SUBMISSION TO

THE TASK FORCE ON MARIJUANA LEGALIZATION AND REGULATION

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Introduction

Families for Addiction Recovery ("FAR") is a new grassroots national nonprofit organization. FAR's mission is to support families affected by substance use disorder ("SUD") and protect persons struggling with SUD, particularly youth, through the promotion of compassionate evidence-based treatment, supporting research and working to end stigma. Most of our members are parents whose children struggle with addiction. Many of these children have struggled with cannabis use disorder since early adolescence.

We are grateful for this opportunity to provide a written submission regarding the legalization and regulation of cannabis. Further, we request the opportunity to make oral representations to the Task Force on Marijuana Legalization and Regulation (the "Task Force").

Toward the Legalization, Regulation and Restriction of Access to Marijuana- Discussion Paper written by the federal government (the "Discussion Paper") makes it clear that the federal government intends to take a public health approach to the legalization of marijuana. It acknowledges that prohibition has not worked.

We believe it is fair to characterize the government's vision for the legalization of marijuana as set out in the Discussion Paper as a social contract for the greater good of all. Non-problematic users will win because they will be able to use cannabis without fear of prosecution. The government will win because they will earn billions in profits and save in enforcement costs. Society will win because the government will use the profits for prevention and public safety. Problematic users will win because the government will use the profits for treatment, including counselling. However, as will be discussed later in this submission, if the same regulatory framework is used for cannabis as is currently used for the regulation of alcohol, there is every reason to believe that problematic users will remain untreated, especially our youth. The concern is that, without dedicated funding, the governments will make billions in profits largely from problematic users and will not provide effective treatment, just like any other individual or entity that profits from the sale of psychoactive substances.

If the federal government honours its obligations under this social contract, and if it can bind the provincial/territorial governments to do the same, then FAR supports the legalization and regulation of cannabis which, aside from funding treatment, will address these concerns:

1. Criminalizing non-problematic users of cannabis:
    - is unjustifiable as they are neither a harm to themselves or others;
    - diverts funds needed for treatment to enforcement; and
    - does not prevent youth from using cannabis or protect them from developing cannabis use disorder.

2. Criminalizing problematic users, i.e. those with SUD:
    - makes those with a medical condition subject to the criminal justice system instead of the health care system;
    - does not improve the health of those with cannabis use disorder;
    - maximizes harm by adding a legal problem to a medical problem and adding barriers to recovery, employment and out of country travel; and
    - perpetuates stigma.

We are not going to comment on all aspects of regulation. Instead, this submission focuses on the aspects of regulation that are of greatest importance to families affected by addiction.

Objectives of the Task Force

There are nine objectives of the Task Force. The first objective is to "protect young Canadians by keeping marijuana out of the hands of children and youth". The seventh objective mentions, in passing and as a part of many other matters, "programmatic support for addiction treatment, mental health support and education programs". It is extremely disappointing that a primary stated objective of the Task Force is not "to protect children and youth with cannabis use disorder by ensuring, under a regulated system, that there will be publicly-funded, timely, compassionate, evidence-based treatment available to them".

Dedicated Funding for Treatment

It is imperative to have publicly-funded, timely, compassionate, evidence-based treatment available for children, youth and adults with cannabis use disorder and/or other SUDs prior to the legalization of cannabis. Treatment meeting all these criteria is rarely available today. Currently, a choice must be made between publicly-funded or timely treatment. Further, although it is recognized that SUD and co-occurring mental health disorders must be treated at the same time to be effective, this is still the exception to the rule. The impact of this cannot be overstated. Persons with SUD and their families often lose hope when relapse occurs, believing the patient has failed

when, in reality, effective treatment was never received. Further, it is waste of public funds to provide ineffective treatment.

