Health Impacts Subgroup—Meeting Two DRAFT Minutes
September 14, 2020
9:00 AM
Virtual Meeting via WebEx
Meeting Video Link will be Available Soon

Meeting Attendees:
Annette Kelley (Board of Pharmacy), on behalf of Caroline Juran
Assistant Secretary Catie Finley, on behalf of Secretary Daniel Carey
Heather Martinson (Co-chair for Prevention Council VASCB), on behalf of Jennifer Faison
James Hutchings (Department of Forensic Science)
Jenn Michelle Pedini (Virginia NORML)
Ngiste Abebe (Columbia Care)
Nour Alamiri (Chair of Community Coalitions of VA)
Dr. Sam Caughron (Charlottesville Wellness Center Family Practice)
Michael Carter (VSU and local farmer)
James Thompson (Virginia Center of Addiction Medicine)
James Christmas (River City Integrative Counseling)

Nour Alamiri called the meeting to order at 9:05 AM.

Approval of August 19, 2020 Minutes

- Nour Alamiri called for a vote to approve the minutes of the subgroup's last meeting on August 19, 2020.

Roll Call Vote: 8 yes, 0 no

- Unanimous in favor of approval of minutes

Nancy Haans, Executive Director, Prevention Council of Roanoke

<u>Introduction and Health Impacts of Marijuana, Slides 1-3</u>

- The Prevention Council is a former Drug Free Community Support Grantee (U.S. Office of National Drug Control Policy)
    - Been around for 20 years, non-profit in Roanoke
    - Use strategic prevention framework prevention out of SAMHSA (U.S. Substance Abuse and Mental Health Services Administration)
- Have been looking at the marijuana issue since around 2004
    - Work closely with the Community Coalitions of Virginia (CCOVA) and with Smart Approaches to Marijuana (SAM)
- Their biggest concern is the brain and teenage use. The marijuana of today is different than marijuana 5-7 years ago – the opioid and fentanyl crisis, along with legalization in the western states, has allowed marijuana to look different. We also know so much more about adult and teen brains than we used to. They work closely with several research teams including Virginia Tech Research Institute, a data team at Virginia Tech, a

researcher at Radford, and Lauren Bickel who has a large body of work around tobacco, opioids, and marijuana.

- See slides 2-3 for their one-pagers on why marijuana is no joke.
- Youth are now using pens and you can vape almost anything. They are also very concerned about edibles.

Current Virginia Data on Marijuana, Slides 4-6

- CCOVA has been looking at this since 2014, when she and a representative from Chesterfield SAFE held a law enforcement summit and met with representatives from Colorado about their experience.
- They started seeing what data localities had on marijuana use and trends, and similar to when started to look at the opioid crisis, they did not have all the data they needed to attack it.
- See slides. Overall, there is either no or insufficient marijuana-related data on poison center calls, poisoning incidents at hospitals and clinics, impaired driving, marijuana use rate, and butane hash oil explosions.
- While they cannot get marijuana use rate by locality, they do have the state-wide Youth Risk Behavior Survey which randomly selects 1,500 students. Some coalitions, especially Drug Free Community Grantees, do have to collect larger data sets.
    - In Roanoke, they work closely with Carilion and the local Virginia Department of Health but neither had the necessary data.
- The lack of data is a concern, especially when looking at the experience of western states who have legalized.

Youth Risk Behavior Survey (YRBS), Slides 8-11

- Last week, they were able to prevent 20 years of survey data on 6th to 12th graders and their parents to the Roanoke County School Board. In Roanoke, they use that date for programming, planning, and interventions.
- See slide 10 for middle school survey trends. Nancy's concern is that peer disapproval and perception of harm are going down since they began collecting this marijuana use data in 2006. Also, even though parental disapproval is in the 90th percentile, many parents are unsure of what to saw.
- The high school data looks different (slide 12). They have gotten it down to 3 out of 10 students who have ever used. YRBS leadership - including students, parents, and school administrators – often look at the 30-day past use (16%) to get the landscape and guide future actions and questions.
- A year and a half ago (2020) they started asking specifically about dabbing and dabbing pens 5% of middle schoolers and 20% of high schoolers reported use. (Teens are often very literal so if dabbed, will report they have not smoked marijuana.)
- For high schools, Nancy highlighted that peer disapproval is around 50% and the perceived risk of harm is steady around 50-55%. Anecdotally, youth have easy access to marijuana.

