in THC for all products except topicals and tinctures, whereas similar proportions reported using products high and low in CBD. Despite some evidence of greater knowledge in legal jurisdictions, knowledge was still low in states with legal cannabis markets.

14. Prevalence of Cannabis Withdrawal Symptoms Among People With Regular or Dependent Use of Cannabinoids A Systematic Review and Meta-analysis

Bahji A et al. JAMA Network Open. 2020;3(4):e202370

In this meta-analysis of observational studies including 23 518 participants, the prevalence of cannabis withdrawal syndrome was found to be 47%. Factors that were associated with higher cannabis withdrawal syndrome were clinical settings (particularly inpatient and outpatient vs population settings), concurrent tobacco or other substance use, and daily cannabis use. Cannabis withdrawal syndrome appears to be common among regular users of cannabis, particularly those in outpatient and inpatient settings and individuals with substance use disorders; clinicians should be aware of the high prevalence of cannabis withdrawal syndrome to counsel patients and support individuals who are reducing their use of cannabis

15. Progression of cannabis withdrawal symptoms in people using medical cannabis for chronic pain

Coughlin LN et al. Addiction 2021 doi:10.1111/add.15370

Adults with chronic pain seeking medical cannabis certification or recertification appear to experience mild to severe withdrawal symptoms. Withdrawal symptoms tend to be stable over a 2-year period, but younger age is predictive of worse symptoms and of an escalating withdrawal trajectory.

16. Association of Naturalistic Administration of Cannabis Flower and Concentrates With Intoxication and Impairment

Bidwell LC et al. JAMA Psychiatry 2020;77(8):787-796.

This study provides information about the association of pharmacological and neurobehavioral outcomes with legal market cannabis. Short-term use of concentrates was associated with higher levels of THC exposure. Across forms of cannabis and potencies, users' domains of verbal memory and proprioception-focused postural stability was primarily associated with THC administration.

17. Psychotic disorders hospitalizations associated with cannabis abuse or dependence: A nationwide big data analysis- Portugal

Gonçalves-Pinho M. et al. Int J Methods Psychiatr Res. 2020;29:e1813.

The number of hospitalizations with a primary diagnosis of psychotic disorder (PD) and schizophrenia associated with cannabis use (CU) rose 29.4 times during the study period, from 20 to 588 hospitalizations yearly (2000 and 2015, respectively) with a total of 3,233 hospitalizations and an average episode cost of €3,500. Male patients represented 89.8% of all episodes, and the mean/median age at

discharge were 30.66/29.00 years, respectively. From all hospitalizations with a primary diagnosis of PD or schizophrenia, the ones with a secondary

diagnosis of CU rose from 0.87% in 2000 to 10.60% in 2015. Conclusions: The increase on secondary diagnosis coding and the change on cannabis patterns of consumption in Portuguese population with an increasing frequency of moderate/high dosage cannabis consumers may explain the rise on PD Hospitalizations.

18. A genetically informed study on the association of cannabis, alcohol, and tobacco smoking with suicide attempt

Orri M et al. *Molecular Psychiatry* 2020 <https://doi.org/10.1038/s41380-020-0785-6>

To evaluate the potential causal contributions of cannabis use, alcohol use, and tobacco smoking to suicide attempt, we applied two-sample Mendelian randomization, an instrumental variable approach using single-nucleotide polymorphisms (SNPs) as instrumental variables for three exposures: lifetime cannabis use (yes/no; 42 instrument SNPs; GWAS sample size [N] = 162,082), alcohol use (drinks-per-week; 53 instrument SNPs; N = 941,280), and tobacco smoking (initiation, yes/no; 156 instrument SNPs; N = 1,232,091; heaviness; 27 instrument SNPs; N = 337,334). The main outcome was suicide attempt measured from hospital records (N = 50,264). Using multivariable Mendelian randomization, we found that only cannabis showed a direct pathway to suicide attempt (P = 0.001), suggesting that the effect of alcohol and smoking was mediated by the other substance use phenotypes. No evidence was found for reverse causation, i.e., associations of suicide attempt on cannabis (P = 0.483), alcohol (P = 0.234), smoking initiation (P = 0.144), and heaviness (P = 0.601). In conclusion, evidence from this quasiexperimental study based on genetic data from large-scale GWASs are consistent with a causal role of cannabis, alcohol, and tobacco smoking on suicide attempt.

19. Association of Cannabis Use in Adolescence and Risk of Depression, Anxiety, and Suicidality in Young Adulthood—A Systematic Review and Meta-analysis Gobbi G et al. *JAMA Psychiatry* 2019 [doi:10.1001/jamapsychiatry.2018.4500](https://doi.org/10.1001/jamapsychiatry.2018.4500)

In this systematic review and meta-analysis of 11 studies and 23 317 individuals, adolescent cannabis consumption was associated with increased risk of developing depression and suicidal behavior later in life, even in the absence of a premorbid condition. There was no association with anxiety. Preadolescents and adolescents should avoid using cannabis as use is associated with a significantly increased risk of developing depression or suicidality in young adulthood; these findings should inform public health policy and governments to apply preventive strategies to reduce the use of cannabis among youth.

20. The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study

Di Forti M et al. *The Lancet Psychiatry* 2019 [http://dx.doi.org/10.1016/S2215-0366\(19\)30048-3](http://dx.doi.org/10.1016/S2215-0366(19)30048-3)

This multicentre case-control study across ten European and one Brazilian site replicates the strong effect of daily use of high-potency cannabis (>10%THC) on the odds for psychotic disorder in the whole sample—which, to our knowledge, is the largest to date to address this question. This effect was particularly visible in London and Amsterdam. Additionally, we show that, assuming causality, if high-potency cannabis types were no longer available, then 12% of

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cases of first-episode psychosis could be prevented across Europe, rising to 30% in London and 50% in Amsterdam. Most importantly, we provide the first direct evidence that cannabis use has an effect on variation in the incidence of psychotic disorders. We show that differences in the prevalence of daily use of cannabis, and in use of high-potency cannabis, among the controls from the different study sites made a major contribution to the striking variations in the incidence rates of psychotic disorder that we have previously reported across the same sites.

