I am writing with comments on proposed changes to cannabis legislation that the committee is considering. I work in Winooski and live in Burlington and my work currently is in preventing substance use disorders, which necessitates a focus on built environment factors at the intersection of economic equity, racial equity, and equitable access to the opportunities for healthful living.

A dozen years ago, I worked on a series of projects for the Colorado Dept of Public Health examining the associations of their retail market landscape to demographic variables at the census tract. I've seen the evolution of markets and both public health opportunities that were acted on, as well as those that were missed... Controlling density, proximity to youth-serving outlets, advertising, potency, prices, serving sizes, and health messaging are among those health-protective opportunities that we **do not want to miss in VT**.

I'd like to reframe the approach to cannabis regulation to focus on the plan to protect Vermonters from developing Cannabis Use Disorder (CUD). Potential impact on rates of CUD, diagnosis, and treatment plans, and recovery infrastructure are the lens through which I see cannabis policy.

There was a recent NYT piece that captures some of the concerns I typically feel when looking at expanding cannabis access - the population level rate of use, the understanding in healthcare about diagnosis of CUD (and subsequently CHS, which may come after a CUD screening/diagnosis opportunity has been missed), and unfortunate spread of misinformation, such as cancer curative claims (which have happened in VT even through CCB-vetted communication, and have yet to be corrected) that may lead extraordinarily vulnerable patient groups to be taken advantage of.

In this slidedeck, you can find some recent data summarized from a group of public health researchers in April 2025. My main takeaway from that slidedeck is the current population level estimates for CUD:

Cannabis use disorder
• Developed in 20-25%of those who use cannabis
• 45% of those who start before age 16
• This progression to CUD has doubled over past 20 years (used to be 1 in 10)

With that prevalence and change in mind, below are some general principles for controlling the risk of developing cannabis use disorder in VT:

1. -limit the number and density of places where cannabis can be purchased. We know that when density increases, use increases, as do substance use disorders and subsequent harms. **I was at a retail density roundtable with the CCB a few weeks ago and both licensed retailers and public health professionals expressed that they do not want more retail outlets at this time.**
2. -keep advertising limited, especially in venues where youth may be exposed. Advertising is associated with youth initiation of cannabis use. Young initiation of use is a key predictor of future CUD.

3. -keep potency low. Use of higher potency is associated with higher risk of developing CUD, psychosis, and other issues that will be hard for our health system to adequately address right now.
4. -invest in treatment of CUD. This could be through legislation, increased taxation, or other means. CUD will be underdiagnosed for many years to come as the market expands and as people start to realize that CUD is a possible outcome of cannabis use.
5. -invest in messaging so that people can self-examine their use and hear corrective messaging. Misinformation about cannabis has spread rapidly, but accurate information about CUD has not reached consumers or the general public in VT.
6. -invest in corrective messaging that **cannabis is *not* prescribed,** excepting 4 FDA authorized medications. This is a common piece of misinformation that teenagers cite to me as a reason why they feel safe using cannabis - they believe that people are being prescribed it. Unfortunately, some of the misinformation takes advantage of incredibly vulnerable population groups, such as suggestions (including in previously approved CCB messaging) that cannabis can be used to treat or cure cancer (as opposed to alleviating the pain and nausea associated with cancer and cancer treatment, which is what is supported by the existing evidence).
7. -last but not least, consider the experiences of people in recovery from CUD. These same interventions mentioned above that protect people from developing CUD, **also make it easier for those in recovery to avoid relapse.** And, when people *do* relapse (which is an expected part of recovery from any SUD), consider what the messaging is in the community to encourage that person to find help... is it messaging that alienates them by making them feel like CUD isn't real or is it messaging that embraces them and reconnects them to support?

I know this is a difficult issue to legislate and I appreciate your effort to take into consideration how to best ensure access to health for everyone and reduce strain on our healthcare system in Vermont.

Respectfully,
Marielle

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Book time with me here.
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