- In terms of parental disapproval, increasingly parents report that messaging is confusing, especially with what they hear in the media and from legalized states. More messaging and education is needed.

National Partners, Slides 12-15

- They just finished their first year of Partners of Success grant from SAMHSA, which will be looking at alcohol, marijuana, and methamphetamines.
- Another national partner is Clear Alliance in Oregon.
- When perception goes down usage goes up, and that is pretty much the case for any of these states across the country.
- Oregon 11th Grade Data – Slide 13. You can see that 2014-2018 – with legalization being in 2016 – perception of harm for marijuana went down and 30-day use went up.
- Roanoke is collaborating with Oregon and using their TMEC model (slide 14) because it is the first curriculum they have seen that includes marijuana prevention and messaging.
    - Update the curriculum every two years based on the environment.
    - Working closely with the Surgeon General.
- In addition to adapting the TMEC curriculum, they are using the Did You Know Campaign and offering it at 10 sites.
- Prevention programming is key. In Colorado, Washington, and Oregon no prevention programs were in place. We have an opportunity to collect data and start these prevention programs as soon as possible to get good education and messaging for both youth and for families.

Additional Data re: Use Rates, slide 16-18

- YRBS 2019 looked at percentage of co-occurring substance behavior among high school students that reported prescription opioid misuse in the past 30 days, and you can see that see that lifetime marijuana use is closely connected to co-occurring use (slide 16).
- Monitoring the Future Survey from Dr. Nora Valkow (NIDA) shows increasing vaping. It is important to understand that teens can vape anything and pens allow for repeated, hidden use.
- See takeaway from national data on slide 18.
- What they have found in the community is that there is a myth about kids using only one substance when it reality the substance are connected. They can use the data to examine those connections and trends.
- Takeaways: We need to slow down and get as much data as we can and build on what they have been able to collect in the last five years.

Tom Bannard, VCU Program Coordinator for Rams in Recovery (College Recovery Program at VCU)

Biases and Disclosures, Slide 2

- The Virginia College Collaborative and Jason Kilmer from the University of Washington helped him put together these slides. They are on the front lines of understanding the impacts of legalization, especially on young adults.
- In terms of his background, he is in long-term recovery and hasn't used substances since December of 2006. His recovery has given him a good life and he did not have that prior. He has a felony as a result of distribution of cannabis, which has impacted his ability to find employment. If he had not had substantial resources for his own recovery and his career, he would not be able to have the life he has today.
- He works with students in recovery, including from cannabis use disorder, and can see the devastating impacts. His bias is towards policies to prevent and educate.

Outline & Policy Continuum, Slides 3-4

We have options here and policy occurs on a continuum, and sometimes do not pull levers can to protect public health.

- Prohibition or criminalized has major unintended side effects including mass incarceration and the driving of organized crime that we have seen.
- Decriminalization has advantages in that it does not criminalize the individual; however it doesn't eliminate the black market.
- Medicalization means it has to be a medically recommended product, but that not necessarily eliminate risk and may even increase risk (think opioids).
- Legalizing options:
    - Fully commercialized (e.g. caffeine)
    - Limits – Seen a spectrum of good policies when it comes to tobacco that limit use. In alcohol that is less true; we do have limits but choose not to pull a lot of the public health levers.

