VERMONT

Date: 11-14-2018

Marijuana Advisory Commission Recommendations

Purpose

Executive Order No 15-17 was issued on September 7, 2017, to establish Governor Phil Scott's Marijuana Advisory Commission. The Commission is comprised of three subcommittees: Roadway Safety, chaired by the Commissioner of the Department of Public Safety; Education and Prevention, chaired by the Commissioner of the Department of Health; and Taxation and Regulation, chaired by the Commissioner of the Department of Tax. The Commission will provide recommendations to the Governor on implementing and operating a comprehensive regulatory and revenue system for an adult marijuana market and accompanying legislation on or before December 15, 2018.

The following is the report developed by the Education and Prevention Committee chaired by Commissioner of Health, Dr. Mark Levine.

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Introduction

With the highest rates in the country of recent marijuana use among youth, prevention must be a top priority.[1] Prevention is best when it comes in the form of promotion of healthy lifestyles and norms that reduce the risks associated with the use of alcohol, tobacco and other drugs, and the promotion of protective factors that support the health and well-being of children and families.

National data shows that more Vermonters (ages 12 and up) are using marijuana compared to the country overall. The number of Vermonters who try marijuana for the first time between the ages of 12 and 17 is also higher in our state than in the country overall. The Vermont Department of Health, in partnership with the Agency of Education (AOE), has conducted the Youth Risk Behavior Survey (YRBS) since 1993 for high school students and more recently for middle school students. The survey is conducted every two years and allows Vermont to obtain data over time, or trend data, to analyze substance use (and other risky behavior) patterns among middle and high school students. The 2017 results were recently released and for the first time in ten years, current marijuana use has increased significantly in the previous two years to 24% of high school students. The data also show that marijuana use increases with each grade level. The amount used, and frequency of use among those who reported use of marijuana also showed increases.[2]

Early and continuous use of marijuana significantly increases the risk of not completing high school, not enrolling in or completing college, low educational achievement, lower income, unemployment and welfare dependence as an adult, premature workforce retirement due to disability, and reduction in IQ in middle adulthood.[3]

Eighty percent of the brain develops in the first three years of life, therefore, helping to promote healthy children, families and communities during this critical period is central to lifelong health. It is essential that every child and family in Vermont is connected to the kinds of help that can make a real difference in a child's health, development and ability to learn.

Programs and services that help communities become as healthy and involved as they can be are a key part of drug and alcohol use prevention in Vermont. Bringing communities together is a job for many people from all walks of life, including parents, students, community coalitions, law enforcement, and health care providers.

This report provides the committee's recommendation of how to proceed with meaningful measures to reduce potential abuse of marijuana among the general population, but we must note that legalizing marijuana could have a significant deleterious effect on Vermont's youth.

Health Impact Assessment (HIA): Marijuana Regulation in Vermont

In January 2016, the Vermont Department of Health released a Health Impact Assessment (HIA): Marijuana Regulation in Vermont.[4] The HIA began with an extensive review of the existing literature to identify the strength of evidence associated with potential health impacts of marijuana use. Indicators (impacts) were rated as: not well researched, a fair amount of evidence, strong evidence, or very strong evidence. The report identified physical, mental and social health indicators associated with non-medical marijuana use and the research demonstrated the majority of them were worse with marijuana use.

[1] Past 30-day marijuana use is 38% among 18-25 year-olds.

[2] http://www.healthvermont.gov/sites/default/files/documents/pdf/CHS_YRBS_statewide_report.pdf page 80

[3] http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP_HIA_Marijuana_Regulation_in_Vermont.pdf

[4] http://www.healthvermont.gov/sites/default/files/documents/2016/12/ADAP_HIA_Marijuana_Regulation_in_Vermont.pdf.

Using this review of all available research findings, and experiences of states that have legalized marijuana, the HIA answered the following questions if Vermont regulated and taxed marijuana:

- What would happen to the prevalence of marijuana use?
- Would traffic safety change?
- What would be the impact on mental health?
- What might change in other substance use disorders and treatment?
- What might change in academic outcomes?
- Would emergency department admissions change?