If legalization results in an increase in cannabis use, wait times are going to increase unless immediate steps are taken to build capacity to provide evidence-based treatment. Given the historical chronic underfunding of addiction and other mental health disorders, FAR recommends that the federal government immediately assists the provincial/territorial ministries of health to start to build capacity to treat youth and adults with addiction and other mental health disorders. Building capacity includes teaching and training medical students and doctors to inquire about, identify and treat SUD. Addiction medicine is not taught as a core course in any Canadian medical school. In addition, there is a significant shortage of addiction specialists in Canada.[1]

FAR believes that the following statement regarding the US health care system is equally true in Canada:

"Stigma in the U.S. health care system contributes to disparities in funding for research and treatment of mental disorders in comparison with physical disorders and to the negative attitudes, beliefs, and behaviors of health care professionals toward people with mental and substance use disorders. Structural stigma is manifested in the health care system in the low quality of care for people with mental and substance use disorders and the limited access to behavioral health treatment and other services (Institute of Medicine, 2006; Schulze, 2007; Schulze and Angermeyer, 2003…"[2].

The outcomes of untreated addiction and other mental health disorders in our youth, at every socio-economic level, include:

- chaotic living arrangements: homelessness, group homes (even where the child is from a functional home), psychiatric wards, juvenile detention and revolving door visits to hospital emergency departments;
- illegal activities: prostitution, drug dealing, and stealing to fund the addiction, and driving impaired;
- serious health problems: sexual abuse, physical abuse, HIV, Hepatitis C, substance use induced psychosis, suicide, overdose leading to permanent brain damage, heart attack or death; and

[1] McEachern, J., Ahamad, K., Nolan, S., Mead, A., Wood, E., Klimas, J. *A Needs Assessment of the Number of Comprehensive Addiction Care Physicians Required in a Canadian Setting*. Journal of Addiction Medicine, July/August 2016 - Volume 10 - Issue 4 - p 255–261.

[2] *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change (2016),* National Academies Press (p.45-46).

- dropping out of school.

Treatment is the most effective and cheapest alternative. However, the vast majority of our youth do not receive any treatment. The wait time at Ontario's Pine River Institute, for example, the only long term treatment center in Ontario for youth with concurrent addiction and other mental health disorders was 14 months in 2012 and 16 months in 2014. There are currently 204 youth on their waiting list for their 29 publicly funded beds. Most of these youth have problematic use of cannabis and/or alcohol. In BC, the only long term treatment center actually closed (although it apparently is now scheduled to reopen). Bad things happen when youth wait for treatment. It has been estimated that 70% of juvenile offenders have addiction and/or mental health disorders.

Canada spends just over 7% of its public health budget on addiction and other mental health disorders but the burden of these diseases in Canada in 2013 was between 10% and 11%[3]. CAMH has estimated that this spending deficit in Ontario alone is $1.5 billion[4]. By comparison, countries like the UK and New Zealand spend 10%-11% of their public health budget on addiction and other mental health disorders. In 2012, the Mental Health Commission of Canada in *Changing Directions, Changing Lives, The Mental Health Strategy for Canada*, called for Canada to increase the amount it spends on addiction and other mental health disorders from 7% to 9% over 10 years. This recommendation pre-dates the federal government's commitment to legalize cannabis, which will generate income for the federal and provincial governments, and the current opioid overdose epidemic which is killing thousands of Canadians annually, many of them our youth and young adults.

FAR recommends that the federal government ensures that all the net profits from the taxation and regulation of cannabis, both federally and provincially, be used to fund the treatment of addiction and other mental health disorders in each province/territory until such spending is equal to the burden of those disorders in such province/territory. This presents a perfect opportunity for the federal government to ensure it achieves its central goal in regulating cannabis as set out in the "Minimizing Harms" section of the Discussion Paper which states, "Protecting youth and children from the negative consequences of marijuana use is central to the Government's interest in legalizing, regulating and restricting access." The renegotiation of the Health Accord may provide an avenue to achieve this goal and legally bind the provinces/territories.