Potency, Slides 5-8

- We have seen a dramatic increase in potency over the last 40+ years and we know that in states that have legalized the concentration is higher.
- In Washington State, legalization included funds for research so have ongoing study of young adults and cannabis use that is the source of a lot of the data from theses slides (see slide 6).
- Vape, extract, and dab products have high a concentration of THC.
- Higher potency associated with both acute and chronic problems
- Where CBD seems to have a little more evidence pointing to medical benefits, we don't see a high percentage of THC in any of those products. That is a "hard fake" from the marijuana industry, since THC is what sells. if we look at what sells it is THC
- Dose and delivery makes a difference (slide 8). Potential for harm reduction in vaping vs. smoking, though science is still out.

Science is still good that weed is not good for you – see slide 9

Impacts on Collegiate Settings, Slides 10-11

- If we care about college affordability, we should care about cannabis use. Students are more likely to take breaks as they increase use (slide 10).
- See slide 11 re: short- and long-term negative outcomes for students. Those who are heavy users of marijuana end up with lower earning results 10 years later (UMD research).

Washington State – Good and Bad News, Slides 12-14

- Decreasing perception of risk, which impacts use and is not in line with the science
- Increasing perception of risk for alcohol (may or may not be associated with marijuana)
- For 21-25 year olds: Statistically significant increases in both past-month use and at-least-weekly. It is interesting that weekly use increase in higher than increase in overall prevalence, which may be attributed to the potency of the product or increased availability.

Public Health Policy Strategies, Slides 15-16

- Legalization does not necessitate increased use. There have been public health policies around tobacco use that may be our best window into finding policy that reduces marijuana use.
- See takeaways from reviewing the research on slide 16. The goal is to prevent another Big Tobacco, since those in the prevention and intervention cannot compete the resources of the marijuana industry. He advises starting with more restrictive policies, since it is easier to liberalize policies than to tighten them. Tom's commentary on the slides included:
    - People who can profit from the marijuana industry should not be involved in policy-making decisions. Organizations that are doing advocacy work on behalf of the marijuana industry put out highly inaccurate information that overstates the benefits and understates the harms.
    - Out state monopoly on alcohol sales has been an effective policy strategy in Virginia, so we should replicate what has been done well there.
    - The harms around substance use are likely to outweigh the tax revenues, so any revenue we collect should be put back into prevention, treatment, harm reduction, repairing the harms of past drug policy (war on drugs), and research to measure the efficacy of those policies.

Public Health Wins in Washington State – see slide 17

Virginia Incarceration Rates, slides 18-21

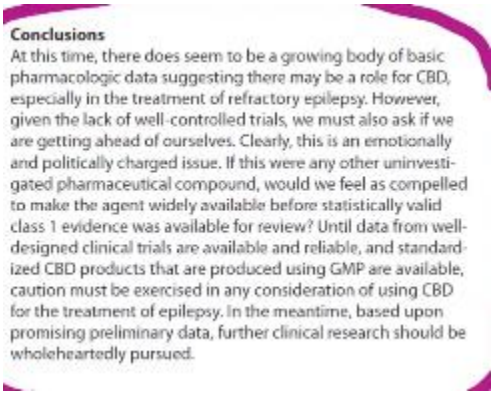
- The positive impacts of reducing overall arrests due to marijuana is very positive from a public health standpoint, especially given the disproportionate incarceration of Virginians and of people of color.

Considerations, Slide 22

Tom closed with some considerations that need more evidence. He also showed an excerpt from a study re: medicalization, and said we may be getting ahead of ourselves with marijuana policies given the lack of research. He reminded the group of the opioid epidemic, where physician prescribing pushed use and addiction in populations that would not otherwise have tried opioids.