The report concludes with lessons learned from tobacco and alcohol control and cessation efforts that could apply to marijuana regulation, and recommendations to consider should Vermont decide to regulate and tax marijuana for non-medical use. Those lessons are below, and the Research and Data Collection, as well as the Policy Committees drew upon and reaffirmed the work done during this extensive HIA for their recommendations.

Lessons from Tobacco and Alcohol that Could Apply to Marijuana Regulation

The following policies are taken from evidence-based alcohol and tobacco work and should be fully applied to any regulated marijuana market:

1. **Smoke-free policies** reduce secondhand smoke, increase the number of people who quit smoking, reduce tobacco initiation rates, and reduce tobacco-related morbidity and mortality. Vermont law currently allows for tobacco substitutes (i.e. vaporizers) in many places where smoking is banned. Vermont smoke-free laws do not cover the use of marijuana.

2. **Limiting access** to alcohol and tobacco has been proven to reduce use. This includes:
   - Limiting outlet density – controlling the number of stores that can sell the substance within a certain area. This is true for alcohol or tobacco.
   - Limiting the type of outlet that can sell tobacco can decrease initiation and youth use. If youth have access to tobacco or exposure to tobacco advertising in the retail outlets they frequent, they are more likely to begin smoking cigarettes.
   - Limiting the times of day that alcohol can be sold.
   - Limiting the age at which a person can purchase alcohol or tobacco.

3. **Increasing taxes** and establishing minimum price laws reduce the amount of alcohol or tobacco people use. In addition, prohibiting price discounting is an effective strategy to reduce use.

4. **Allowing local control** over outlet density and advertising contributes to a culture of health in the community, despite the fact that people can easily travel from one town to another.

5. **Limiting the age** of legal alcohol purchase to 21 years old or older decreases the number of motor vehicle accidents, reduces initiation of use, and use of alcohol.

6. **Child-resistant packaging** saves lives.

7. **Limiting tobacco and alcohol advertising** can reduce youth initiation and use. Prohibiting self-service displays, Internet sales, free samples, mass media advertising and flavored products are all established means of limiting youth tobacco use.

8. **Enforcing laws** that restrict sale to those of legal age is an effective way to keep alcohol and tobacco out of the hands of youth. This requires a strong enforcement effort.

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The following set of recommendations originated in subcommittees focused on: community prevention, school prevention, research and evaluation, and policy. The committee met twice to deduplicate, prioritize and organize the following recommendations:

