Opponent Testimony Regarding House Bill 160

Submitted to the Ohio House Judiciary Committee
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I. Introduction

A. Personal Introduction

Esteemed Chair Thomas and Members of the House Judiciary Committee, thank you for the opportunity to submit written testimony today regarding House Bill 160.[3] My name is Alex Soduk. I am a resident of Stark County, Ohio, represented by Representative Jim Thomas.[5] I am submitting this testimony as a concerned citizen primarily because House Bill 160 proposes significant changes that undermine the cannabis legalization framework approved by 57% of Ohio voters through Issue 2 in November 2023.[6]

B. Statement of Position

Based on the principle of respecting the democratic will of Ohioans and a review of the proposed changes in HB 160, I am here today to express strong opposition to House Bill 160 in its current form.

C. Formal Address

Chair Thomas and Members of the Committee, your consideration of this bill touches upon complex issues with significant implications for the regulatory structure Ohioans voted for.

D. Purpose of Testimony

The purpose of this testimony is to argue that HB 160 deviates substantially from the voter-approved Issue 2, introducing unnecessary restrictions and recriminalization that contradict the mandate given by the electorate.[6] Furthermore, this testimony will highlight specific provisions within HB 160 that are overly restrictive and fail to align with the goal of regulating cannabis similarly to alcohol, as intended by the "Regulate Marijuana Like Alcohol" campaign name for Issue 2.[6] It will also touch upon the scientific evidence regarding potential mental health risks associated with cannabis, arguing that while regulation is necessary, HB 160's approach may not adequately address these concerns and could create unintended negative consequences.

II. Analysis of HB 160 and Proponent Rationale: Regulation vs. Voter Intent

A. Acknowledging Proponent Focus

It is understood that proponents of HB 160, including the bill's sponsor, emphasize specific regulatory goals.[9] Key objectives highlighted in available testimony and bill summaries include closing the perceived "hemp loophole" by restricting the sale of intoxicating hemp derivatives (such as delta-8 and delta-9 THC products derived from hemp) exclusively to licensed dispensaries.[9] This measure is frequently framed as a necessary step to protect children from accessing these products in unregulated environments like gas stations and convenience stores, and to ensure basic product testing and safety standards are met.[9]

Additional stated goals involve aligning certain aspects of Ohio's adult-use cannabis law (established by Issue 2) with perceived public safety needs, such as implementing bans on public consumption and affirming employer rights regarding drug-free workplaces.[9] The bill also introduces specific THC potency caps – 35% for plant material and 70% for extracts – presented as a regulatory control measure.[10]

B. Critiquing the Deviation from Issue 2 and Potential Motivations

While the focus on regulatory control and child safety is noted, a critical examination reveals that HB 160 significantly alters the framework Ohio voters approved with Issue 2.[6] Issue 2 passed with the slogan "Regulate Marijuana Like Alcohol," yet HB 160 introduces measures far more restrictive than those applied to alcohol, such as banning the sharing of homegrown cannabis between adults and imposing harsh penalties, including mandatory jail time, for passengers consuming cannabis in vehicles – penalties much stricter than open container laws for alcohol.[14] These changes represent a departure from the voter mandate.[7]

Furthermore, the available proponent testimony appears to focus heavily on controlling access and ensuring product consistency, without presenting substantial evidence that the specific regulatory choices in HB 160 (like the high 70% THC cap for extracts) are optimally designed based on public health science regarding mental well-being.[9] The argument that simply moving intoxicating hemp sales to dispensaries inherently promotes safety overlooks the documented risks associated with THC consumption, regardless of the point of sale.[17]

It is also worth considering the motivations behind some proponent arguments. For instance, testimony from groups representing established industries, such as the Wine Institute [24], may reflect concerns about market competition from emerging cannabis and hemp-derived products, particularly beverages, as much as concerns purely

focused on public health.[25] Restricting access to low-dose THC beverages, as HB 160 proposes, could limit consumer choice and protect existing markets from new competitors.[25] This potential conflict between public health goals and economic protectionism warrants careful consideration by the Committee. The bill's approach risks prioritizing market control and specific industry interests over fully respecting voter intent and implementing a truly balanced, evidence-informed public health strategy.

