INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) Marijuana Prevention Workgroup is led by the Office of Recovery Oriented Systems of Care with members from various areas within MDHHS including Public Health, Tobacco Section, Legal, Communications, Equity & Minority Heath, Injury & Violence Prevention, Policy, and Maternal & Infant Health.

The purpose of the workgroup is to develop a statewide plan to address public health concerns related to the passing of the voter-initiated ballot proposal for Adult Use Marijuana. This workgroup will help to maintain internal communication within MDHHS and among other state departments, as well as provide information to share with providers, community partners and the general public.

Just to note, LARA's Bureau of Marijuana Regulation is frequently asked why marijuana is sometimes spelled with an "h" and other times is spelled with a "j". The spelling of marijuana has a long history in the United States. Michigan's history primarily starts from the spelling that was chosen for the Marihuana Tax Act of 1937. Michigan adopted its statutory definition of marijuana in the Public Health Code, utilizing the then-current federal spelling, marihuana. In legal communication and references to statutes and the corresponding administrative rules, an "h" will be used in the spelling of Marihuana. In non-formal communication, "j" will be generally used.

For the purposes of this document, the work group decided to use cannabinoid to reference both components of the cannabis plant and synthetics. Cannabinoids are any of various naturally occurring, biologically active, chemical constituents (such as cannabidiol or cannabinol) of hemp or cannabis including some (such as THC) that possess psychoactive properties. It also refers to synthetics, a substance that is structurally or functionally similar to cannabinoids derived from hemp or cannabis; a substance that is synthetically produced to mimic the effects of natural cannabinoids.

SCOPE OF THE ISSUE

Marijuana Use among Youth

- In 2016/2017, 7.7 percent of adolescents aged 12 to 17 were current users of marijuana, which means approximately 60,000 adolescents used marijuana in the past month.
- Approximately, 41,000 (6.0%) adolescents aged 12 to 17 reported trying marijuana for the first time in 2016/2017.
- The percentage of adolescents in 2016/2017 who were current marijuana users was similar to the percentages in years between 2012 and 2017.

Marijuana Use among Individuals aged 18 to 25

- Almost one in four (24.2%) of individuals aged 18 to 25 reported current marijuana use, rising from 22.2 percent in 2012/2013.
- In 2016/2017, 48,000 (8.9%) individuals aged 18 to 25 reported marijuana use for the first time.

Changes in Perceived Risk

- Among the illicit drugs, marijuana has the lowest perceived risk, with approximately 24 percent of adolescents aged 12 to 17 thinking regular use (i.e., at least once a month) carries great risk.
- In 2016/2017, 83.2 percent of individuals aged 18 to 25 perceived great risk of harm from use of heroin (83.2 percent) and crack (64.5 percent).
- Only 9.8 percent of individuals aged 18 to 25 perceived great risk from regular marijuana use.

Pregnant Women aged 12 to 44

- In 2016/2017, 7.5 percent of pregnant women aged 12 to 44 reported current marijuana use.
- While 21 percent of pregnant women aged 12 to 44 perceived great risk from using marijuana one to two times per week, 13.7 percent of pregnant women aged 12 to 44 perceived great risk from using marijuana once a month.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016 and 2017.

SCOPE OF THE ISSUE (cont.)

Marijuana Publicly Funded Treatment

- In 2018, marijuana was most commonly reported primary substance by youth (12-17 years of age), with 990 admissions at 63.5 percent.
- In 2018, marijuana represented 22.0 percent of all primary substance treatment admissions among young adults (18-25 years of age). Marijuana is most commonly reported secondary substance among young adults.

Source: Treatment Episode Data Set, 2018

Other Data / Data Sources to Consider:

211 Call Centers

Behavioral Risk Factor Surveillance System

Fires Due to Grow Efforts

Michigan Traffic Crash Facts (Impaired Driving)

Poison Control Center

Pregnancy Risk Assessment Monitoring System

Truancy

Unemployment Rates

Youth Risk Behavior Survey

GOALS

1. Reduce cannabinoid abuse and misuse among youth, young adults, and pregnant women.
2. Offer evidence-based practices, policies, and programs that impact risk and protective factors related to substance use, including cannabinoids.
3. Promote positive infant health outcomes.
4. Reduce the number of poisonings from cannabinoid products and the exposure to second-hand marijuana smoke among children.