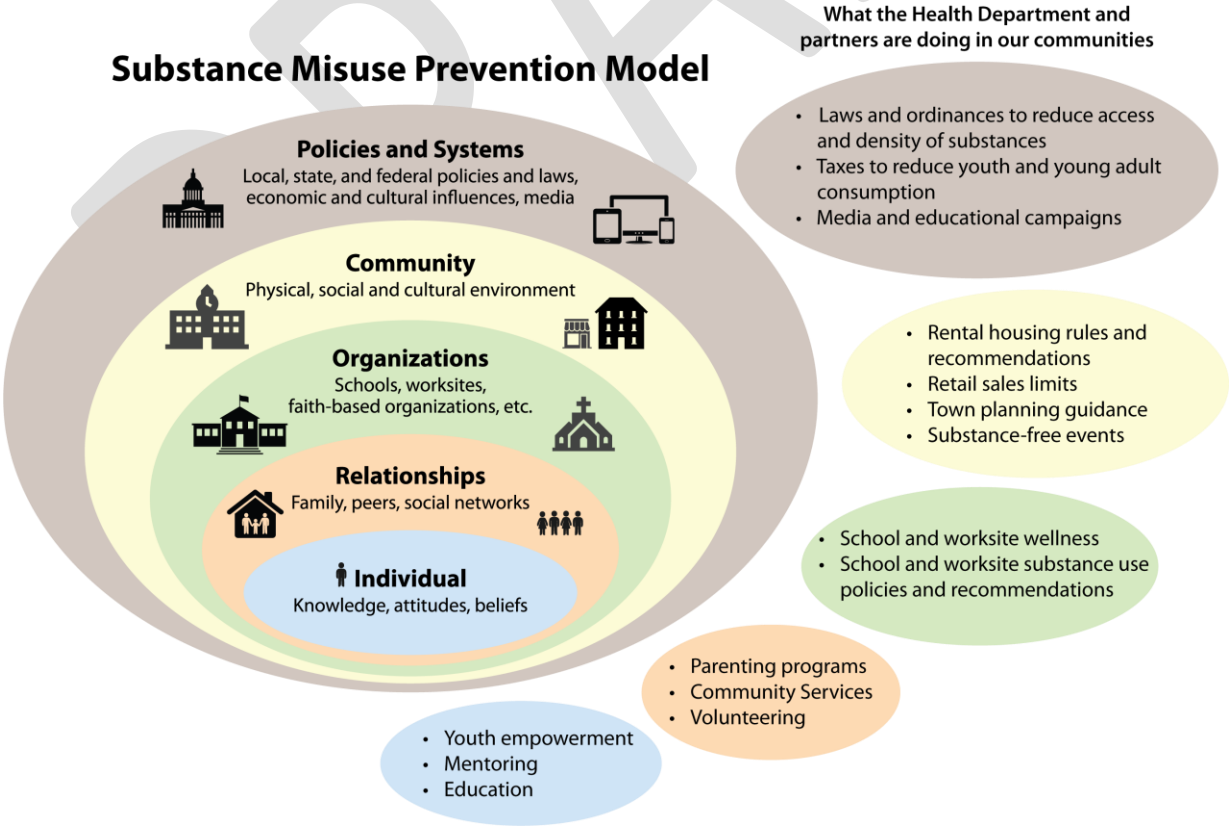
Recommendations requiring prevention funding

Fund Substance Misuse Prevention – $7 million

Establish a Substance Misuse Prevention Fund. Direct the Agency of Human services to oversee the use of the fund to implement comprehensive substance misuse prevention strategies throughout the state. Establish a Substance Misuse Advisory Committee (SMAC) underneath the Commissioner of Health to provide the State with specific advice on the use of the funds.

Vermont funds most substance misuse prevention programs and strategies through federal grant funding, with little to no state funding. Because federal grants vary in both amount and priority area, the inconsistency of the current funding structure makes it difficult to maintain population level substance use outcomes. Too often federal grants allow for the roll-out of strategies, and then the evaluation of the strategies, but fail to continue to fund them once proven effective.

The evidence is very clear that substance misuse prevention works best when it is comprehensive and sustained. Comprehensive prevention means that strategies are implemented at each level of the prevention framework: policies and systems, community, organizations, relationships and individual. Sustained means that these strategies are consistently funded so that they can be implemented, evaluated and adjusted over time to meet the needs of the community. Substance misuse prevention is not substance-specific and these efforts work to avoid and delay any substance use among youth, and reduce the quantity and risk of use among adults.



Why comprehensive? Shouldn't we just focus on *the* thing that works best?

Each community is different

Vermont is made up of distinct communities. Each one has its own risk factors and different abilities to adopt and implement strategies. Implementing a one-size-fits-all approach does not work well in such an environment.

The model in action

One intervention will not keep any given individual from misusing substances. An individual needs support on all levels of the prevention framework to have the best opportunity for success. This is even more true at a population level – what one individual needs, is not necessarily what another would benefit from.

For example, Sarah is an 8th grade student. She lives in rural Vermont with a single father in an apartment above a general store. Her father is very supportive, but he works late shifts to make enough to feed them both and pay rent. He smokes cigarettes, but otherwise uses few substances. What could a prevention fund do to help keep Sarah from using substances in her life?