21. Association between medical cannabis laws and opioid overdose mortality has reversed over time

Shover CL et al. PNAS 2019 www.pnas.org/cgi/doi/10.1073/pnas.1903434116

Medical cannabis has been touted as a solution to the US opioid overdose crisis since Bachhuber et al. [M. A. Bachhuber, B. Saloner, C. O. Cunningham, C. L. Barry, JAMA Intern. Med. 174,1668–1673] found that from 1999 to 2010 states with medical cannabis laws experienced slower increases in opioid analgesic overdose mortality. In this study, we used the same methods to extend Bachhuber et al.'s analysis through 2017. Not only did findings from the original analysis not hold over the longer period, but the association between state medical cannabis laws and opioid overdose mortality reversed direction from –21% to +23% and remained positive after accounting for recreational cannabis laws. We also uncovered no evidence that either broader (recreational) or more restrictive (low-tetrahydrocannabinol) cannabis laws were associated with changes in opioid overdose mortality. We find it unlikely that medical cannabis—used by about 2.5% of the US population—has exerted large conflicting effects on opioid overdose mortality. A more plausible interpretation is that this association is spurious. Moreover, if such relationships do exist, they cannot be rigorously discerned with aggregate data. Research into therapeutic potential of cannabis should continue, but the claim that enacting medical cannabis laws will reduce opioid overdose death should be met with skepticism.

22. Medical Marijuana Users are More Likely to Use Prescription Drugs Medically and Nonmedically

Caputi TL, Humphreys K. J Addict Med 2018 DOI: 10.1097/ADM.0000000000000405 Medical marijuana users were significantly more likely (RR 1.62, 95% confidence interval [CI] 1.50–1.74) to report medical use of prescription drugs in the past 12 months. Individuals who used medical marijuana were also significantly more likely to report nonmedical use in the past 12 months of any prescription drug (RR 2.12, 95% CI 1.67–2.62), with elevated risks for pain relievers (RR 1.95, 95% CI 1.41–2.62), stimulants (RR 1.86, 95% CI 1.09–3.02), and tranquilizers (RR 2.18, 95% CI 1.45–3.16). Our findings disconfirm the hypothesis that a population-level negative correlation between medical marijuana use and prescription drug harms occurs because medical marijuana users are less likely to use prescription drugs, either medically or nonmedically. Medical marijuana users should be a target population

in efforts to combat nonmedical prescription drug use.

23. Effect of cannabis use in people with chronic non-cancer pain prescribed opioids: findings from a 4-year prospective cohort study

Campbell G et al. www.thelancet.com/public-health Vol 3 July 2018

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. As cannabis use for medicinal purposes increases globally, it is important that large well designed clinical trials, which include people with complex comorbidities, are conducted to determine the efficacy of cannabis for chronic non-cancer pain.

24. Cannabis Use and Risk of Prescription Opioid Use Disorder in the United States

Olfson M et al. AJP in Advance 2017 doi: 10.1176/appi.ajp.2017.17040413

In a nationally representative sample of adults evaluated at waves 3 years apart, cannabis use was strongly associated with subsequent onset of nonmedical prescription opioid use and opioid use disorder. These results remained robust after controlling for the potentially confounding effects of several demographic and clinical covariates that were strongly associated with cannabis use. The association of cannabis use with the development of nonmedical opioid use was evident among adults without cannabis use disorders

and among adults with moderate or more severe pain. Among adults with nonmedical prescription opioid use, cannabis use was associated with an increase in the level of nonmedical prescription opioid use at follow-up.

25. Maternal and paternal cannabis use during pregnancy and the risk of psychotic-like experiences in the offspring

Bolhuis K et al. Schizophrenia Research 2018;202: 322-327.

In this prospective cohort, we examined the relationship between parental cannabis use during pregnancy and offspring psychotic-like experiences. Comparisons were made between maternal and paternal cannabis use during pregnancy to investigate causal influences of intrauterine cannabis exposure during foetal neurodevelopmental. This study was embedded in the Generation R birth cohort and included N = 3692 participants. We demonstrated that both maternal and paternal cannabis use were associated with more offspring psychotic-like experiences at age ten years. This may suggest that common aetiologies, rather than solely causal intra-uterine mechanisms, underlie the association between parental cannabis use and offspring psychotic-like experiences. These common backgrounds most likely reflect genetic vulnerabilities and shared familial mechanisms, shedding a potential new light on the debated causal path from cannabis use to psychotic-like phenomena. Our findings indicate that diagnostic screening and preventative measures need to be adapted for young people at risk for severe mental illness

25. Cannabis-associated psychosis: Neural substrate and clinical impact

Murray RM et al. Neuropharmacology 2017 doi.org/10.1016/j.neuropharm.2017.06.018

In our opinion, the epidemiological evidence clearly demonstrates that heavy cannabis use, particularly of high potency types, or of synthetic cannabinoids, increases the risk of psychosis, especially in those who start their use in their early teens.

27. Cannabis induced psychosis and subsequent psychiatric disorders

Shah D et al. Asian Journal of Psychiatry 2017;30:180–184.