III. Scientific Evidence: The Overlooked Mental Health Risks of Cannabis and Intoxicating Cannabinoids

A comprehensive review of recent scientific research (post-2012) reveals significant concerns regarding the impact of cannabis and its primary psychoactive component, THC, on mental health.

A. The Neurobiological Impact of THC

THC exerts its effects primarily by binding to and activating cannabinoid receptors (CBRs), particularly CB1 receptors, which are densely concentrated in brain regions critical for mood, memory, cognition, reward processing, and stress response.[26] This activation disrupts the normal functioning of the brain's own endocannabinoid system, which plays a vital role in maintaining homeostasis in these functions.[27] It is crucial to note that the potency of cannabis products, defined by THC concentration, has increased dramatically over the past few decades.[28] Many products available today, including those in regulated markets, contain THC levels far exceeding those common in the past, potentially amplifying both the psychoactive effects and the associated health risks.[28] Intoxicating hemp derivatives, such as delta-8 THC, also produce psychoactive effects by interacting with these same cannabinoid receptors.[31]

B. Documented Association with Psychotic Disorders

A substantial and consistent body of evidence links cannabis use to an increased risk of developing psychotic disorders, most notably schizophrenia.[10] This risk appears particularly elevated for individuals who begin using cannabis during adolescence, use it frequently, and consume high-potency products.[10] Research indicates that cannabis use can precipitate the onset of psychosis in individuals with a pre-existing genetic vulnerability.[10] Furthermore, cannabis intoxication, especially at high doses or with high-potency products, can induce temporary psychotic episodes characterized by hallucinations, paranoia, delusions, and loss of personal identity, even in individuals without a prior history of psychosis.[16] Experiencing such an episode may itself be a

risk factor for developing a persistent psychotic disorder later in life.[18] The association between heavy cannabis use and schizophrenia risk has been found to be particularly strong among young males.[18] While the precise nature of the causal relationship is complex and subject to ongoing research, with some studies yielding differing results in specific populations (e.g., those already at clinical high risk) [41], the established link between cannabis use (especially high-potency) and the triggering or exacerbation of psychosis represents a significant public health concern.[10]

C. Link to Mood Disorders and Suicidality

Beyond psychosis, research has consistently associated cannabis use with an increased risk for other serious mental health conditions. Studies link cannabis use, particularly during adolescence, to depression, social anxiety, and an increased likelihood of suicidal ideation and planning.[10] Large-scale population studies have found that individuals diagnosed with Cannabis Use Disorder (CUD) have a significantly higher risk of subsequently developing both psychotic and non-psychotic forms of unipolar depression and bipolar disorder.[45]

Claims regarding the potential benefits of cannabinoids like CBD for mood disorders require careful scrutiny. While some preclinical or anecdotal reports suggest potential anxiolytic or antidepressant effects [27], robust human evidence is limited.[47] Critically, even the FDA-approved CBD product, Epidiolex, lists depression and suicidal ideation as possible adverse reactions in its prescribing information. Data from large clinical trials involving Epidiolex indicated an increased risk of suicidal ideation compared to placebo, with actual suicides occurring in the treatment group but not the placebo group.[46] This underscores the complexity of cannabinoid effects and cautions against assumptions of universal benefit or safety, even for non-intoxicating cannabinoids like CBD when used pharmacologically.

D. Risk of Cannabis Use Disorder (Addiction)

Cannabis use can lead to addiction, clinically diagnosed as Cannabis Use Disorder (CUD).[28] CUD is characterized by compulsive drug-seeking and use despite significant negative consequences in various life domains, including family, school, work, and health.[32] National survey data indicate that millions of Americans meet the criteria for cannabis dependence or abuse, and it is a common reason for seeking substance abuse treatment.[48] The risk of developing CUD is not insignificant: estimates suggest that approximately 1 in 10 adults who use cannabis, and a concerning 1 in 6 individuals who start using during adolescence, may become addicted.[28] The increasing availability of high-potency THC products is thought to contribute to higher rates of

dependence and addiction.[28]

E. Cognitive Impairment

Cannabis use is well-documented to cause acute impairments in cognitive functions essential for daily life, learning, and safety. These include deficits in short-term memory, attention, concentration, learning, judgment, coordination, balance, and reaction time.[12] While some effects are temporary, persistent impairments in memory and learning skills have been observed in individuals even after cessation of use, particularly with chronic or heavy use patterns.[12]

