NYC Health

Epi Data Brief

September 2025, No. 148

Recent Trends in Cannabis Use and Associated Morbidity in New York City, 2015 to 2023

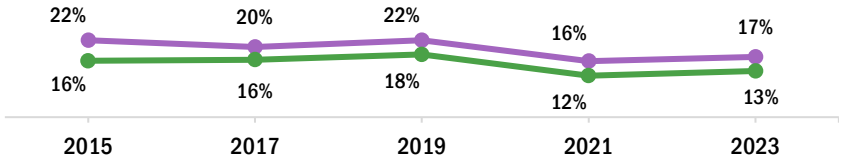
In March 2021, adult use of cannabis was legalized in New York for people ages 21 and older. As access to the legal market expands across New York, it is important to understand cannabis use patterns and monitor health impacts across New York City (NYC) communities. This report examines current cannabis use among both youth and adults by demographic groups and explores cannabis-related emergency department visits.

Cannabis use among New York City public school youth lower than U.S. youth overall

- In 2023, 13% of NYC public high school students reported cannabis use in the past 30 days (recent use), a decrease from 16% in 2015.[A]
- The prevalence of recent cannabis use among U.S. high school students in 2023 was 17%, a decline from 22% in 2015.[B]

Recent cannabis use among New York City youth has declined, aligning with the national trend

Prevalence of use in the past 30 days in the United States and New York City, 2015–2023



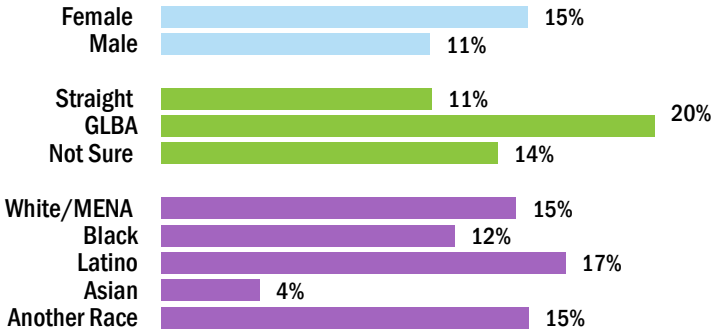
Sources: NYC Youth Behavior Risk Survey and CDC Youth Risk Behavior Surveillance System, 2015-2023

Cannabis use among New York City public school youth differs across groups[A]

- A greater proportion of female youth in NYC reported recent cannabis use than male youth (15% vs. 11%).
- Among youth who identified as gay, lesbian, bisexual, or another sexual orientation, 20% reported recent cannabis use compared with 11% of youth who identified as straight.
- Asian students were less likely to report cannabis use compared with white students (4% vs. 15%).
- Among students who recently used cannabis, the majority (65%) typically smoked it, while smaller proportions preferred edibles or drinks (17%), vaping it (12%), dabbing it (4%), or some other way (3%*).

Youth who do not identify as straight are more likely to report cannabis use than their straight peers

Prevalence of use in the past 30 days by demographic characteristics, New York City, 2023



GBLA: Gay, Lesbian, Bisexual, or Another sexual orientation; Race/ethnicity: White/MENA (Middle Eastern or North African), Black, Asian, and Another Race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Another Race: Includes American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, or multi-race people.

Source: NYC Youth Behavior Risk Survey, 2023

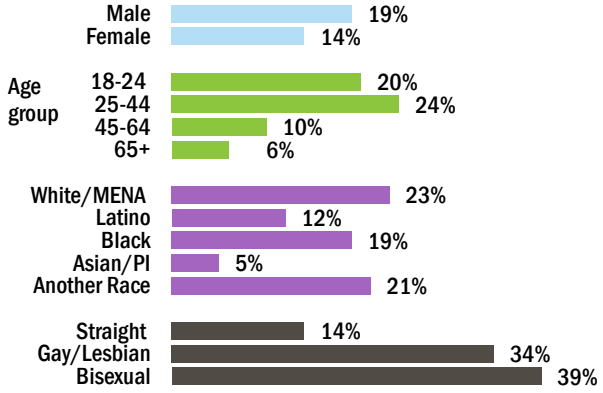
*Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30%, or the 95% Confidence Interval half-width is greater than 10 or the sample size is too small, making the estimate potentially unreliable. **Definitions:** **Cannabis** is also known as marijuana, pot, or weed. **Youth (NYC YRBS):** NYC public high school students in grades 9 through 12. **Recent cannabis use**: Using cannabis in the past 30 days. **Edible**: Candy or baked good that contains cannabinoids. **Dabbed**: use of concentrated cannabis products. **GLBA:** Gay, Lesbian, Bisexual, or Another sexual orientation; **Race/ethnicity:** Latino includes people of Hispanic or Latino origin, as identified by the survey question "Are you Hispanic or Latino?" and regardless of reported race. Black, white/Middle Eastern or North African (MENA), Another Race, and Asian (for NYC YRBS) or Asian/Pacific Islander (for CHS) race categories exclude those who identified as Latino. Another Race (NYC YRBS) includes respondents who are American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, or multiple race categories.