Patients who completely abstained from cannabis after the 1st episode had no relapse of psychiatric illness. They showed marked improvement in socio-occupational functioning as well. All those who relapsed to cannabis use had a recurrence of illness. Half the patients with predominantly non-affective psychosis progressed to an independent psychiatric disorder; while only 7.7% of patients with predominantly affective psychosis developed an independent disorder ($p = 0.01$). Besides this, early onset of cannabis use (≤ 18 years), younger age at onset of 1st episode, positive family history of psychiatric illness, being unmarried and lower socio-economic status were associated with poor prognosis. Abstinence later in the course of illness did not improve outcome significantly.

28. Rates and Predictors of Conversion to Schizophrenia or Bipolar Disorder Following Substance-Induced Psychosis

Starzer MSK et al. AJP in Advance (doi: 10.1176/appi.ajp.2017.17020223) Substance-induced psychosis is strongly associated with the development of severe mental illness, and a long follow-up period is needed to identify the majority of cases. The highest conversion rate (47.4%) was found for cannabis-induced psychosis. Young age was associated with a higher risk of conversion to schizophrenia; the risk was highest for those in the range of 16–25 years.

29. Cannabis use disorder and suicide attempts in Iraq/Afghanistan-era Veterans

Kimbrel NA et al. Journal of Psychiatric Research 2017;89: 1-5

The objective of the present research was to examine the association between lifetime cannabis use disorder (CUD), current suicidal ideation, and lifetime history of suicide attempts in a large and diverse sample of Iraq/Afghanistan-era veterans (N= 3233) using a battery of well-validated instruments. As

expected, CUD was associated with both current suicidal ideation (OR= 1.683, $p = 0.008$) and lifetime suicide attempts (OR = 2.306, $p < 0.0001$), even after accounting for the effects of sex, posttraumatic stress disorder, depression, alcohol use disorder, non-cannabis drug use disorder, history of childhood sexual abuse, and combat exposure. Thus, the findings from the present study suggest that CUD may be a unique predictor of suicide attempts among Iraq/Afghanistan-era veterans; however, a significant limitation of the present study was its cross-sectional design. Prospective research aimed at understanding the complex relationship between CUD, mental health problems, and suicidal behavior among veterans is clearly needed at the present time.

30. Long Lasting Effects of Chronic Heavy Cannabis Abuse

Nestoros JN et al. The American Journal on Addictions 2017;26:335-342

We provide evidence that chronic and heavy cannabis abuse results in long-lasting brain dysfunction in all users and in long-lasting schizophrenia-like psychotic symptoms in more than half of all users. These findings suggest a reevaluation of the current classification of cannabis as a “soft narcotic” which erroneously, therefore, is typically considered harmless.

31. U.S. cannabis legalization and use of vaping and edible products among youth

Borodovsky JT et al. Drug Alcohol Depend. 2017; 177: 299–306.

This study examined relations among specific provisions of LCL and cannabis vaping and use of edibles in youth ages 14–18. Consistent with our previous study of adult cannabis users recruited via Facebook, the present analyses indicated that longer LCL duration and higher dispensary density were related to a higher likelihood of lifetime vaping and edible use. The current study extended those findings by showing that provisions for recreational cannabis use and for permitting home cultivation were also related to a higher likelihood of lifetime vaping and edible use. Some of these increased likelihoods were substantial. For example, living in a high dispensary density state doubled the likelihood of trying vaping and tripled the likelihood of trying edibles.

32. The association between regular marijuana use and adult mental health outcomes

Guttmannova K et al. Drug and Alcohol Dependence 2017;179:109–116

Objective: The present study is a prospective examination of the relationship between regular marijuana use from adolescence through young adulthood and mental health outcomes at age 33. Methods: Data came from a gender-balanced, ethnically diverse longitudinal panel of 808 participants from Seattle, Washington. Outcomes included symptom counts for six mental health disorders. Regular marijuana use was tracked during adolescence and young adulthood. Regression analyses controlled for demographics and early environment, behaviors, and individual risk factors. Results: Nonusers of marijuana reported fewer symptoms of alcohol use disorder, nicotine dependence, and generalized anxiety disorder than any category of marijuana users. More persistent regular marijuana use in young adulthood was positively related to more symptoms of cannabis use disorder, alcohol use disorder, and nicotine dependence at age 33. Conclusions: Findings highlight the importance of avoiding regular marijuana use, especially chronic use in young adulthood. Comprehensive prevention and intervention efforts focusing on marijuana and other substance use might be particularly important in the context of recent legalization of recreational marijuana use in Washington and other U.S. states.

33. Patterns of marijuana use among psychiatry patients with depression and its impact on recovery

Bahorik AL et al. Journal of Affective Disorders 2017;213:168–171

Participants were 307 psychiatry outpatients with depression; assessed at baseline, 3-, and 6-months on symptom (PHQ-9 and GAD-7), functioning (SF-12) and past-month marijuana use

for a substance use intervention trial. Longitudinal growth models examined patterns and predictors of marijuana use and its impact on symptom and functional outcomes.

Results: A considerable number of (40.7%; n=125) patients used marijuana within 30-days of baseline. Over 6-months, marijuana use decreased ($B=-1.20$, $p < .001$), but patterns varied by demographic and clinical characteristics. Depression ($B=0.03$, $p < .001$) symptoms contributed to increased marijuana use over the follow-up, and those aged 50+ ($B=0.44$, $p < .001$) increased their marijuana use compared to the youngest age group. Marijuana use worsened depression ($B=1.24$, $p < .001$) and anxiety ($B=0.80$, $p=.025$) symptoms; marijuana use led to poorer mental health ($B=-2.03$, $p=.010$) functioning. Medical marijuana (26.8%; n=33) was associated with poorer physical health ($B=-3.35$, $p=.044$) functioning.