Commentary around considerations:

- Re: whether the illegality of cannabis reduces the effectiveness of prevention messaging, that means are we discrediting ourselves with illegality since young people know that cannabis is less harmful that alcohol by almost every measure.
- Re: evidence of legalization and crime rates, he is suspect of the data showing increases in violent crime from legalization



Conclusions

At this time, there does seem to be a growing body of basic pharmacologic data suggesting there may be a role for CBD, especially in the treatment of refractory epilepsy. However, given the lack of well-controlled trials, we must also ask if we are getting ahead of ourselves. Clearly, this is an emotionally and politically charged issue. If this were any other uninvestigated pharmaceutical compound, would we feel as compelled to make the agent widely available before statistically valid class 1 evidence was available for review? Until data from well-designed clinical trials are available and reliable, and standardized CBD products that are produced using GMP are available, caution must be exercised in any consideration of using CBD for the treatment of epilepsy. In the meantime, based upon promising preliminary data, further clinical research should be wholeheartedly pursued.

(Welty, et al., 2014 (p. 251) *GMP = Good Manufacturing Pracitices*

Dr. Dustin Sulak, Owner and Medical Director, Integr8 Health

<u>Introduction, Slide 2</u>

Dr. Sulak's expertise is as a practitioner and a clinician for patients that do not respond to traditional therapy.

<u>Public Safety Impacts, Slides 5-13</u>

He went through statistics that pointed to the fact that states with liberalized cannabis policies are not seeing negative public health/safety impacts in terms of youth use patterns, traffic safety, crime, and workplace safety. See slides 5-13. Associated commentary included:

- Youth use: We are seeing perception or risk of marijuana decrease. That is usually associated with increased use, but in this case we are seeing decreasing use. He thinks that has to do with education from the government/others and messaging to youth. As mentioned earlier, if we overstate the harms then youth will not believe use and wonder what else we are lying to them about.
- Traffic safety: These studies don't show causality, just an association, but still not a big signal that liberalizing the cannabis laws increased in traffic fatalities, in fact it's the opposite.

- Again, the impacts have to do with education and policy.
- Occupational injuries: People can use marijuana in a way that causes impairment, but can also substitute it for other medication that are more likely to cause workplace injuries like opioids or benzodiazepines.

Individual Health Impacts, Slides 14-20

His patients and patients more broadly are using cannabis as a substitute for prescription medications, whether their doctors tell them to or not and whether they are in a legalized state or not.

- See slide 14 for substitutions for other prescriptions, including narcotics and opiates.
- See slide 15. When we look at Medicaid reimbursements we can see significant decreases in Medicaid prescribing in several categories (including pain) in states with medical cannabis laws. New Jersey and Washington State saved $900,000 and $2 million (respectively)that are potentially related to liberalization of cannabis laws.
- In the past people have focused on the harms of marijuana, but we are now starting to see the benefits.
    - Overall lower death rates show that cannabis may protect individuals experiencing a heart attack or a traumatic brain injury. He is not suggesting all put THC in our system to prevent this occurrence, but showing there could be public health benefits, especially if replacing other substances like tobacco, opioids and alcohol.
    - There is also a lower incidence of obesity, though we can't say that is causal.
- There is also therapeutic value in growing cannabis. You can safely grow a year's supply in your backyard. In its raw state it's pretty much harmless, because heat is needed to activate the THC component.

Conclusion, slide 21

We need an honest, evidence-based look at what responsible use looks like as the most important component of the policy change. Most teens have only used cannabis to get high quickly and secretly. They know what responsible use looks like for alcohol, but not marijuana. See the considerations on slide 21.

We know some people who are using are abusing, and there are ways to address that while maximizing the benefits.

Q&A:

Question from Assistant Secretary Catie Finley: Can you talk about how you distinguish between the benefits of medical and adult use, since medical cannabis is already legal in Virginia?