Cannabis use among New York City adults differs by age, sex, race and ethnicity, and sexual orientation[C]

- In 2023, 16% of adult New Yorkers reported recent cannabis use in the past 30 days, similar to 2022 (17%).
- Among NYC adults who recently used cannabis, about one-third used cannabis for 20 or more days within a 30-day period (heavy use).
- Adult males were more likely to report recent cannabis use than adult females (19% vs. 14%).
- New Yorkers ages 45 to 64 and 65 and older had a lower prevalence of recent cannabis use compared with younger residents ages 18 to 24 (10% and 6% vs. 20%, respectively).
- The prevalence of cannabis use among adults who identified as gay or lesbian (34%) or bisexual (39%) was more than double compared with straight adults (14%).
- In 2022, smoking was the most common method of cannabis consumption among NYC adults reporting recent use (76%), followed by edibles (45%), vaping (28%), and dabbing (8%). (Note: respondents could select more than one method.)

Adults who identify as gay, lesbian, or bisexual are more likely to report cannabis use than straight adults

Prevalence of use in the past 30 days, by demographic characteristics, New York City, 2023



Race/ethnicity: White/MENA (Middle Eastern or North African), Black, Asian/PI (Native Hawaiian or other Pacific Islanders), and Another Race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Another Race: Includes respondents who are American Indians/Alaskan Natives, or multiple race categories.

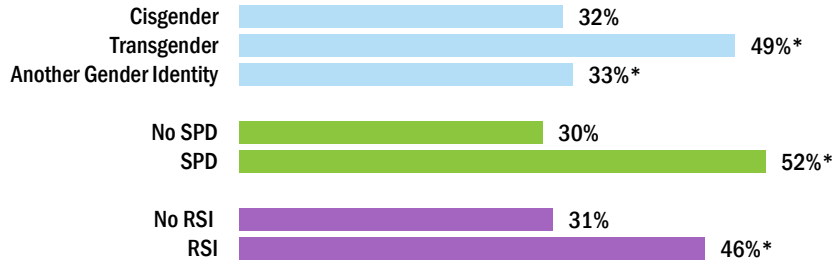
Source: NYC Community Health Survey, 2023

Heavy cannabis use is more likely among transgender adults, adults with psychological distress, and adults at risk for social isolation[C]

- Transgender adults in NYC reported heavy cannabis use at a higher rate than cisgender adults (49%* vs. 32%).
- New Yorkers with serious psychological distress (SPD) were more likely to report heavy cannabis use than New Yorkers without SPD (52%* vs. 30%).
- Heavy cannabis use was more prevalent among NYC residents at risk for social isolation compared with residents who were not (46%* vs. 31%).

Heavy cannabis use more likely to be reported by transgender adults, people with serious psychological distress, or people at risk for social isolation

Proportion of adults who used cannabis 20 or more of the past 30 days among recent cannabis users, New York City, 2023



SPD: Serious psychological distress; RSI: Risk for social isolation

*Estimate should be interpreted with caution due to large relative standard error or small sample size.

Source: NYC Community Health Survey, 2023

Definitions:

Serious Psychological Distress (SPD) is defined as having a score greater than or equal to 13 on the Kessler 6 (K6) scale, a six-item scale developed to identify people highly likely to have a diagnosable mental illness and associated functional limitations.

At Risk for Social Isolation: is defined as having a score of less than six (max score 15) on three questions modeled after the Lubben Social Network Scale; the questions measure self-reported engagement with family and friends.

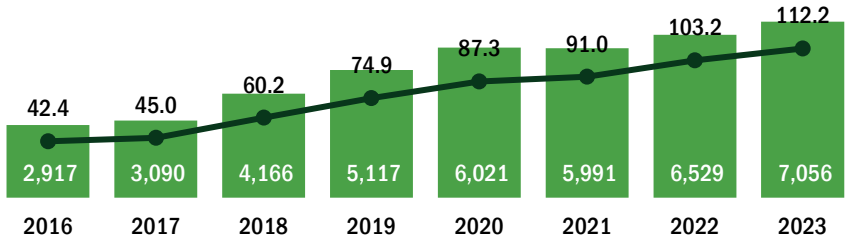
Health equity is attainment of the highest level of health and well-being for all people. Not all New Yorkers have the same opportunities to live a healthy life. Achieving health equity requires focused and ongoing societal efforts to address historical and contemporary injustices such as discrimination based on race/ethnicity, and other identities. For more information, visit the World Health Organization's Health Equity webpage.

In New York City, emergency department visits for cannabis have increased overall[D]

- In 2023, there were 7,056 emergency department (ED) visits in NYC where a cannabis-related condition was the primary diagnosis.
- The rate of ED visits with a cannabis-related primary diagnosis more than doubled among NYC residents from 2016 to 2023 (42.4 per 100,000 people vs. 112.2 per 100,000 people).