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[3] Institute for Health Metrics and Evaluation (2015). *Global Burden of Diseases, Injuries, and Risk Factors Study, 2013*. Data retrieved from http://www.healthdata.org/data-visualization/gbd-compare

[4] http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx

Minimum Legal Age of Purchase

FAR recommends that the minimum legal age ("MLA") for the purchase of cannabis be 21 years of age. It is clear that the adolescent brain continues to develop until the mid-20's and that the use of addictive substances can impact that development. The government should err on the side of caution. Much more research is required with respect to the effect of cannabis on the adolescent brain. It will be much easier to lower the MLA if it is subsequently determined to be too high than to raise the MLA if it is subsequently determined to be too low.

It may seem illogical to recommend a higher MLA for the purchase of cannabis than for alcohol and tobacco when those substances are significantly more harmful than cannabis. Alcohol ranked first and cannabis eighth in a study ranking various psychoactive drugs in terms of their relative harms to self and harms to others[5]. A Canadian Centre on Substance Abuse ("CCSA") report found that in 2002 direct alcohol-related health care costs ($3,306.2 million) were nearly three times as high as for all illicit drugs combined excluding cannabis ($1,061.6 million), and over 45 times higher than the direct health care costs of cannabis ($73 million)[6].

FAR's position is that the MLA for the purchase of tobacco and alcohol should be 21. With respect to alcohol and a minimum legal drinking age ("MLDA"), one article examined emergency records in Ontario from 2002 to 2007 and concluded, "Our study demonstrates that significant and abrupt increases in alcohol-use disorders, assault victimization, and suicides (entirely attributable to alcohol) occur immediately after the MLDA. In addition, young men making the transition across the MLDA exhibit significant increases in hospital-based episodes for a broad class of injuries."[7]

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[5] Wood E, McKinnon M, Strang R, Kendall PR. *Improving community health and safety in Canada through evidence-based policies on illegal drugs.* Open Medicine. 2012;6(1):e35-e40. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3329118/

[6] Thomas, G.B., & Davis, C.G. (2006). *Comparing the Perceived Seriousness and Actual Costs of Substance Abuse in Canada: Analysis drawn from the 2004 Canadian Addiction Survey*. Ottawa, ON: Canadian Centre on Substance Abuse. http://www.ccsa.ca/Resource%20Library/ccsa-011350-2007.pdf

[7] Callaghan RC, Sanches M, Gatley JM, and Cunningham, J.K. *Effects of the Minimum Legal Drinking Age on Alcohol-Related Health Service Use in Hospital Settings in Ontario: A Regression–Discontinuity Approach*. Am J Public Health. 2013; 103:2284–2291.(p. 2291) http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301320

A plethora of recent academic articles in Canada, the US, Australia and New Zealand provide compelling evidence of the public health benefits of increasing the MLDA to 21 years of age.[8] [9] As one such article states:

"Our results have important implications for policy development. In light of our findings, a persuasive argument can be made that raising the MLDA would result in substantial decreases in mortality among Canadian young people, particularly males. However, major political obstacles may arise in the implementation of increased MLDAs: it is unclear whether there would be broad population support in Canada for implementing higher MLDAs; underage voters would likely oppose such legislative efforts; and the alcohol industry would likely work to undermine proposals to raise MLDAs. Nonetheless, if the proposal of raising MLDAs does not receive popular or legislative support, it may be possible to achieve the same public-health aims of reducing harms among young people by implementing zero-tolerance blood-alcohol policies—legislation which restricts the blood alcohol content (BAC) among young drivers to 0% BAC until substantial driving experience has been gained (usually 3–5 years after the initial driver's license."[10]

This statement illustrates how important it is to ensure that the MLA for purchase of cannabis is not too low as it will be difficult to increase it if this is the case. It also raises a question with respect to cannabis impaired driving if the MLA for purchase of cannabis is less than 21, and that is whether it will be possible to achieve the same public health aims of reducing harms among young people by implementing zero-tolerance THC levels among young drivers. This will depend on whether there are roadside tests that can accurately detect minimal levels of THC from recent use. If these tests are not available, then a MLA of 21 for cannabis purchase becomes even more important.