- Dr. Sulak: There is a huge overall benefit. When Maine allowed physicians to treat anyone with medical cannabis, not just those with certain conditions, many that had not been eligible for medical use had already been treating themselves through the adult use program. Sleep disturbance and insomnia is a good example of that. Some surveys out of

Colorado showed that 40% were using to help with sleep, which is a medical issue that has a huge impact on chronic disease and health care utilization. The data showing causation is more clear when we look at controlled clinical trials for multiple sceloris patients that are using pharmaceutical grade cannabis, so we can get clues about what is happening to patients using for things like anxiety, and insomnia regardless of what kind of legalization we are discussion. The education needs to anticipate that.

Question from Tom Bannard: Do you have any relevant disclosures?

- Dr. Sulak replied that he is:
    - Equity owner and Director of Healer Incorporated, which does cannabis education and processing/extraction technology
    - A paid speaker for Spectrum Therapeutics, which is part of Canopy Growth (focused on clinician education)
    - On the Advisory Board of two cannabis science companies: Zeelira Therapeutics and Core Analytics
    - A Board Member in the Society of Cannabis Clinicians (unpaid position)

Question from Dr .Caughron: The current thought is age of 21 for legality. Is there thought on if that is the best age?

- Dr. Sulak supports 21. He has seen a lot of parents that take away their teens' cannabis and say academic performance decreases and anxiety increases. Then they give it back, and things improve again. There is a growing cohort of teens that are using but don't know how, and he steers their ship towards responsible (not risky) use. His experience is that there is a level of responsibility at 21 that is often appropriate. If someone needs to use under 21, they can do it under medical supervision.

Question from Ms. Ngiste Abebe – What is the scale or your practice? She also noted that her takeaways from his and other presentations is the importance of continuing research and making sure that youth use (under 21) should be under doctor supervision with pharmacist assistance.

- Dr. Sulak: Over last 11 years, their three sites across Maine and Mass (about 12 providers) have seen 18,000 patients. Currently, his site in Maine is following 8,000 patients and they are seeing the age demographic shift to elder and youth use, a trend that is continuing as far as the research goes. As far as research and education goes, it should start with a needs assessment to establish people's gaps in knowledge and inform outcomes research.

Dr. Peter Breslin, Board Certified Psychiatrist/Board Certified Addiction Medicine

Dr. Breslin is a formally trained psychiatrist who got additional training in addiction medicine.

<u>Cannabis Use Disorder (CUD), Slides 2-3</u>

What is addiction, dependence, and abuse (how do you differentiate)? The DSM created criteria that is extrapolate to all SUD, so we generalize CUD to alcohol use disorder, cocaine use disorder, etc.

That means we are in a gray area in terms of diagnosing it, because there is push to talk about the positive medical uses (like Dr. Sulak's presentation) and to consider daily use (similar to Prozac). That positive utility is not something that exists with all drugs, like methamphetamines, which really blurs the boundary as to what addiction is, because in the addiction community they would say that dependence is frequent use. In other words, how do you make the distinction between dependence and medical use?

Of these criteria, two important ones stand out: tolerance (need more in order to achieve the same effect) and whether the person has a hard time cutting down when they want to. Another key factor is any negative repercussions – can look at legal repercussion (e.g. DWI) or, under legalization, whether use is impacting multiple areas of their life e.g. social, work, and responsibilities. If it is negatively affecting their life, regardless of whether the patient look at marijuana as medicinal, it is considered CUD. See the severity definitions on slide 3.

Cannabis Research, Slide 4

Dr. Breslin had a point of contention with Dr. Sulak re: research. There is not a lot of cannabis research, in part because THC has been Schedule 1 substance, so it is difficult to do human studies incorporating THC. Other countries have been able to do more research, but the other factor is that there is a lot of propaganda around CBD (see chat box discussion). CBD is not necessarily FDA approved, minus a couple products that are not what is being provided over-the-counter. That means there are not studies even if people argue that there are. The studies that are out there do not have any weight, they are usually 5 to 10 people and the results are often not discernible. It is not appropriate to extrapolate those results to the whole population and say that CBD has generalizable benefit.