Among New York City residents, the number and rate of cannabis-related emergency department (ED) visits increased from 2016 to 2023

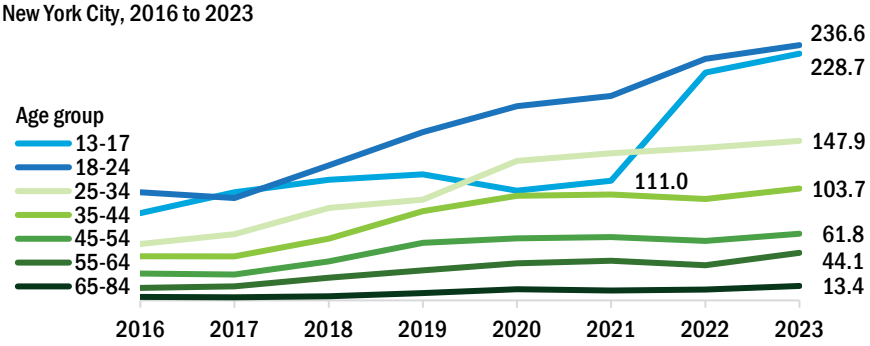
Number and age-adjusted rate (per 100,000) of ED visits with a cannabis-related condition as the principal diagnosis



Source: New York State Planning and Research Cooperative System, 2016-2023

Since 2021, rates of emergency department (ED) visits for cannabis-related diagnosis doubled among residents ages 13 to 17

Age-specific rate (per 100,000) of ED visits with a cannabis-related primary diagnosis by age group, New York City, 2016 to 2023



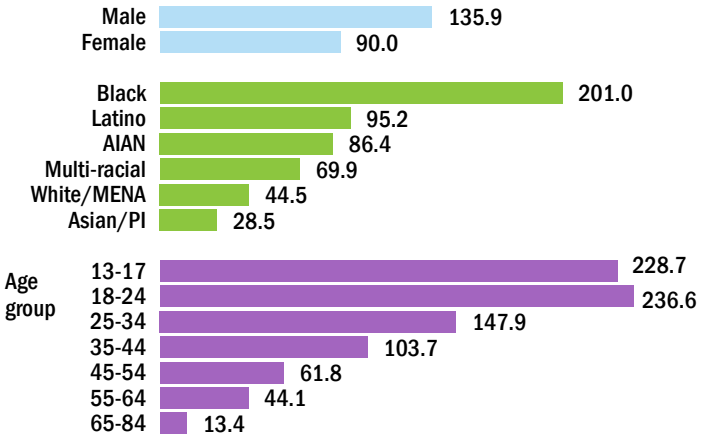
Source: New York State Planning and Research Cooperative System, 2016-2023

- The rate of ED visits with a cannabis-related primary diagnosis more than doubled among NYC residents ages 13 to 17 from 111.0 per 100,00 residents in 2021 to 228.7 per 100,000 residents in 2023.
- From 2016 to 2023, the rate of ED visits with a cannabis-related primary diagnosis more than doubled among NYC residents between the ages of 18 to 24 (100.2 to 236.6 per 100,000 residents).

Cannabis-related emergency department visits differed across groups in New York City[D]

- The rate of ED visits with a cannabis-related primary diagnosis among NYC males was higher than among females (135.9 vs. 90.0 per 100,000).
- New Yorkers who are Black had the highest rate of ED visits with a cannabis-related primary diagnosis (201.0 per 100,000).
- Residents ages 18 to 24 had the highest rate of ED visits with a cannabis-related primary diagnosis (236.6 per 100,000), followed by residents ages 13 to 17 (228.7 per 100,000).

Age-adjusted rates per 100,000 New Yorkers of emergency department (ED) visits with a cannabis-related principal diagnosis, by sex, race/ethnicity and age group, 2023



Race/ethnicity: White/MENA (Middle Eastern or North African), Black, Asian/PI (Native Hawaiian or other Pacific Islanders), AIAN (American Indian or Alaskan Native) and Multi-racial categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Multi-racial: Patients who are multiple race categories.

Source: New York State Planning and Research Cooperative System, 2023

Definition: **Cannabis-related principal diagnoses** are determined by having a cannabis-specific ICD-10 diagnosis code, F12.1 (cannabis abuse), F12.2 (cannabis dependence), F12.9 (cannabis use, unspecified), or T40.7X1/T40.711 (accidental poisoning by cannabis/cannabis derivatives) billed as the principal/ primary/first listed diagnosis field for that visit. For more details of codes see: icd10data.com.

Implications

The Health Department prioritizes evidence-based public education about the health effects of cannabis and is committed to help heal the harms of discriminatory cannabis prohibition laws. Cannabis use was most prevalent among youth and adults who identify as Lesbian, Gay, Bisexual, Transgender, or Queer; individuals reporting serious psychological distress; and individuals at risk of social isolation. These findings suggest the importance of engaging with communities who disproportionately experience stigma and isolation. Smoking was the most common method of use among people who recently used cannabis, indicating a continuing need to educate New Yorkers on lung health and the risks of smoking and vaping of both cannabis and nicotine products.

Critically, the prevalence of cannabis use among youth and adults have remained stable since adult use of cannabis was legalized in March 2021. However, the rate of emergency department visits with cannabis-related primary diagnoses has increased substantially from 2016 to 2023, with youth between the ages of 13 to 17 experiencing a near-doubling in the rate of cannabis-related ED visits in the year following legalization. This highlights the urgency of efforts to prevent problem cannabis use among youth through evidence-based education and curtailed access to cannabis, especially unregulated products with unpredictable potencies and effects.