The developing brain, which continues to mature until approximately age 25, is particularly vulnerable to the effects of THC.[28] Cannabis use during adolescence has been linked to potentially lasting negative consequences, including structural brain changes, poorer academic and vocational outcomes, and potentially permanent reductions in IQ.[28]

F. Risks of Intoxicating Hemp Derivatives (Delta-8, etc.)

The rise of intoxicating hemp derivatives, such as delta-8 THC and other synthetically or semi-synthetically derived cannabinoids, presents unique public health challenges.[31] These products contain psychoactive THC compounds designed to mimic the effects of delta-9 THC found in marijuana.[11] A major concern is the largely unregulated nature of the current market for these products. Lack of stringent oversight often results in inaccurate labeling (including undisclosed or incorrect THC levels), potential contamination with harmful chemicals or heavy metals introduced during the manufacturing process, and products designed with packaging attractive to youth.[12] The chemical processes used to convert CBD from hemp into delta-8 THC may themselves introduce unknown and potentially harmful byproducts.[31] Accidental ingestion, particularly by children, has led to serious illness and hospitalization.[12]

G. Summary Table: Documented Mental Health and Cognitive Risks Associated with Cannabis (THC) Use (Post-2012 Research)

The following table summarizes key risks identified in recent scientific literature:

Risk Category	Specific Risk	Supporting Evidence Snippets

Psychotic Disorders	Increased risk of developing schizophrenia, especially with early onset, frequent, high-potency use	10
	Triggering acute psychotic episodes (hallucinations, paranoia, delusions)	16
	Worsening symptoms in individuals with existing psychotic disorders	17
Mood Disorders	Association with depression and anxiety, particularly with adolescent use	28
	Increased risk of subsequent diagnosis of unipolar depression and bipolar disorder following CUD	45
	Association with suicidal ideation and behavior, particularly among teens and veterans	10
	Potential for CBD products (including FDA-approved) to worsen depression or cause suicidal ideation	46
Addiction	Risk of developing Cannabis Use Disorder (CUD) / Addiction (1 in 10 adults, 1 in 6 adolescent users)	28
	Increased risk associated with higher THC potency	28
Cognitive Impairment	Acute impairment of short-term memory, attention, learning, judgment,	12

	coordination, reaction time	
	Potential for persistent deficits in learning and memory, especially with chronic/heavy use	[12]
	Particular vulnerability of the developing adolescent brain (until ~age 25), potential for IQ loss and structural changes	[28]
Other	Impaired driving ability, increased risk of motor vehicle accidents	[12]
	Potential adverse effects on fetal development if used during pregnancy	[28]
	Respiratory issues (chronic bronchitis, cough) associated with smoking	[12]

IV. HB 160's Insufficiency in Addressing Voter Intent and Public Health

While HB 160 introduces regulatory changes, its provisions appear insufficient to meaningfully address the significant mental health risks outlined above and represent a significant departure from the voter-approved Issue 2.

A. Potency Caps - A Partial Measure Contradicting Available Evidence

The bill proposes THC potency caps of 70% for extracts and 35% for plant material.[10] While acknowledging potency is a factor in risk, a 70% cap for extracts represents an extremely high concentration of THC. Recent research indicates that such high-potency products are precisely those associated with greater risks for adverse mental health outcomes, including psychosis and addiction.[10] Setting the cap at this level fails to establish a truly health-protective standard based on the available science. Furthermore, imposing such caps without addressing consumer demand for higher potency products could lead to unintended negative consequences. It might incentivize the use of potentially harmful cutting agents or diluents in legally produced products to meet demand while staying under the cap, or it could drive users seeking

higher potency products towards the unregulated, untested illicit market, thereby undermining the bill's stated public safety objectives.[6]