Dr. Sulak is also using correlation and implying causation. If medical cannabis had become legal in Virginia and there was also a 10% decrease in heart attacks, that does not mean THC is causing it. We know how to do peer review studies and that is not what Dr. Sulak presented.

Dr. Bresline agrees with Tom Bannard that there is highly inaccurate information and progaganda around CBD. It if often presented as a panacea and the studies generally do not show it is better than a placebo.

Mental Health Negatives of Cannabis, Slide 5

As a psychiatrist, he sees the negative impacts of cannabis use and those generally occur when a high amount of THC is involved.

- Can cause acute psychosis, but that generally goes away after intoxication ends.
- When look at data, marijuana does not cause schizophrenia, which has been one of the myths. It can cause acute psychosis in those patients, but again that is temporary.
- Re: anxiety – have seen on Dr. Sulak's webpage that he talks about this point - cannabis can help anxiety but it can also worsen it, especially acutely (e.g. paranoia).
- Anecdotally, this affects his practice. This past Friday he had a patient that did well in college and is now in recovery housing due to marijuana. He has schizophrenia, which was not caused by marijuana, but he now has a fixed delusion that if he can keep smoking

weed and write music he will be a millionaire. He also thinks his recovery house is exploiting him and stealing his money. So it's terrible thing for him to have access to cannabis.
- Dr. Breslin is pro-legalization, but thinks we need to have safeguards and regulations in place and those with certain diagnoses should not have access.

Mental Health Positive of Cannabis, Slide 6

- There is a good amount of data from true studies that it does help with chronic pain, PTSD, and some forms of anxiety.
- He is not trying to "naysay" cannabis, but agrees with the paragraph that Tom Bannard read (above, from Welty et al 2014 study). It doesn't yet demonstrate a significant benefit over placebo and therefore studies are inconclusive.
- There needs to be further research before we jump to conclusions. Creating propaganda that using correlations to imply causation and overstates the benefits is harmful to the legalization process.
- Takeaways: Need to prepare, fund research, provide preventive care, have effective regulations, and keep it from minors (except special medial cases where positives outweigh the negatives).
- Pointed to Department of Veterans Affairs Study entitled "Benefits and Harms of Cannabis in Chronic pain or Post-traumatic Stress Disorder" that reviewed the literature and show that many studies were low-quality or inconclusive.

Q&A

Dr. Sulak – Are you suggesting that we should discriminate access to cannabis based on bipolar disorder or psychosis? At-risk populations already have access to illegal cannabis, couldn't we disconnect them from the underground market and provide them peer support and supervision instead of discriminate against them? Should the state bar them from dispensaries and drive them to the underground market?

- Dr. Breslin: Are you asking whether psychosis and schizophrenia, where there is evidence that marijuana use worsens their prognosis and treatment outcomes, should have access? No one is saying go to the underground – it is about education and the harm reduction model. He does 90% addiction and opioids are much worse than cannabis. As a physician in Virginia he can't encourage it, but can provide them with education. If you can use one substance to get off another, that is fantastic. And yes, needs to be certain diagnoses that have less access to marijuana for their safety.
- Dr. Sulak noted that while there are at-risk population, we do not do that with tobacco and alcohol. For example, we do not restrict tobacco for those with COPD. That would reduce health care utilization tremendously, but gets into civil liberties.

Group Discussion:

Assistant Secretary Finley: What are the next steps in terms of presenters or topics for us to discuss?

Ms. Nour Alamiri, one of the subgroup co-chairs, facilitated the conversation.

- Dr. Caughron: There is no question that unregulation of the industry has led to a huge problem. How can we use the experience of other states to give guidance in how we word things and positively impact the environment in Virginia.
    - He is concerned about use or marijuana in children and under age. Part of growing up is learning where are limits are, especially between 13 and 17. The regulations must be clear and we must have education.
- Ms. Alamiri agreed. She heard the theme of concentrating on regulations and encouraging safety and what the restrictions are in terms of age and maybe "dosage," as well as the limits of medical and recreational use.