Although adult-use cannabis is now legalized, it is important to acknowledge the lasting consequences of cannabis criminalization on the health and well-being of Black and Latino New Yorkers. While the specific reasons are not fully understood, Black New Yorkers experience cannabis-related emergency department visits at four times the rate among white New Yorkers. Historically, Black and Latino New Yorkers in NYC experienced higher rates of cannabis-related arrests, incarceration, and mandated treatment compared with white New Yorkers, despite lower reported use of cannabis compared with white New Yorkers.[1] The lifelong impact of the criminal-legal system on the lives of Black and Latino New Yorkers manifests in poor health outcomes among communities. Additional information can be found at nyc.gov/health/cannabis and by searching "E-cigarettes" at nyc.gov/health-topics/smoking-e-cigarettes.page. For free, confidential mental health and substance use support, call or text 988 or chat online at nyc.gov/988, anytime.

Data Sources: A. NYC Youth Risk Behavior Survey (YRBS), 2015-2023: The NYC YRBS is a biennial self-administered, anonymous survey conducted in NYC public high schools by the Health Department and NYC Public Schools. For more survey details, visit nyc.gov/site/doh/data/data sets/nyc-youth-risk-behavior-survey.page. NYC estimates of the prevalence of recent cannabis use were defined according to the Centers for Disease Control and Prevention (CDC) validation standards. Estimates of the method of use were defined according to NYC DOHMH-specific validation standards, which differ from those used by the CDC for estimating overall recent cannabis use.

B. CDC Youth Risk Behavior Surveillance System 2015-2023: A national school-based survey of public and private school students in grades 9 to 12 in the 50 states and the District of Columbia.

C. NYC Community Health Survey (CHS) 2022-2023 is conducted annually by the Health Department with approximately 10,000 non-institutionalized adults ages 18 and older. Estimates are age-adjusted to the U.S. 2000 standard population. For more survey details, visit: nyc.gov/site/doh/data/datasets/community-health-survey.page

D. Statewide Planning and Research Cooperative System (SPARCS) 2016-2023 is an administrative database of all hospital discharges reported by New York State (NYS) hospitals to the NYS Department of Health**.** Age-adjusted rates were calculated using NYC intercensal estimates updated 2024 and are adjusted to the U.S. Census 2000. The raw data used to produce this publication was provided by the New York State Department of Health (NYSDOH). However, the calculations, metrics, conclusions derived, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty, or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here**.**

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References: 1. Chauhan P, Tomascak S, Cuevas C, et al. Trends in Arrests for Misdemeanor Charges in New York City, 1993-2016. New York; February 2018.
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Epi Data Tables

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Recent Trends in Cannabis Use and Associated Morbidity in New York City, 2015 to 2023

Data Tables

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Data Sources

NYC Youth Risk Behavior Survey (YRBS), 1999-2023: The NYC YRBS is a biennial self-administered, anonymous survey conducted in NYC public high schools by the Health Department and the NYC Department of Education. For more survey details, visit nyc.gov/site/doh/data/data sets/nyc-youth-risk-behavior survey.page.

Centers for Disease Control and Prevention (CDC), Youth Risk Behavior Surveillance System (YRBSS) 1999-2023: A national school-based survey of public and private school students in grades 9 to 12 in the 50 states and the District of Columbia. New York State estimates at nccd.cdc.gov/youthonline/.

NYC Community Health Survey 2022-2023 is conducted annually by the Health Department with approximately among non-institutionalized adults ages 18 and older. Estimates are age-adjusted to the U.S. 2000 standard population. For more survey details, visit: nyc.gov/site/doh/data/datasets/community-health-survey.page.

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Table 1. Prevalence of cannabis use in the past 30 days among public high school students in New York City and all high school students (public and private) in the United States, 1999-2023

Sources: Centers for Disease Control and Prevention, National Youth Risk Behavior Surveillance System, 1999-2023, which is administered to both public and private schools, and the NYC Youth Risk Behavior Survey, 2009-2021, which is administered to public schools only.

	United States		New York City		
Year	Prevalence %	95% Confidence Interval	Prevalence %	95% Confidence Interval	P-Value[1]
2015	21.7	(19.3-24.2)	15.9	(13.9-18.0)	**0.032**
2017	19.8	(18.1-21.6)	16.2	(14.7-17.8)	**0.006**
2019	21.7	(19.9-23.7)	17.7	(16.2-19.3)	**<0.001**
2021	15.8	(14.1-17.6)	11.7	(9.4-14.5)	0.405
2023	17.0 *	(15.4-18.7	13.0	(11.4-14.8)	ref.

[1] Statistical testing is limited to comparisons between each year's New York City prevalence estimate and that of 2023.

*Analyses conducted by CDC state there was a significant decrease from 2015 to 2023:
https://yrbs-explorer.services.cdc.gov/#/graphs?questionCode=H48&topicCode=C03&location=XX&year=2023

95% Confidence Intervals (CIs) are a measure of estimate precision: the wider the CI, the more imprecise the estimate.
Bold p-values are significant at the 0.05 level.