34. Changes in cannabis potency and first-time admissions to drug treatment: a 16-year study in the Netherlands

Freeman TP et al. Psychological Medicine 2017 doi.org/10.1017/S0033291717003877

In this 16-year observational study, we found positive time-dependent associations

between changes in cannabis potency and first-time cannabis admissions to drug treatment. These associations are biologically plausible, but their strength after adjustment suggests that other factors are also important

35. Traditional marijuana, high-potency cannabis and synthetic cannabinoids: increasing risk for psychosis

Murray RM et al. World Psychiatry 2016;15:195–204

Epidemiological evidence demonstrates that cannabis use is associated with an increased risk of psychotic outcomes, and confirms a dose response relationship between the level of use and the risk of later psychosis. High-potency cannabis and synthetic cannabinoids carry the greatest risk.

36. Association of cannabis use with hospital admission and antipsychotic treatment failure in first episode psychosis: an observational study

Patel R et al. BMJ Open 2016;6:e009888. doi:10.1136/bmjopen-2015-009888

Cannabis use in patients with first episode psychosis (FEP) was associated with an increased likelihood of hospital admission. This was linked to the prescription of several different antipsychotic drugs, indicating clinical judgement of antipsychotic treatment failure. Together, this suggests that cannabis use might be associated with worse clinical outcomes in psychosis by contributing towards failure of antipsychotic treatment.

37. Limitations to the Dutch cannabis toleration policy Assumptions underlying the reclassification of cannabis above 15% THC

Van Laar M et al. International Journal of Drug Policy 2016;34:58–64

The purpose of this measure was twofold: to reduce public health risks and to reduce illegal cultivation and export of cannabis by increasing punishment. This paper focuses on the public health aspects and describes the (explicit and implicit) assumptions underlying this ‘15% THC

measure’, as well as to what extent these are supported by scientific research. Based on scientific literature and other sources of information, we conclude that the 15% measure can provide in theory a slight health benefit for specific groups of cannabis users (i.e., frequent users preferring strong cannabis, purchasing from coffee shops, using ‘steady quantities’ and not changing their smoking behaviour), but certainly not for all cannabis users. These gains should be weighed against the investment in enforcement and the risk of unintended (adverse) effects. Given the many assumptions and uncertainty about the nature and extent of the expected buying and smoking behaviour changes, the measure is a political choice and based on thin evidence.

38. Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study

DiForti M. et al. Lancet Psychiatry 2015 http://dx.doi.org/10.1016/S2215-0366(14)00117-5 The

association between cannabis use and increased risk of developing schizophrenia-like psychosis has been

consistently reported by prospective epidemiological studies.^{2,3} Our previous study was the first to show that use of high-potency (skunk-like) cannabis (>15% THC) carries the highest risk for psychotic disorders.⁸ In the present larger sample analysis, we replicated our previous report and showed that the highest probability to suffer a psychotic disorder is in those who are daily users of high potency cannabis. Indeed, skunk use appears to contribute to 24% of cases of first episode psychosis in south London. Our findings show the importance of raising awareness among young people of the risks associated with the use of high-potency cannabis. The need for such public education is emphasised by the worldwide trend of liberalisation of the legal constraints on cannabis and the fact that high potency varieties are becoming much more widely available. Finally, in both primary care and mental health services, a simple yes-or-no question of whether people use skunk might be more useful to identify those at increased risk to develop psychosis because of their cannabis use.

39. Effects of continuation, frequency, and type of cannabis use on relapse in the first 2 years after onset of psychosis: an observational study

Schoeler T et al. Lancet Psychiatry 2016; 3: 947–53

Continued cannabis use (at least monthly use) after the onset of psychosis, especially use of high-potency cannabis, is associated with a significantly worse outcome in individuals with first episode psychosis. In our study, outcomes were better in those who used cannabis in smaller doses (reduced frequency, lower potency, and shorter duration of continuation) after onset, which suggests that interventions should aim to reduce frequency of use or shift to less potent forms of cannabis when complete cessation of cannabis use might not be a realistic goal.

40. Daily Use, Especially of High-Potency Cannabis, Drives the Earlier Onset of Psychosis in Cannabis Users

Di Forti M et al. Schizophrenia Bulletin vol. 40 no. 6 pp. 1509–1517, 2014

We confirm an association between cannabis use and earlier age onset psychosis (AOP) and further show this to be independent of gender. Moreover, daily cannabis use and the use of high-potency cannabis are independently associated with a significantly higher hazard to make contact with services for psychosis at any given time. Finally, a younger age at first cannabis

use (≤ 15 years) is associated with a younger AOP only in those who had used cannabis daily. All these findings support a true effect of cannabis use on AOP, which is dose dependent, similar to its effect on risk of developing a psychotic disorder.

41. Examining the profile of high-potency cannabis and its association with severity of cannabis dependence

Freeman TP, Winstock AR. Psychological Medicine 2015; 45: 3181–3189

High-potency cannabis use is associated with an increased severity of dependence, especially in young people. Its profile is strongly defined by negative effects (memory, paranoia), but also positive characteristics (best high, preferred type), which may be important when considering clinical or public health interventions focusing on cannabis potency.

42. Young adult sequelae of adolescent cannabis use: an integrative analysis

Silins E et al. Lancet Psychiatry 2014;1:286–293

We recorded clear and consistent associations and dose-response relations between the frequency of adolescent cannabis use and all adverse young adult outcomes. After covariate adjustment, compared with individuals who had never used cannabis, those who were daily users before age 17 years had clear reductions in the odds of highschool completion (adjusted odds ratio 0.37, 95% CI 0.20–0.66) and degree attainment (0.38, 0.22–0.66), and substantially increased odds of later cannabis dependence (17.95, 9.44–34.12), use of other illicit drugs (7.80, 4.46–13.63), and suicide attempt (6.83, 2.04–22.90).