OBJECTIVE 1:

Increase public awareness and promote subsequent behavior change regarding the risks of cannabinoid use.

Strategy 1.1:

Develop, evaluate, and promote effective education strategies (e.g. health observances, public education campaigns, social media campaigns) to increase public awareness and to prevent cannabinoid abuse and misuse at all stages of life.

Expected Outcomes 1.1:

The media campaign will increase awareness of risk of cannabinoid use by youth and young adults.

Strategy 1.2:

Develop and disseminate products and resources to inform parents, children, youth and young adults, schools, workplaces, and communities about the facts and consequences of cannabinoid abuse and misuse.

Expected Outcomes 1.2:

The completion of an updated Michigan Epidemiological Profile, which includes cannabinoid information and data.

Promotion of the Michigan Collegiate Cannabis Prevention Toolkit and use by colleges and universities throughout the state.

The use of the MDHHS Marijuana Toolkit by organizations, parents, and Michigan residents.

Strategy 1.3:

Strengthen partnerships at a community, state, and national level in order to expand the reach of cannabinoid use and misuse related health messages and to facilitate the implementation of effective prevention, treatment, and recovery strategies.

Expected Outcomes 1.3:

The establishment of a communication strategy to engage other state departments, regional entities, service and medical provider networks, community coalitions and organizations, etc. to strengthen partnerships.

Strategy 1.4:

Educate about the dangers of vaping THC.

Expected Outcome 1.4:

Dissemination of educational material regarding harmful effects of vaping THC.

Strategy 1.5:

Educate about the brain research regarding cannabinoid use in youth.

Expected Outcome 1.5:

Dissemination of educational material regarding harmful effects of cannabinoid use among youth.

OBJECTIVE 2:

Expand engagement with service and medical provider networks and community coalitions and organizations around cannabinoid use prevention, treatment, and recovery services including policies, practices, and programs.

Strategy 2.1:

Promote the Strategic Prevention Framework, SAMHSA’s planning process model, to help communities assess needs, build capacity, plan, implement, and evaluate.

Expected Outcome 2.1:

Communities across the state will implement evidenced-based strategies around cannabinoid use prevention, treatment, and recovery.

OBJECTIVE 3:

Reduce youth cannabinoid use initiation through strengthening protective factors and reducing risk factors.

Strategy 3.1:

Identify, expand, and maximize the use of best practices and evidence-based programs through technical assistance programs, educational programs, campaigns, Substance Abuse and Mental Health Services Administration's Evidence-Based Practices Resource Center, and collaborations with other state agencies.

Expected Outcome 3.1:

The creation of a best practice and evidence-based program list to be used throughout the state.

An increase in practices and programs utilized to address cannabinoid abuse and misuse.

OBJECTIVE 4:

Strengthen state and community coordination to improve cannabinoid use prevention, treatment, and recovery support services.

Strategy 4.1:

Convene expert panel meetings on various related topics to gather input on actions to improve the delivery of services for individuals with or at risk for cannabinoid use disorders.

Expected Outcome 4.1:

Monthly meetings of the MDHHS Marijuana Prevention Workgroup to garner feedback from workgroup members.

Include cannabinoid prevention information during existing state and community meetings, including the SEOW, TSC Prevention Workgroup, etc.

Strategy 4.2:

Establish communication procedures to incorporate a focus on community group and providers' voice.

Expected Outcome 4.2:

Increase the state's communication with community groups and providers.

OBJECTIVE 5:

Reduce cannabinoid use among pregnant women.

Strategy 5.1:

Screen pregnant women to increase the early identification of cannabinoid use.

Expected Outcome 5.1:

Women being screened for cannabinoid use during pregnancy.

Strategy 5.2:

Educate providers, parents, and pregnant women about the relationship of cannabinoid use and the impact on infants.

Expected Outcome 5.2:

Dissemination of educational material appropriate for intended population regarding the relationship of cannabinoid use and the impact on infants.

Decrease in women using cannabinoids during pregnancy and breastfeeding.

OBJECTIVE 6:

Reduce cannabinoid ingestion and inhalation exposure among children.

Strategy 6.1:

Educate professionals, parents, adults, and children about the risk of cannabinoid ingestion and exposure of marijuana second-hand smoke and the effects on infants, toddlers, and children.

Expected Outcome 6.1:

Dissemination of educational material appropriate for intended population regarding cannabinoid ingestion and inhalation exposure among children.