Table 2. Prevalence of cannabis use in the past 30 days among New York City public high school students by demographic groups, 2023

Source: NYC Youth Risk Behavior Survey, 2023

Data are weighted to the NYC public high school student population

	2023			
	Prevalence (%)	Lower 95% Confidence Interval	Upper 95% Confidence Interval	P-Value
Overall Prevalence	**13.0**	**11.4**	**14.8**	**~**
Sex				
Female	14.8	12.6	17.2	ref.
Male	10.8	9.4	12.2	**<.001**
Sexual Orientation				
Straight	11.1	9.9	12.4	ref.
Gay/Lesbian/Bisexual/Another Sexual Orientation	20.2	14.2	27.9	**0.010**
Not Sure	13.8	9	20.6	0.368
Race/Ethnicity				
White/Middle Eastern/North African	14.5 U	11.4	18.3	ref.
Black	12.0	8.8	16.2	0.331
Latino	16.6	14.8	18.5	0.265
Asian	4.0	2.8	5.9	**<.001**
Another Race	15.0	12.1	18.6	0.760
Grade				
9th grade	9.1	7.6	10.9	**<.001**
10th grade	11.0	8.5	14.1	0.059
11th grade	17.4	13.4	22.3	0.226
12th grade	14.5 D	12	17.3	ref.

[1]Latino includes people of Hispanic or Latino origin, as identified by the survey question "Are you Hispanic or Latino?" and regardless of reported race. Black, white/Middle Eastern or North African (MENA), Another Race, and Asian race categories exclude those who identified as Latino. Another Race includes respondents who are American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, or multiple race categories.

95% confidence intervals (CIs) are a measure of estimate precision; the wider the CI, the more imprecise the estimate.

D Data rounded down to the nearest whole number for the purposes of reporting in the text.

U Data rounded up to the nearest whole number for the purposes of reporting in the text.

Bold p-values are significant at the 0.05 level.

Table 3. Prevalence of the primary method of cannabis use in the past 30 days among New York City public high students who recently used[1] cannabis, 2023

Source: NYC Youth Risk Behavior Survey, 2023
Data are weighted to the NYC public high school student population

	2023		
	Prevalence (%)	Lower 95% Confidence	Upper 95% Confidence
Smoking	**64.6**	**60.9**	**68.2**
Edible[2]	**16.9**	**14.1**	**20.2**
Vaping	**11.7**	**9.2**	**14.9**
Dabbing	**3.7**	**2.7**	**5.0**
Some other way	**3.0 ***	**1.6**	**5.5**

[1] Recent use refers to cannabis use in the past 30 days.This estimate was defined according to NYC DOHMH-specific validation standards, which differ from those used by the Centers for Disease Control and Prevention (CDC) for estimating overall recent cannabis use.

[2] Candy or baked good that contains cannabinoids.

* Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, making the estimate potentially unreliable.

95% confidence intervals (CIs) are a measure of estimate precision; the wider the CI, the more imprecise the estimate.

Bold p-values are significant at the 0.05 level.

Table 4. Prevalence of cannabis use in the past 30 days among New York City adults by demographic groups, 2022-2023

Source: Community Health Survey, 2022 and 2023. Data for 2022 and 2023 are weighted to the adult residential population according to the American Community Survey, 2021 and 2022, respectively.
Data are age-adjusted to the US 2000 Standard Population.

	2022					2023					
	Prevalence (%)		Lower 95% Confidence Interval	Upper 95% Confidence Interval	P-Value	Prevalence (%)		Lower 95% Confidence Interval	Upper 95% Confidence Interval	P-Value	% Change	2022 vs. 2023 P-Value
Overall Prevalence	**16.5**	**U**	**15.3**	**17.8**	**~**	**16.1**		**14.9**	**17.4**	**~**	-5.3%	**0.650**
Sex												
Male	18.7		16.8	20.8	**<.001**	18.6		16.7	20.7	**<.001**	-10.7%	0.930
Female	14.5	U	13.1	16.1	ref.	13.9	U	12.4	15.5	ref.	-6.0%	0.562
Gender Identity												
Cisgender	16.0		14.9	17.3	ref.	15.8		14.6	17.0	ref.	-5.8%	0.771
Transgender	22.9	*	15.4	32.7	0.122	18.9	*	8.5	36.8	0.666	-22.5%	0.628
Another Gender Identity	51.1	*	40.0	62.1	**<.001**	33.6	*	22.9	46.3	**0.004**	16.0%	**0.036**
Sexual Orientation												
Gay/Lesbian	40.0		33.3	47.1	**<.001**	33.9		27.4	41.1	**<.001**	-1.8%	0.219
Straight	14.4		13.2	15.7	ref.	14.4		13.2	15.8	ref.	-9.3%	0.947
Bisexual	33.0		26.3	40.4	**<.001**	38.9		30.2	48.4	**<.001**	-48.0%	0.316
Age group (years)												
18-24	23.9		18.9	29.7	ref.	19.8		15.6	24.9	ref.	-4.9%	0.260
25-44	22.7		20.6	24.9	0.684	23.6		21.4	25.9	0.157	-14.3%	0.594
45-64	11.3		9.7	13.1	**<.001**	10.3		8.7	12.1	**<.001**	-5.8%	0.395
65 or older	5.5	D	4.2	7.0	**<.001**	6.0		4.5	7.9	**<.001**	-43.2%	0.619
Race/Ethnicity[1]												
White/Middle Eastern/North African	20.7		18.6	23.0	ref.	22.6		20.3	25.2	ref.	-21.7%	0.258
Black,	21.0		17.7	24.7	0.914	19.4		16.5	22.7	0.110	-9.6%	0.511
Latino	12.0		10.0	14.3	**<.001**	11.8		9.8	14.1	**<.001**	-17.9%	0.897
Asian/Pacific Islander	7.6		6.1	9.5	**<.001**	5.1		3.7	6.9	**<.001**	16.6%	**0.031**
Another Race	24.8		19.1	31.7	0.228	20.7		15.3	27.2	0.546	-8.2%	0.344
Borough of Residence												
Bronx	17.2		14.3	20.6	**<.001**	14.9		12.4	17.8	0.057	-4.3%	0.270
Brooklyn	18.3		16.3	20.5	**<.001**	19.3		17.1	21.8	0.775	-18.6%	0.522
Manhattan	23.5	D	20.3	27.0	**<.001**	18.8		16.0	21.9	ref.	7.5%	**0.039**
Queens	10.3		8.6	12.4	ref.	11.3		9.4	13.6	**<.001**	-31.7%	0.483
Staten Island	11.0		7.4	16.0	0.767	14.7		9.7	21.7	0.233	-99.3%	0.316
Neighborhood Poverty[2]												
Low	14.4		12.2	17.0	ref.	17.0		14.3	20.2	ref.	-39.7%	0.172
Medium	16.0		14.1	18.0	0.331	15.4		13.7	17.3	0.343	-9.2%	0.678
High	19.9		17.2	22.8	**0.004**	16.5	D	14.0	19.3	0.774	4.2%	0.087
Very high	17.3		14.1	21.1	0.181	16.2		13.4	19.5	0.697	-15.0%	0.636