43. The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research (2017) National Academies of Sciences, Engineering, Medicine
PDF available at <http://nap.edu/24625>

44. Cannabinoids for Medical Use A Systematic Review and Meta-analysis Whiting PF et al. *JAMA*. 2015;313(24):2456-2473

Randomized clinical trials of cannabinoids for the following indications: nausea and vomiting due to chemotherapy, appetite stimulation in HIV/AIDS, chronic pain, spasticity due to multiple sclerosis or paraplegia, depression, anxiety disorder, sleep disorder, psychosis, glaucoma, or Tourette syndrome. A total of 79 trials (6462 participants) were included; 4 were judged at low risk of bias. Most trials showed improvement in symptoms associated with cannabinoids but these associations did not reach statistical significance in all trials. There was moderate-quality evidence to support the use of cannabinoids for the treatment of chronic pain and spasticity. There was low-quality evidence suggesting that cannabinoids were associated with improvements in nausea and vomiting due to chemotherapy, weight gain in HIV infection, sleep disorders, and Tourette syndrome. Cannabinoids were associated with an increased risk of short-term AEs.

45. Benefits and harms of medical cannabis: a scoping review of systematic reviews

Pratt M et al. Systematic Reviews (2019) 8:320 <https://doi.org/10.1186/s13643-019-1243-x> After screening 1975 citations, 72 systematic reviews were included. The reviews covered many conditions, the most common being pain management. Several reviews focused on management of pain as a symptom of conditions such as multiple sclerosis (MS), injury, and cancer. After pain, the most common symptoms treated were spasticity in MS, movement disturbances, nausea/vomiting, and mental health symptoms. Results from the included reviews were mixed, with most reporting an inability to draw conclusions due to inconsistent findings and a lack of rigorous evidence. Mild harms were frequently reported, and it is possible the harms of cannabis-based medicines may outweigh benefits.

46. Exploring cannabis concentrates on the legal market: User profiles, product strength, and health-related outcomes

Bidwell LC et al. Addictive Behaviors Reports 2018;8:102-106.

Background: Concentrated cannabis products are increasingly available and used, particularly in states with legal cannabis, but little is known about the profiles and characteristics of concentrate users. We aimed to characterize user profiles of cannabis users living in states with legal medical or recreational cannabis who reported using concentrates to those who do not use concentrates. Methods: An anonymous online survey was advertised in California, Colorado, Nevada, Oregon, and Washington. We compared respondents who endorsed frequent concentrate use (FC; N = 67) (i.e. 4 days/week) with cannabis users who never use concentrates (NC; N = 64), and with those who smoke/vaporize cannabis flower frequently but never or very rarely use concentrates (FF; N = 60), on measures related to cannabis use patterns and cannabinoid product strength, other substance use, and occupational functioning and health. Results: FC endorsed more symptoms of cannabis use disorder as compared to non-concentrate users ($p < 0.05$), but were similar to FF and NC on other health and occupational outcomes. FC also differed from FF and NC in that they tended to use cannabis that was higher in THC ($p < 0.0005$), even when using non-concentrated forms of cannabis ($p < 0.005$). Over half of FC users reported typically using concentrates of at least 80% THC, and 21% endorsed use of (non-concentrated) dry cannabis flower containing at least 30% THC. Conclusions: Concentrate users endorsed higher symptoms of cannabis use disorder and use higher strength cannabis even when using non-concentrated forms. Frequent use of concentrates may be associated with additional risks over and above frequent use of flower forms.

47. Acute Effects of Cannabis Concentrate on Motor Control and Speed: Smartphone-Based Mobile Assessment Hitchcock LN et al. *Frontiers in Psychiatry*

2021 <https://doi.org/10.3389/fpsy.2020.623672>

Use of cannabis concentrates in frequent users impairs movement speed and balance similarly in men and women. The motor impairment is largely uncorrelated with the change in THC plasma levels. These results warrant further refinement of cannabis impairment testing and encourage caution related to use of cannabis concentrates in work and driving settings.

48. Acute effects of naturalistic THC vs. CBD use on recognition memory: a preliminary study
Curran T et al. Journal of Cannabis Research 2020 2:28

Thirty-two regular cannabis users consumed cannabis of differing THC and CBD levels purchased from a dispensary and were assessed via blood draw and a verbal recognition memory test both before (pretest) and after (posttest) ad libitum home administration in a mobile laboratory. Memory accuracy decreased as post-use THC blood levels increased ($n = 29$), whereas performance showed no relationship to CBD blood levels. When controlling for post-use THC blood levels as a covariate, participants using primarily THC-based strains showed significantly worse memory accuracy post-use, whereas subjects using strains containing both THC and CBD showed no differences between pre- and post-use memory performance. Using a brief and sensitive verbal recognition task, our study demonstrated that naturalistic, acute THC use impairs memory in a dose dependent manner, whereas the combination of CBD and THC was not associated with impairment.

49. Association between Friends' Use of Nicotine and Cannabis and Intake of Both Substances among Adolescents

Herold R et al. Int. J. Environ. Res. Public Health 2021, 18, 695

Over one-third of the 517 surveyed adolescents reported using tobacco and one-third reported using cannabis. A significant relationship between friends' substance use and self-use was found. For both tobacco and cannabis, over 90% ($p < 0.01$) of participants with urinary biomarker levels above cutoff had friends who used the respective substance. Friends' nicotine and friends' cannabis use were each independently associated with urinary biomarker levels for those substances (for nicotine, $\beta = 88.29$, $p = 0.03$; for cannabis, $\beta = 163.58$, $p = 0.03$). Friends' use of nicotine and cannabis is associated with adolescents' intake, as well as the physiological exposure to those substances. These findings underscore the importance of including peer influence in the discussion with adolescents about tobacco and cannabis use.