B. Regulating Hemp Sales Channels ≠ Addressing Product Risk or Voter Intent

Moving the sale of intoxicating hemp products from unregulated outlets to licensed dispensaries is a central feature of HB 160.[9] This addresses the legitimate concern of youth access in places like gas stations.[9] However, this change primarily addresses the *point of sale* and *access*, not the *inherent risks* associated with consuming the psychoactive THC contained within these products, nor does it align with the broader market access implied by Issue 2's framework. Whether purchased legally in a dispensary or illicitly, THC interacts with the brain in the same way, carrying the potential for the adverse mental health and cognitive effects detailed earlier. The legal source or regulatory channel does not fundamentally alter the substance's pharmacological impact. While the bill attempts to bring hemp-derived intoxicants under a regulatory umbrella similar to marijuana [54], potentially creating conflict with the federal definition of hemp [12], the critical point remains: regulating the *where* and *how* of sales does not sufficiently mitigate the *what* – the risks of THC itself – and restricts access in ways voters likely did not envision when passing Issue 2.

C. Undermining Issue 2's Funding and Equity Goals

A significant deficiency in HB 160 is its drastic alteration of the funding allocations established by Issue 2, undermining key public health and social equity goals approved by voters.[6] Issue 2 specifically allocated funds for substance abuse treatment, education, social equity programs, and host community support.[6] HB 160 eliminates the Social Equity and Jobs Program entirely and redirects the vast majority of tax revenue to the General Fund, providing only temporary and reduced funding (from 36% in perpetuity to 20% for four years) for host communities.[10] This directly contradicts the financial structure voters approved and removes dedicated funding intended to address the harms of past prohibition and support public health initiatives related to cannabis use. Responsible public health policy requires sustained investment in prevention, education, and treatment – investments Issue 2 provided for but HB 160 largely eliminates.[6]

D. Recriminalization and Ignoring the "Regulate Like Alcohol" Mandate

HB 160 introduces several measures that recriminalize cannabis-related activities that Issue 2 legalized or treated less severely.[14] Banning the sharing of homegrown cannabis among adults [14], prohibiting possession of legally purchased cannabis from

other states [6], and imposing mandatory minimum jail sentences for passengers consuming cannabis [14] are stark examples of how this bill treats cannabis far more punitively than alcohol, directly opposing the voter mandate.[6] This approach ignores the will of the 57% of Ohioans who voted for Issue 2 and risks driving consumers back to the illicit market.[17]

V. Conclusion and Recommendations

A. Summary of Opposition

In conclusion, I strongly oppose HB 160. It represents a significant step backward from the cannabis regulation framework Ohio voters decisively approved in Issue 2.[6] The bill introduces overly restrictive measures, recriminalizes conduct legalized by voters, undermines the intended funding allocations for public health and social equity, and fails to regulate cannabis "like alcohol" as voters intended.[14] While addressing intoxicating hemp and public safety are valid goals, HB 160's approach is flawed, potentially driven by factors beyond pure public health concerns [25], and disrespects the democratic outcome of Issue 2.

B. Call for Respecting Voter Intent

The Committee is urged to respect the will of the Ohio voters by rejecting HB 160. Any necessary adjustments to the cannabis law should be made within the spirit and framework established by Issue 2, prioritizing the "regulate like alcohol" principle and maintaining the funding structures voters approved. Policy decisions should be guided by voter mandate and balanced public health considerations, not by a desire to overturn or excessively restrict what Ohioans have already decided.

C. Specific Recommendations

1. **Reject HB 160:** The bill fundamentally undermines Issue 2 and should not proceed.
2. **Uphold Issue 2:** Implement the cannabis program as approved by voters, including the original tax revenue allocations for host communities, social equity, and substance abuse treatment.[6]
3. **Address Hemp Intoxicants Separately or Consistently:** If intoxicating hemp products require regulation beyond Issue 2's scope, address this through legislation that aligns with Issue 2's principles (e.g., reasonable regulation, taxation, age limits) rather than using it as a pretext to dismantle the voter-approved adult-use cannabis framework. Ensure any regulations do not unduly harm the existing, federally legal hemp industry.[12]

4. **Focus on Evidence-Based Public Health:** If adjustments are needed, base them on current scientific evidence regarding actual risks (e.g., consider lower, evidence-based potency caps if necessary [37]) and invest in robust public education and treatment programs funded as intended by Issue 2, rather than resorting to recriminalization.

D. Closing

Thank you, Chair Thomas and Members of the Committee, for your time and careful consideration of this testimony and the importance of upholding the decision made by Ohio voters.[3]

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