1Latino includes people of Hispanic or Latino origin, as identified by the survey question "Are you Hispanic or Latino?" and regardless of reported race. White/MENA (Middle Eastern or North African), Black, Asian/PI (Native Hawaiian or other Pacific Islanders), and Another Race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Another Race: Includes respondents who are American Indians/Alaskan Natives, or multiple race categories.

[2] Neighborhood poverty (based on United Hospital Fund areas) is defined as the percentage of residents with incomes below 100% of the Federal Poverty Level (FPL), based on the American Community Survey (ACS) 2016–2020 for 2022 data and ACS 2018–2022 for 2023 data. It is categorized into four groups.: Low: < 10% living below FPL; Medium: 10 to <20%. High: 20 to <30% Very High: ≥30% below FPL. Missing values have been imputed.

* Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, making the estimate potentially unreliable.

95% confidence intervals (CIs) are a measure of estimate precision; the wider the CI, the more imprecise the estimate.
U When reporting to nearest whole percent, round up.
D When reporting to nearest whole percent, round down.
Bold p-values are significant at the 0.05 level.

Table 5. Prevalence of heavy cannabis use[1] among adult recent consumers[2] by demographic groups, 2023

Source: Community Health Survey, 2023. Data for 2023 are weighted to the adult residential population according to the American Community Survey 2022.
Data are age-adjusted to the US 2000 Standard Population.

	2023				
	Prevalence (%)			Lower 95% Confidence Interval	Upper 95% Confidence Interval	P-Value
Overall Prevalence	**31.9**			**28.1**	**36.0**	**~**
Sex						
Male	31.9			26.6	37.6	0.975
Female	31.8			26.4	37.7	ref.
Gender Identity						
Cisgender	31.9			28.0	36.1	ref.
Transgender	48.9	*		45.3	52.6	**<.001**
Other gender identity	32.9	*		16.8	54.4	0.919
Sexual Orientation						
Gay/Lesbian	27.0			19.2	36.5	0.298
Straight	32.2			27.8	37.0	ref.
Bisexual	46.0	*		32.4	60.3	0.073
Age group (years)						
18-24	28.3	*		19.1	39.8	ref.
25-44	31.7			26.9	36.8	0.571
45-64	35.0			27.6	43.2	0.312
65 or older	29.9	*		19.1	43.5	0.852
Race/Ethnicity [3]						
White/Middle Eastern/North African	29.0			23.7	35.1	ref.
Black	37.5		U	29.3	46.5	0.110
Latino	35.1			27.1	44.1	0.246
Asian/Pacific Islander	14.1	*		7.5	24.8	**0.004**
"Another Race"	33.3	*		21.9	47.0	0.553
Neighborhood Poverty[4]						
Low	29.4			21.8	38.3	ref.
Medium	28.2			22.8	34.4	0.826
High	38.2			29.7	47.4	0.159
Very high	41.5	*		30.8	53.0	0.091
Non-specific psychological distress past 30 days[5]						
Yes	51.9	*		41.5	62.1	**<.001**
No	30.5		D	26.4	34.8	ref.
Risk for social isolation[6]						
Yes	46.1	*		35.7	56.8	**0.011**
No	31.1			27.0	35.5	ref.

[1] Heavy cannabis use is defined as consuming cannabis on 20 or more days within the past 30 days

[2] Recent consumers are adult New York City residents who used cannabis in the past 30 days

[3] Latino includes people of Hispanic or Latino origin, as identified by the survey question "Are you Hispanic or Latino?" and regardless of reported race. White/MENA (Middle Eastern or North African), Black, Asian/PI (Native Hawaiian or other Pacific Islanders), and Another Race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Another Race: Includes respondents who are American Indians/Alaskan Natives, or multiple race categories.