Ms. Abebe sees 3 clear lines in terms of outlining policy:

1) Limit youth use to medical use. She noted that the medical cannabis industry has no interest in marketing to minors.
2) Research is necessary. The first presenter showed there is data that is not yet required to report, and that is important in showing any adverse effects of legalization and in tracking changes in youth use rates. The general topline has been downward but we need to continue to understand the products that are being used and update evidence-based education curriculum, perhaps even including state approval process.
3) Public health prevention and campaigns are critical, as well as around safe storage and child proof packaging, especially with edibles. There must be education on responsible purchasing and consumption. Education and prevention is a shared concern, as is reducing interactions of law enforcement and additional criminalization, which falls disproportionately on certain communities.
    a. Remember that legalization does not end systemic racism re: resource distribution and where law enforcement is patrolling, so need to move beyond legalization and ensure that enforcement mechanisms do not continue to be disproportionate.

Mr. Michael Carter – We need to get to the root causes of marijuana use. We need to look at the disproportionate arrest rates of black males and see how those activities increase anxiety and lead to marijuana use.

Revenues should be used to support *all* Virginians, such as mental health supports including for anxiety and depression. Decriminalization doesn't get rid of the underlying anxiety of going through life. Prohibition stemmed from racist policies and that trickled down to enforcement. When 53% of those being arrested for marijuana are African American, that is quite alarming for him and his four sons, even though he has never used marijuana in his life.

Legalization will offset the challenges that we have in terms of interactions with law enforcement, but we need to get down to the root causes or why people are using instead of blaming the substance.

Ms. Alamari recapped: what are the limits, what is responsible use so that youth can identify that, education should include a public health campaign that includes safe storage. We need to keep in mind the disproportionate effect on black and brown communities.

Dr. James Thompson emphasized that the number one risk that we face with increased access to cannabis is an increase in substance use disorder (SUD) and addiction. That association is pretty well established. There is an 8-9% chance for any adult who uses a substance regularly that they develop the disease of addiction, which is a disease of the brain. With such a prevalent illness and the impact of increased SUD incidence related to cannabis, we focus on that and mitigate the downside of legalization. SUD is going to be the most expensive, most destructive, and most likely to grown if we legalize in Virginia.

Public Comment:

Dr. Jonathan Lee, physician board certified physician in psychiatry. According to national capital poison center, Colorado reported an increase in the number of children brought to the emergency room after swallowing medical marijuana products, including children as young as eight months. A three-year-old was admitted to the Intensive Care Unit. Since Colorado legalized recreational marijuana, last month use ages 12 and older increase 58% and adult use increased by 94% according to some of the data. Traffic deaths in which drivers tested positive increased by 109% and all traffic deaths increased 31%. According to National Institute on Drug Abuse (NIDA), 9-12% of people who use marijuana over a period of time will become addicted, and up to 17% of those who started using in their teens. With increased potency, several have indicated during development can cause long term adverse changes in brain and peer reviewed journal have shown psychosis and other very negative mental health effects.

Lisa Davis, forensic toxicologist, central reporting system for adverse reactions. Need to evaluate and also need a testing process for those products that are associated with those adverse reactions including adulterants. Tamper evident packaging in also important.

Michelle Peace said that policies need to be based on data that is scientifically and statistically robust and a lot of what she heard is neither. California established a research center and are in the process of releasing data re: vehicular crashes and THC and we should look at that. She agreed with adverse reporting system and we should look at states in upper Midwest for guidance. She also agreed with having tamper evident packaging.

Mary Crozier, retired academic in field of addiction, said marijuana is powerful psychoactive judge an is effective for many people but doesn't mean it's wise for them to use. Marijuana youth use in states that have legalized it, because it increased with availability similar to alcohol and guns, and that can lead to decrease in academic achievement and poisonings. We don't know are all the unintended consequences, and as we face budgetary challenges we need a new model and not just copy the same playbook of legalizing, maybe even a hybrid approach without fulling legalizing.