***Individual**:*

At school, Sarah decided to join a club called Above the Influence, or ATI. The youth in the ATI club was learning how to understand data, leadership skills, public speaking, understand advertising and media, and how living above the influence of substances, including marijuana.

***Relationships**:*

Sarah also got involved in a new mentoring program at her school, and met with her mentor every week and one week they talked about the new VT marijuana legalization law. Sarah and her mentor talked about the health effects of marijuana and Sarah enjoyed having a trusted adult she could ask questions of on this topic.

***Organizations**:*

Sarah used the skills she learned in ATI and volunteered to be part of a youth work group to re-write her schools substance use policies that had included detention or expulsion if caught with or using marijuana on school grounds. Sarah and her classmates changed the policy to include the youth be screened for substance use, attend a 3-session educational group on the health effects of marijuana and completion of community service hours

***Community**:*

By the time a few months went by, Sarah had taken a leading role at ATI and is working with the Recreation Department to put up Smoke Free signage in the local park to include both tobacco and marijuana. Sarah and her Dad attended a Select Board meeting to advocate for an increase in substance free events to focus on children, youth and families.

***Policy**:*

Sarah participated in the states yearly "Prevention Works!" rally at the Vermont statehouse and met with her legislators to learn more about the goals of the marijuana legislation and shared with legislators how the law is impacting children and youth.

Funding breakout for Substance Misuse Prevention

$6 million – Establish Six Regional Prevention Networks (RPN)

These networks will be responsible for developing capacity, support and oversight of existing infrastructure, and ensuring utilization of proven population health models. Specifically, communities will apply the Strategic Prevention Framework to identify risk and protective

factors. Once identified, communities could use approaches like the 7 Strategies for Change from Community Anti-Drug Coalitions of America (CADCA) which provides guidance on how to impact individual behaviors through community conditions.

Specifically, the regional network would (for concrete examples, please see what is being done by the Deerfield Valley Community Partnership[5], the Iceland Model[6], or Vermont Afterschool[7]):

- fund prevention programs, such as afterschool programming, youth leadership and community coalitions,
- maintain and coordinate educational and counter marketing campaigns (through all methods including social media);
- serve as a policy institute, educating local decision-makers and leaders about the best practices and model polices for health;
- produce data and reports for needs assessments and program evaluation;
- develop a strategic plan for their region; and
- engage youth and young adults in prevention activities.

$10,000 – Establish and manage the Substance Misuse Advisory Committee (SMAC)

Establish a committee to manage an investment funding model for sustainable substance use primary and secondary prevention. The $10,000 will cover the cost to run the committee and reimburse members for time and expenses.

$500,000 – Evaluation

Run sustained evaluation and quality improvement on all Substance Misuse Prevention Fund (SMPF) activities to ensure SMPF funds are used appropriately.

While long-term surveillance is critical, short-term studies to evaluate the effectiveness of programs and policies must be more nimble and timely. A team of University of Vermont researchers and Health Department analysts are designing a flexible tool that could be used for this type of work, but do not yet have sustainable funding.

$300,000 – Research, develop, implement, and evaluate statewide media and communication strategies

Topics include: increasing awareness and understanding of marijuana legislation; perceived harm of marijuana use; health effects on youth and young adults; and marijuana use during pregnancy. Development of each communication strategy includes formative research with the intended audience, message and creative concept development and testing, strategic implementation, and evaluation of audience reach and engagement based on identified metrics. To be run by the Health Department with existing staff and with input from the SMAC.

$100,000 – Fund one full-time position at the Health Department

This individual would oversee the Substance Misuse Prevention Fund (SMPF), staff the Substance Misuse Advisory Committee, run technical assistance to the Regional Prevention Networks and manage evaluation to ensure the SMPF dollars are well spent.