[4] Neighborhood poverty (based on UHF) defined as percent of residents with incomes below 100% of the Federal Poverty Level (FPL) per American Community Survey 2018-2022 categorized into four groups: Low: < 10% living below FPL; Medium: 10 to <20%. High: 20 to <30% Very High: ≥30% below FPL. Missing values have been imputed.

[5] Serious psychological distress is defined as having a score greater than or equal to 13 on the Kessler 6 (K6) scale, a six-item scale developed to identify people highly likely to have a diagnosable mental illness and associated functional limitations.

[6] At Risk for Social Isolation is defined as having a score of less than six (max score 15) on three questions modeled after the Lubben Social Network Scale; the questions measure self-reported engagement with family and friends.

* Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the sample size is less than 50, making the estimate potentially unreliable.

95% confidence intervals (CIs) are a measure of estimate precision; the wider the CI, the more imprecise the estimate.

U When reporting to nearest whole percent, round up.
D When reporting to nearest whole percent, round down.

Table 6. Prevalence of cannabis mode of use among adult recent consumers[1], 2022

Source: Community Health Survey 2022.Data for 2022 are weighted to the adult residential population according to the American Community Survey 2021.
Data are age-adjusted to the US 2000 Standard Population.

	2023		
	Prevalence (%)	Lower 95% Confidence	Upper 95% Confidence
Smoking	**75.7**	**71.9**	**79.2**
Edible[2]	**44.7**	**40.6**	**48.8**
Vaping	**27.6**	**24.0**	**31.5**
Dabbing	**8.2**	**6.1**	**11.1**

[1] Recent consumers are adult New York City residents who used cannabis in the past 30 days.

[2] Candy or baked good that contains cannabinoids.

95% confidence intervals (CIs) are a measure of estimate precision; the wider the CI, the more imprecise the estimate.

Table 7. Unintentional cannabis-related principal diagnosis emergency department (ED) visits by demographic groups, in New York City, 2016-2023

Source: New York State Department of Health, Statewide Planning and Research Cooperative System (SPARCS), 2016-2023 (Data Update: March 2025)

All rates are age adjusted except those that are age-specific and per 100,000 residents. Data are calculated using NYC intercensal estimates updated 2024, and are adjusted to U.S. Census 2000. Data are restricted to New York City residents ages 13-84.