Mary Lynn Mathrey, registered nurse doing addiction consult work and founder of Patients Out of Time and American Cannabis Nurses Association, which puts out accredited content re: the

medical use of cannabis, which means it makes the scientific standards. IN the majority of cases cannabis is an exit, not a gateway, drug. Opioid death rates have gone down that have legalized cannabis (up to 33%). You can't overdose on a raw plant and all drugs have risk but cannabis has the fewest.

Robbie Berkley, started smoking marijuana in 1974, and he agrees with the woman before him. You already have a lot of people smoking marijuana, regardless of whether you legalize it. Legalization doesn't increase use it just makes more money for the state. The doctors that are saying there will be more negative impacts are not accurate, since people are already using. Also, people want flower and you need to sell flower to make money.

Lennis Worth, Virginians Against Drug Violence, was forced to use cannabis medically and legalization has had negative impact on her life and that cannabis has had a positive impact . We should go after black market and allow home grow and gifts. We would know if cannabis were really dangerous since people have been suing for a while, and criminalization comes down much harder on minorities.

Thomas Malone said this meeting has been great, since this is a complicated issue. It does have negative effects. Cannabis saved his life because he has struggled with depression, and he thinks it is hypocritical that alcohol and opioids are looked at through the same lens. They are not comparable.

Regina Whitsett, Executive Director of SAFE in Chesterfield, recommended several additional speakers for this workgroup: Thomas Gorman, the director of the Rocky Mountain HIDTA Report; Sue Ruesche, National Families in Action; and Kevin Sabet from Smart Approaches to Marijuana.

The meeting was adjourned at 11:12 AM

Chat Conversations during the meeting:

from Michael Krawitz to all panelists: 9:48 AM
that is outdated data from 2014, CBD has been subsequently FDA approved

from Michael Krawitz to all panelists: 9:49 AM
"The FDA has approved only one CBD product, a prescription drug product to treat two rare, severe forms of epilepsy. It is currently illegal to market CBD by adding it to a food or labeling it as a dietary supplement. ... The FDA will continue to update the public as it learns more about CBD.Mar 5, 2020"

from Michael Krawitz to all panelists: 9:50 AM
And it should be noted that THC is a approved FDA drug also

from Michael Krawitz to all panelists: 9:52 AM
DESCRIPTION Dronabinol is a cannabinoid designated chemically as (6aR-trans)-6a,7,8,10a-tetrahydro-6,6,9- trimethyl-3-pentyl-6H-dibenzo[b,d]pyran-1-ol. Dronabinol has the following

empirical and structural formulas:
https://www.accessdata.fda.gov/drugsatfda_docs/label/2005/018651s021lbl.pdf

from Jenn Michelle Pedini to all panelists: 9:55 AM
If you aren't presenting, please mute.

from Tom Bannard to all panelists: 9:56 AM
Thanks Micheal. This is perhaps a better article:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5964385/pdf/0640111.pdf

from Tom Bannard to all panelists: 9:59 AM
Its less about CBD or THC for very specific cases, however the rates of Medical Use are far beyond the prevalence of those health conditions

from Tom Bannard to all panelists: 10:13 AM
https://pubmed.ncbi.nlm.nih.gov/27676176/ A Public Health Framework for Legalized Retail Marijuana
Based on the US Experience: Avoiding a New Tobacco Industry

from Michael Krawitz to all panelists: 10:20 AM
a specially formulated seseme seed oil capsule :-)

from Tom Bannard to all panelists: 10:26 AM
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6948106/ Did marijuana legalization in Washington State reduce racial disparities in adult marijuana arrests?

from Jenn Michelle Pedini to all panelists: 10:35 AM
Please mute if you arent speaking. It's very difficult to hear speakers when mutliple mics are open.