50. When Cannabis Use Goes Wrong: Mental Health Side Effects of Cannabis Use That Present to Emergency Services

Crocker CE et al. Frontiers in Psychiatry 2021doi: 10.3389/fpsy.2021.640222

The situation in Colorado is also interesting from an epidemiological point of view as the past month cannabis use level among native Coloradans has remained constant since recreational legalization but healthcare utilization associated with adverse events due to cannabis has increased (38, 75). Some authors have noted that this may be related to the current market forces being focused on sales with ever increasing concentrations of THC in cannabis products (38). This may suggest a cumulative dose dependency for at least certain types of adverse events associated with cannabis use as has been suggested by others for the development of psychosis (28, 29, 76). The lack of research in these areas is not surprising given the challenges of doing research in urgent care and across disciplines to obtain outcomes for longer term psychiatric care. This lack of information further impacts clinical care as if we knew the frequency of conversion from a severe adverse mental health event related to anxiety symptoms or depressive symptoms with cannabis use to a diagnosed disorder requiring ongoing care, clinical guidelines could be developed. As we move to greater cannabis use with greater acceptance of the product, the ED may be one of the sentinel locations to monitor any

emerging mental health trends. There are also opportunities for public education that may be possible in the ED setting. The effects we present here are, we suspect, more commonly associated with higher (often

defined as 12% and greater) THC concentration strains of cannabis with little to no cannabidiol in the material as these are the most commonly sold strains in the marketplace in legalized settings (78, 79). The sale of these higher THC strains is based on consumer preference (80). However, there is evidence that consumers do not understand the significance of the percentages of THC and CBD in sales materials in the legal marketplace (81).

51. Recreational Marijuana Legalization and Use Among California Adolescents: Findings From a Statewide Survey

Paschall MJ et al. J. Stud. Alcohol Drugs 2021; 82: 103–111

We found no overall statistically significant association between RML and frequency of marijuana use among youth who reported any past-30-day use. However, marked increases in marijuana use frequency were observed in 2018–2019 across almost all demographic subgroups. This may reflect the recent substantial increases in vaping of tobacco and marijuana products among adolescents in the United States (Miech et al., 2019b). Our findings also indicate differential effects of RML on marijuana use prevalence among demographic subgroups of adolescents in California, notably having greater effects for those groups with historically lower prevalence rates of marijuana use. For example, stronger associations between RML and lifetime and past-30-day marijuana use were observed among females relative to males, and past-30-day marijuana prevalence use rates have converged in these two subgroups since 2010. Similarly, stronger RML effects on marijuana use were observed among non-Hispanic/Latinx relative to Hispanic/Latinx students, and marijuana use prevalence rates have converged in these two subgroups. Stronger associations between RML and marijuana use were also observed among White youth relative to African American and American Indian/Alaska Native youth, although somewhat higher prevalence rates persisted for these two groups

52. Association Between Recreational Marijuana Legalization in the United States and Changes in Marijuana Use and Cannabis Use Disorder From 2008 to 2016 Cerda M et al. JAMA Psychiatry 2020; 77(2):165-171.

Key Points Question How did marijuana use and cannabis use disorder change during 2008 to 2016 after the legalization of recreational marijuana in the United States? **Findings** In this multilevel, difference-in-difference survey study with 505 796 respondents comparing marijuana use before and after the legalization of recreational marijuana in the United States, the proportion of respondents aged 12 to 17 years reporting cannabis use disorder increased from 2.18% to 2.72%, while the proportion of respondents 26 years or older reporting frequent marijuana use increased from 2.13% to 2.62% and those with cannabis use disorder, from 0.90% to 1.23%. **Meaning** This study's findings suggest that possible increases in the risk for cannabis use disorder among adolescent users and increases in frequent use and cannabis use disorder among adults after legalization of recreational marijuana use may raise public health concerns and warrant ongoing study.

ATTACHMENT 4

<https://www.youtube.com/watch?v=XdFsU9gJbrQ>

Colorado Attorney General, Philip J. Weiser stated about the need for HB 1317:

"The rise of teenage use of high-potency concentration THC marijuana is a critical public health challenge. It demands our action and it is important what is being done here today. It is a model for the nation. Just consider the latest report for the Colorado Department of Health Public Health and Environment in their Colorado Healthy Healthy Kids Survey They surveyed the use of dabbing which has been discussed as a way of accessing high THC potency. It went from went from 4.3% of students in 2015, to over 20% in 2019. This is an alarming rise. And this HB1317 represents an important and critical response to this threat. ...our substance abuse trend and task force which I chair.. has focused on this issue with leadership from parents , from public health advocates identifying this troubling trend. This legislation meets that trend and addresses the fact that **our... medical marijuana laws have enabled teen access to high potency marijuana.** As we in Colorado work to address this public health challenge and refine the regulatory program ... we need to do so in a way that protects kids."

ATTACHMENT 5

https://www.youtube.com/watch?v=RPea6KtDW_A

Dr. Chris Rogers, Medical Director of Child and Adolescent Services at Medical Center of Aurora Colorado, the largest non-publicly owned psychiatric hospital in the state
Services at Medical Center of Aurora Colorado, the largest non-publicly owned psychiatric hospital in the state of Colorado, testified about the need for HB 1317.

“Inpatient psychiatrists have a front-row seat to the emerging epidemic of cannabis abuse and addiction that threatens to swallow the lives of a whole generation of Coloradans. On our adult inpatient unit, it's hard to keep count of the number of psychotic and suicidal patients that are admitted with THC on board, and regardless of the data and clear evidence of how cannabis contributes to their illness, person after person refuses to accept that marijuana could be bad for them. How could it be? They've been taught to believe this is a harmless plant and a medicine that is good from headaches, to cancer, to anxiety. It's natural, without side effects without the risk of addiction. This is the lie that is ruining the lives of far too many people in our state. The story on our adolescent unit is even more tragic, as we repeatedly treat kids that are too psychotic to know what's real, who they can trust, or where they are. The rates of adolescent psychosis have risen steadily.”