[5] http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Deerfield_Valley_Community_Partnership.pdf
[6] https://ec.europa.eu/health/sites/health/files/alcohol/docs/ev_20180320_co08_en.pdf
[7] http://www.vermontafterschool.org/

Fund School-based Prevention - $15 million

Fund one full-time substance use prevention professional for no more than 250 student cases.[8] Fund and staff these positions outside of the per-pupil spending. These professionals provide prevention and education services to all students and organize and implement peer leadership groups. They provide intervention, screening and referral services for those students who are identified as having substance abuse problems. Additionally, they educate and train the school and community in the areas of substance misuse, interpersonal skills, and group and stress management.

In order to scale this up, the system would begin in year one with 15 schools, prioritizing schools based on level of need and demonstrated commitment to comprehensive school-based prevention. This would be run out of the Health Department, coordinated by current staff.

Cost: $65,000 – $75,000/annual salary and benefits for a full-time trained professional in substance use prevention.

Year 1: $1,125,000 (assuming 15 positions at $75,000)
Year 5: $18,750,000 (assuming 250 positions at $75,000)

Fund Research on Health Effects - $1 million

Fund at least one longitudinal study at an academic institution to determine the impact of marijuana use on the health of Vermonters. This subcommittee recommends $1 million annually for a minimum of 15 years. This estimate is based on National Institutes of Health funding levels. Funding this type of research will also provide opportunities for scientists in Vermont to apply for federal and private funding to supplement this effort.

The heightened interest in marijuana use and the related health effects due to state legalization of marijuana use has revealed shortcomings in research and state-wide data collection. States face a lack of funding for research and data collection activities surrounding marijuana use and a lack of research on marijuana-related health outcomes. The Council of State and Territorial Epidemiologists (CSTE) has a set of recommendations for strengthening research and data collection across the nation.[9] Using the work of CSTE and the Health Impact Assessment, the Subcommittee on Research and Data Collection spoke with stakeholders from data collection and research organization in Vermont and developed the following recommendations.

Little is known about the health effects of the marijuana consumed today. The potency and mode of use is very different from the longitudinal studies relied on to determine the effect of marijuana use on human health.

Priority policy-level recommendations that do not require prevention funding

Put infrastructure in place before sales begin

Ensure that all critical staff are hired, all regulations and rules are in place, and all testing infrastructure is built and functioning before allowing for the licensing of production, distribution or retail of marijuana products. Authorize a governing body or administrative unit responsible for overseeing the implementation of the regulation and taxation of marijuana.

[8] The Vermont Board of Education standard is that no school counselor should exceed 250 students on a caseload.
[9] https://cdn.ymaws.com/www.cste.org/resource/resmgr/2016PS/16_CC_02.pdf

Do not allow infused products on the regulated market

Do not include retail sales of products infused with marijuana for non-medical purposes.

Never allow infused products that could appeal to children. Mandate that should future legislation ever allow for infused/edible products, they are never allowed in a format that could be attractive to youth (e.g. gummy bears, cookies, brownies, etc.). Before any future regulation regarding edibles is implemented, ensure that full testing and regulatory bodies are in place. This includes development, implementation and full funding for comprehensive food inspection.

Standardize and test packaging and potency. Ensure that all THC concentration regulations, particularly those relating to packaging, labeling and testing, are in place before implementation. Marijuana and marijuana products should be batch-tested and labeled for potency. Procedures must be in place to regulate and test final products for contaminants.

Restrict Advertising

Put in place advertising restrictions to ensure that youth and young adults are not targeted by, or exposed to, marijuana advertising. Restrict advertising from any area where youth could potentially be exposed.

Additional Critical Recommendations to Ensure Youth and the Public are Protected in a Fully Regulated Marketplace

The two sets of recommendations above are those prioritized by the committee. However, the additional recommendations below are important to consider in the implementation of a fully regulated marijuana marketplace.

1. **Expand Existing Tobacco Laws**. Expand and enhance *all* current tobacco smoking laws and regulations to include the use of tobacco *or* marijuana and include any potential type of delivery system or tobacco substitute (electronic cigarettes, vape pens, etc.).

2. **Do not allow use of marijuana in public places.** Ensure children and youth are not exposed to marijuana use or second-hand smoke.