	2016			2017			2018			2019			2020			2021			2022			2023		
	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate	N	% of claims with primary cannabis-related ED visit	Age-adjusted rate
Claims with ED visit with a cannabis-related principal diagnosis[2]	**2,917**	**100.0%**	**42.4**	**3,090**	**100.0%**	**45.0**	**4,166**	**100.0%**	**60.2**	**5,117**	**100.0%**	**74.9**	**6,021**	**100.0%**	**87.3**	**5,991**	**100.0%**	**91.0**	**6,529**	**100.0%**	**103.2**	**7,056**	**100.0%**	**112.2**
Sex																								
Female	654	22.4%	19.3	801	25.9%	24.1	1,121	26.9%	33.5	1,417	27.7%	41.9	1,749	29.0%	51.6	1,953	32.6%	60.2	2,525	38.7%	81.1	2,793	39.6%	90.0
Male	2,262	77.5%	66.8	2,289	74.1%	67.1	3,045	73.1%	88.6	3,700	72.3%	110.1	4,272	71.0%	125.3	4,036	67.4%	123.8	4,004	61.3%	126.9	4,260	60.4%	135.9
Age-group[3]																								
13-17	376	12.9%	80.9	463	15.0%	100.1	514	12.3%	111.7	534	10.4%	116.8	469	7.8%	101.8	504	8.4%	111.0	942	14.4%	211.3	1,006	14.3%	228.7
18-24	793	27.2%	100.2	733	23.7%	94.9	947	22.7%	125.1	1,162	22.7%	156.1	1,286	21.4%	179.9	1,297	21.6%	189.6	1,526	23.4%	223.8	1,613	22.9%	236.6
25-34	824	28.2%	52.3	966	31.3%	61.3	1,349	32.4%	85.7	1,468	28.7%	93.5	1,972	32.8%	129.3	1,926	32.1%	136.5	1,954	29.9%	141.4	2,017	28.6%	147.9
35-44	491	16.8%	41.0	490	15.9%	40.8	688	16.5%	57.2	996	19.5%	82.8	1,181	19.6%	97.1	1,153	19.2%	98.1	1,083	16.6%	93.9	1,187	16.8%	103.7
45-54	281	9.6%	24.8	270	8.7%	24.0	402	9.6%	36.3	582	11.4%	53.5	624	10.4%	57.6	615	10.3%	58.7	563	8.6%	55.0	619	8.8%	61.8
55-64	119	4.1%	11.6	136	4.4%	13.1	222	5.3%	21.1	295	5.8%	27.9	366	6.1%	34.3	386	6.4%	36.8	337	5.2%	32.7	447	6.3%	44.1
65-84	33	1.1%	3.1	32	1.0%	2.9	44	1.1%	3.9	80	1.6%	6.9	123	2.0%	10.5	110	1.8%	9.2	124	1.9%	10.1	167	2.4%	13.4
Race/Ethnicity[4]																								
Black	1,248	42.8%	80.5	1,357	43.9%	88.2	1,831	44.0%	120.1	2,312	45.2%	154.5	2,863	47.6%	187.6	2,709	45.2%	185.2	2,592	39.7%	186.8	2,716	38.5%	201.0
Latino	668	22.9%	31.8	646	20.9%	30.7	975	23.4%	46.1	1,126	22.0%	54.9	1,414	23.5%	70.1	1,516	25.3%	77.4	1,594	24.4%	84.1	1,781	25.2%	95.2
American Indian or Alaskan Native	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	11	0.2%	74.5	14	0.2%	86.4
Multi-racial	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	62	0.9%	48.7	86	1.2%	69.9
White	352	12.1%	17.5	422	13.7%	20.8	532	12.8%	25.8	598	11.7%	29.5	634	10.5%	29.9	677	11.3%	34.4	915	14.0%	46.8	889	12.6%	44.5
Asian or Pacific Islander	116	4.0%	11.7	126	4.1%	13.1	164	3.9%	16.2	133	2.6%	13.2	132	2.2%	13.5	168	2.8%	17.3	229	3.5%	24.1	274	3.9%	28.5
"Another Race" or Unknown Race	489	16.8%	~	502	16.2%	~	608	14.6%	~	850	16.6%	~	914	15.2%	~	850	14.2%	~	1,126	17.2%	~	1,296	18.4%	~
Neighborhood poverty[5]																								
Low poverty: 0 to <10%	336	11.5%	24.4	362	11.7%	25.7	459	11.0%	33.4	529	10.3%	38.5	609	10.1%	46.3	621	10.4%	48.8	769	11.8%	61.5	833	11.8%	66.4
Medium poverty: 10 to <20%	1,175	40.3%	39.7	1,281	41.5%	42.9	1,594	38.3%	53.1	2,027	39.6%	68.2	2,501	41.5%	76.8	2,450	40.9%	78.9	2,659	40.7%	89.7	3,000	42.5%	101.2
High poverty: 20 to <30%	697	23.9%	45.4	727	23.5%	48.9	1,152	27.7%	76.0	1,342	26.2%	90.7	1,462	24.3%	102.7	1,501	25.1%	110.6	1,463	22.4%	111.0	1,608	22.8%	124.2
Very high poverty: 30 to 100%	708	24.3%	76.9	720	23.3%	76.6	944	22.7%	101.7	1,207	23.6%	133.2	1,430	23.8%	174.9	1,400	23.4%	175.9	1,557	23.8%	200.6	1,516	21.5%	199.4
Borough of Residence																								
Bronx	762	26.1%	63	852	27.6%	70.2	881	21.1%	73.5	1104	21.6%	93.8	1471	24.4%	128	1502	25.1%	133.2	1677	25.7%	156.1	1705	24.2%	161.9
Brooklyn	896	30.7%	42.1	897	29.0%	42.2	1544	37.1%	71.6	1639	32.0%	77.9	1748	29.0%	81.3	1584	26.4%	76.5	1783	27.3%	89.9	1952	27.7%	99.3
Manhattan	528	18.1%	37.3	654	21.2%	47.3	856	20.5%	60.2	1421	27.8%	102.8	1574	26.1%	111.5	1538	25.7%	118.6	1497	22.9%	116.9	1674	23.7%	132.7
Queens	573	19.6%	33.7	544	17.6%	31.4	710	17.0%	41.1	771	15.1%	44.2	1004	16.7%	57.2	1118	18.7%	65.7	1295	19.8%	79.7	1442	20.4%	89.1
Staten Island	158	5.4%	42.4	143	4.6%	39.2	175	4.2%	48	182	3.6%	49.7	224	3.7%	61.6	249	4.2%	69.1	265	4.1%	72.9	262	3.7%	72.5

[1] Age adjusted rates (AAR) are calculated using NYC intercensal estimates updated 2024, and are adjusted to U.S. Census 2000.

[2] Cannabis-related principal diagnosis are determined by having a cannabis specific ICD-10 diagnosis code, F12.1 (cannabis abuse), F12.2 (cannabis dependence), F12.9 (cannabis use, unspecified), or T40.7X1/T40.711 (accidental poisoning by cannabis/cannabis derivatives) billed as the principal/primary/first listed diagnosis field for that visit. For details of codes see: icd10data.com.

[3] Age standardized rates are presented. Unknown age are not included in the percent of total calculation.

[4] Latino includes persons of Hispanic or Latino origin regardless of race. All other race/ethnicity categories exclude those who identify as Latino. ""Another Race"" refers to patients whose race or ethnicity was categorized as "Other" during a visit. The ED visit rate for cannabis-related conditions as the principal diagnosis among New Yorkers who identify as "Another Race" or "Unknown Race" was excluded due to unavailable intercensal population estimates.

[5] Neighborhood poverty (based on ZIP code) defined as percent of residents in the ZIP code with incomes below 100% of the Federal Poverty Level per American Community Survey Census 2019-2023. These categories are based on the whole ZIP code and not patient's individual wealth. The total number of cases do not sum to the total number of cannabis-related ED visits due to missing information.

Cells that could lead to the inadvertent disclosure of private data are marked with a hyphen (-)