ATTACHMENT 6

Testimony of Heather Bacchus regarding Bill H612 April 24, 2024

Chair Lyons and Committee members, thank you for allowing me to submit written testimony in opposition to the Cannabis Bill, H612.

My name is Heather Bacchus, and I am the mother of a forever 21-year-old son who tragically died by suicide while in a state of Cannabis-induced psychosis. I am submitting this written testimony in opposition to H 612 on behalf of the youth and families of Vermont who grapple with addiction and mental health challenges. Many of them cannot be present here today due to the stigma associated with addiction or because they are striving to mend relationships shattered by the impact of substance use. Our son is no longer with us, his promising life cut short by the devastating effects of high-potency marijuana products that he began using at the age of 15. We have nothing left to lose, and we hope that you will listen to our story.

Although marijuana use was illegal when our son, Randy Michael, was 15 years old, it was readily available and easily accessible in our home state of Minnesota. By the time he was almost 17, he had been diagnosed with a severe cannabis use disorder and was sent to Wilderness Therapy. Despite our efforts to help him, Randy was hooked on cannabis and his use brought turmoil into our home.

Randy often echoed the industry's talking points, claiming it was medicinal, aided his ADHD, enhanced his creativity, and was not addictive. Sadly, his belief in the benefits of marijuana led to his demise.

At 18, Randy moved to Boulder, Colorado. He was accepted into the University of Boulder and embarked on a gap year. He established residency, enrolled in community college, and supported himself financially, even starting two companies. We were immensely proud of his accomplishments.

Unbeknownst to us, he obtained a medical marijuana card upon moving to Colorado, which allowed him to legally purchase high-potency THC products from dispensaries before the age of 21. Did you know that "Medical Marijuana" does not come with a prescription? He was never told how much, how often, or how potent of a product to use. His primary physician was never consulted, and he never had to disclose he had a cannabis use disorder to the "pot doctor". He was given a medical card at the age of 19 and allowed to purchase any amount and potency of medical marijuana which eventually destroyed his developing brain. He not only used these products himself but because they were so easily accessible, he illegally sold them to others funding his habit.

In January 2021, Randy began exhibiting concerning behavior, convinced that he would become a famous rapper with a clothing line despite lacking any musical inclination. He also developed paranoia towards his roommates, leading to a confrontation that resulted in his eviction. He gradually isolated himself from friends and family and experienced a complete psychotic break

in March 2021. He became convinced that rappers and the mob were targeting him, leading him to believe he needed to contact the FBI for help.

Recognizing the need for assistance, Randy reached out to us, expressing a desire to seek help “while he still had his brain”. However, after a brief stint in detox and treatment, he left, believing he could overcome his addiction by himself. In April, he felt suicidal, and was placed on a three-day hold, but released after just 24 hours due to the unavailability of mental health beds. Between October 2020 and July 2021, he suddenly quit 5 jobs and racked up over \$23,000.00 in medical bills due to his use.

When Randy took his life in July 2021, we knew that marijuana had played a significant role in his struggles over the past 8 months. What we didn't realize was the extent to which today's high-potency products can trigger cannabis-induced psychosis, suicidal ideation, depression, and anxiety in developing brains. Randy's brain had been irreparably damaged by high-potency Cannabis, as confirmed by a psychiatrist who diagnosed him with bipolar, ADHD, PTSD, anxiety, depression, mood disorder, and psychosis, supposedly resolved, but it was not.

I knew my son intimately. I ensured he received regular medical care, therapy, and support, yet his mental health deteriorated rapidly after he began using marijuana at 15. Randy's story serves as a stark reminder that Cannabis is indeed addictive and can lead to severe mental health consequences, including suicidal ideation, anxiety, depression, and psychosis. His delusions of grandeur, captured in video footage taken during the last months of his life, now serve as a testament to the devastating effects of addiction. View it here:

<https://www.beextraordinarybeyou.com/our-son>

As prevention educators, we used to commend Vermont for implementing potency caps, recognizing the potential dangers of high-potency THC products. Therefore, I implore you not to pass H 612, which would increase accessibility to these products by allowing recreational dispensaries to sell medical marijuana. It is as simple as paying as little as \$100.00 and making an online appointment to get a medical marijuana card. No conversation takes place with family, the person's physician who has access to medical and mental health history.

Allowing medical marijuana to be sold out of Vermont's 75 recreational dispensaries would put the health and well-being of Vermont's youth at risk and could result in immeasurable emotional and financial costs for the state. Instead, I urge you to prioritize evidence-based policies that prioritize public health over the profit motives of the marijuana industry.

Thank you,

Heather Bacchus

ATTACHMENT 7

Bryn Spejcher Statement to Vermont Senate Committee on Health and Welfare, April 24, 2024

My name is Bryn Spejcher. I am a doctor of Audiology. As you know, I was convicted of involuntary manslaughter 4 months ago. The judge later sentenced me to three years' probation, with a condition that I educate the public about the mental health harms and the dangerous risks of THC. That is why I am here today, testifying, on behalf of Every Brain Matters, which is the nonprofit organization that reports on my public engagement to my probation officer.

I understand that H.612 would make high potency marijuana more readily accessible to Vermonters. I am here to let you know that this has grave risks.

I want to protect others from what happened to me and my late friend. Just like the majority of the population, I thought there were no harms in using marijuana. I was wrong.