3. **Fully fund enforcement and oversight.** Follow best practice in protecting youth and young-adults, as well as adult users, by ensuring licensing fees are set at a level, and will continue to grow with inflation and industry growth, that fully funds the necessary enforcement and oversight efforts now and in the future. Note: Current tobacco and alcohol licensing fees are not sufficient to support best practice enforcement efforts.

4. **Restrict Age of Access.** Implement prevention, regulation and enforcement strategies that greatly reduce access to marijuana for those age 25 and younger. This is to protect children, youth and young adults during the time in life of rapid brain development and academic involvement.

5. **Set a blood level operating limit for THC.** Set a per se active-THC blood level limit for

operating a motor vehicle based on the best available evidence. Designate a non-Legislative body with rulemaking authority made up of law enforcement and health officials to review data and determine the exact per se limit. Allow this body to amend that limit in the future based on scientific evidence, surveillance data, and emerging information from other states.

6. **Build driver testing infrastructure.** Build the infrastructure and procedures necessary to conduct appropriate and consistent testing for THC before marijuana is regulated.

7. **Implement a public education strategy about the dangers of driving under the influence of THC.** Do this before marijuana is regulated and ensure that the education includes information on what the legal limits mean in terms of use.

8. **Expand screening in primary care practices.** Expand screening for substance use disorders and mental health problems and trauma in primary care.

9. **Get providers the information they need.** Ensure medical providers receive the most recent information and training related to screening for risk factors for substance misuse disorders (e.g. non-adaptive stress response) as well as Screening, Brief Intervention and Navigation to Services (SBINS). Work with local teaching institutions to ensure that medical students, nursing students (and other allied health professionals) receive the most recent information and training on the health impacts of marijuana.

Appendix A: Subcommittee Members

Members of the Community-based Committee

- Jill S. Rinehart, MD FAAP Hagan, Rinehart & Connolly Pediatricians, PLLC, President, American Academy of Pediatrics Vermont Chapter, Clinical Associate Professor of Pediatrics, Robert Larner College of Medicine at the University of Vermont
- Mariah Sanderson, Director of the Burlington Partnership for a Healthy Community
- Cindy Hayford, Director of the Deerfield Valley Community Partnership and Windham County Regional Prevention Program Coordinator
- Melanie Sheehan, MCHES, Regional Prevention Program Manager, Mt. Ascutney Hospital and Health Center
- Sarah Kleinman, Director, 4-H/Youth Programs, University of Vermont Extension
- Mark Redmond, Director Spectrum Youth Services
- Jolinda LaClair, Director, Drug Prevention Policy, Governor's Opioid Coordination Council
- Rose Gowdey, Community Engagement Liaison, Governor's Opioid Coordination Council
- Robin Rieske, CPS, Prevention Consultant, Division of Alcohol and Drug Abuse Programs, Vermont Department of Health
- Lori Tatsapaugh Uerz, NPN, Director of Prevention Services, Division of Alcohol and Drug Abuse Programs, Vermont Department of Health
- Megan Trutor, Health Department

Members of School-based Committee

- Beth Keister, Tobacco and Substance Use Prevention Coordinator, AOE
- Amy Minor, Superintendent, Colchester School District
- Debby Haskins, Private Substance Abuse Counselor & Consultant
- Dawn Poitras, Association of Student Assistance Professionals & Student Assistance Professional at Barre Supervisory Union
- Other sources who provided information:
- Margo Austin, VSAC Outreach and former SAP at Burlington High School
- John Pandolfo, Barre Supervisory Union superintendent

Research and Data Collection Committee

- John Searles, Substance Abuse Research and Policy Analyst, Department of Health
- Shayla Livingston, Public Health Policy Analyst, Department of Health
- Representative Anne Pugh, Chair of the House Human Services Committee

Policy Committee

- Commissioner Mark Levine, Department of Health
- Shayla Livingston, Public Health Policy Analyst, Department of Health
- David Englander, Senior Policy Advisor and General Counsel, Department of Health