As a novice user, my psychosis was purely the result of cannabis given to me by a regular, experienced user in the state of California, where marijuana is legal. During my trial, the prosecutor's experts and my defense experts agreed this resulted in a cannabis induced psychosis, and that I had no prior or post incident mental health issues. This substance produced a severe psychotic reaction, something that is being seen more frequently around the world. My reaction produced a state of dissociation and detachment from the reality of my surroundings and cognitive processes, to the extreme, resulting in a tragic death and self-inflicting, permanent wounds.

I regret ingesting cannabis of any kind, now that I know the potential and serious risks of high potency THC. Please consider my unforeseen, life-altering example, and please do not make high potency cannabis more readily available in Vermont.

Thank you.

Transcript of Laura Stack Youtube statement in support of Colorado HB 1317, submitted in lieu of testimony about H.612, April 24, 2024

“I’m Laura Stack. My son is Johnny Stack, who died by suicide at the age of 19 after becoming psychotic from using high-potency THC dabs. He was a happy boy who was raised in an attentive, Christian home. He had a 4.0 GPA, a perfect SAT score in Math, and a scholarship to CSU. He first got marijuana at the age of 14 from a friend’s brother who had a med card. He got his own med card at 18, unbeknownst to us. We found the registry login on his computer after he died. Johnny had NO mental or physical conditions prior to using marijuana, and his primary care doctor confirmed they were not consulted. These products were not available to my child in my home and were not allowed in any fashion. These products have no smell and are easy to hide. As a result of THC, Johnny almost flunked his last semester of high school. He had many legal and social problems. He stole our family dog from our home and threatened to kill it if we didn’t give him money. He had three mental hospital stays, many outpatient programs, therapists, , psychiatrists, medications, expensive brain treatment as a last-ditch effort, and a suicide attempt before his psychotic break at the age of 19. Three days before he died, during dinner at our home, Johnny said, “I just want you to know you were right. You said marijuana would hurt my brain. Marijuana has ruined my mind and my life, and I’m sorry. I love you.” He jumped off the top of the RTD garage at Lincoln Station three days later. We recovered his journals after his death, and he wrote that the mob was after him and that everybody knew everything about him. I am very angry at the criminal “pot shop doctor” who gave my perfectly healthy son a med card so he could get high. My son was NOT depressed, abused, neglected, or self-medicating – he wanted to get high and became paranoid, delusional, and suicidal from being addicted to this toxic THC poison. High schoolers can get weed in 5 minutes, and the 18-year-old seniors are selling it to the younger children. I know because I have my son’s phone with his photos on SnapChat doing it. Johnny was not a criminal—he was a victim of the predatory addiction for-profit marijuana industry. Please vote YES on this bill and save our young people from the dangers of today’s potent marijuana products, or many teens will continue to follow Johnny’s path, and we will lose many generations of our youth in Colorado to psychosis and suicide.”

<https://spaces.hightail.com/space/yksDdWpWk0>

ATTACHMENT 9

April 23, 2024

My name is Dr. Kenneth Finn and I live in practice medicine in Colorado Springs Colorado for the past 30 years. I spent much of my childhood summers and winters in Vermont at Lake Bomoseen, and consider Vermont a wonderful and beautiful state.

I am somewhat disappointed regarding the road Vermont is going down as it relates to medical and recreational marijuana, putting its citizens at risk from a public health and safety perspective. Vermont is following the same path Colorado and other states already went down, and Vermont state leaders should acknowledge the unintended consequences other states, such as Colorado, California, Oregon, and Washington experienced under the banner of mass commercialization and expansion of their marijuana programs. Your state leaders cannot claim ignorance in this regard.

Colorado has taken notice of its mistakes and has tried to reel in access to its youth, and is working on trying to limit potency of products due to the well established harms associated with them, such as psychosis, including schizophrenia. The Colorado Department of Public Health and Environment issued a report in January 2023 showing that frequent marijuana use by Colorado youth is associated with psychotic disorders and daily or near daily marijuana used by adolescence and young adults is strongly associated with developing a psychotic disorder, such as schizophrenia in adulthood.

Colorado's medical marijuana program continues to have trouble particularly with the ease of access in obtaining a medical marijuana card. For example, I was able to obtain my medical marijuana card in 60 seconds without any questioning or review of my medical condition which may have justified the potential need for such a card. I applied due to the osteoarthritis in my knee requiring potential bilateral knee replacements however, my knee pain is generally managed with over-the-counter analgesics and is typically rated 0–2/10 on a pain scale. I was approved, however, for severe pain, in a matter of one minute. Full disclosure, I don't use marijuana products. Out of curiosity, I got my renewal the following year within a couple of minutes without any questions by the recommending provider and I cannot obtain any of my medical records by that provider, indicating that our relationship is not bona fide. It is my understanding Vermont has a very similar program structure with access to young adults 18–21 years of age.

Even more concerning is that Vermont will allow similar ease of access to these young adults to products that are very high in potency with known negative psychiatric effects such as cannabis, induced psychosis, suicide, and other behavioral problems. For example, marijuana is now the most common substance found in completed teen suicide, since Colorado has expanded its marijuana programs. That continues to worsen every year with nearly 43% of teenagers killing themselves in Colorado being positive from marijuana as the number one substance with alcohol approximately 27%, which is the second most common substance.

Marijuana is also the number one substance in completed suicide in anybody in Colorado under the age of 25.

The state of Oregon issued an audit report of their program in 2019 and was only able to inspect 3% of stores and 1/3 of growers for compliance and concluded that testing results were not reliable and that products were not even safe for human consumption.

I strongly recommend Vermont reconsider its current position as it relates to marijuana.

I emphatically recommend removing the part of this bill which you are evaluating which would put high THC “medical” marijuana concentrates in recreational stores all over Vermont due to the severe mental health harms this will cause Vermonters in your state

I recommend not supporting H.612.

Regards,
Kenneth Finn, MD