With respect to tobacco, Hawaii and California recently increased the MLA of purchase to 21. Hundreds of cities in other States in the US also provide for a MLA for purchase of 21. The Institute of Medicine of the National Academies recently published a four hundred page report which examined the public health implications of raising the

[8] DeJong W, Blanchette, J. *Case Closed: Research Evidence on the Positive Public Health Impact of the Age 21 Minimum Legal Drinking Age in the United States*
http://www.ncbi.nlm.nih.gov/pubmed/24565317

[9] Toumbourou, J.W., Kypri K., Jones, S.C., Hickie, I.B. *Should the legal age for alcohol purchase be raised to 21?*
https://www.mja.com.au/journal/2014/200/10/should-legal-age-alcohol-purchase-be-raised-21

[10] Callaghan RC, Sanches M, Gatley JM, Stockwell T. *Impacts of drinking-age laws on mortality in Canada*, 1980-2009.
http://www.ncbi.nlm.nih.gov/pubmed/24631002

minimum age of legal access to tobacco to 19, to 21 or to 25[11]. The report concluded that while the changes directly pertained to those over 18, the largest proportionate reduction in the initiation of tobacco use was likely to occur among adolescents 15-17 years old. Another conclusion reached was that the impact on initiation of tobacco use of raising the MLA to 21 was likely substantially higher than raising it to 19, but the added effect of raising it from 21 to 25 would likely be considerably smaller. This is because 15-17 year olds are most likely to get their tobacco from social sources and raising the MLA to 19 may not change social sources significantly whereas raising it to 21 will likely change it significantly.

We recommend that there be one MLA of purchase for cannabis across Canada. It makes no sense for minimum purchase ages to vary from province to province. The minimum purchase age should be based on the best evidence regarding health benefits and the reduction of harms, and it would be surprising if this varied from province to province.

Minimum Legal Age for Possession for Personal Use

It is useful to consider the legal consequences to adolescents who are under the MLA for purchase of tobacco and alcohol who are found in possession of those substances. With respect to tobacco, in all but two provinces (Alberta and Nova Scotia) it is not a criminal offence for those under the MLA for purchase to be in possession. With respect to alcohol, it is a criminal offence in all provinces/territories for those under the MLDA to be in possession. Generally, this can result in a confiscation of alcohol, a fine and/or advising parents. However, these laws seem to be rarely enforced. Cannabis is relatively less harmful than tobacco and, as previously indicated, alcohol.

FAR's position is that a public health approach means that those under the MLA for purchase of cannabis should not face criminal interventions for possession for personal use; rather they should face medical interventions where necessary.

Far recommends that it should not be a criminal offence for an adolescent under the MLA of purchase to be in possession of cannabis for personal use; rather our laws should discourage cannabis use by adolescents, whether problematic or not, by allowing for the confiscation of their cannabis if they are found in possession, fines and allowing parents to be contacted.

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[11] Bonnie, RJ, Stratton, K, Kwan, LY. *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products*. National Academies Press, 2015. http://tobacco21.org/wp-content/uploads/2015/03/Public-Health-Implications-of-Raising-the-Minimum-Age-of-Legal-Access-to-Tobacco-Products-Institute-of-Medicine.pdf

Possession for The Purpose of Trafficking Outside the Regulated System

The Discussion Paper asks, “How should governments approach designing laws that will reduce, eliminate and punish those who operate outside the boundaries of the new legal system for marijuana?”

In order to protect those under the MLA of purchase for cannabis, and to protect the integrity of the regulated system, those trafficking in cannabis outside of the regulated system must be dealt with under the criminal justice system.

However, FAR recommends that the federal government:

- consider altering the definition of “traffic” to exclude gifts or transfers for no consideration, at least with respect to cannabis; and
- establish a task force to study, and make recommendations with respect to, the ongoing criminalization of persons struggling with addiction and other mental health disorders who should be receiving treatment under the health care system instead of punishment under the criminal justice system.

Cannabis Impaired Driving

FAR recommends that the federal government expedite the research it is conducting regarding cannabis impaired driving in order to:

- authorize the use of roadside oral fluid devices;
- develop a per se level for THC equal to a .05 blood alcohol level (“BAC”);
- pass legislation making it a criminal offence to drive in excess of that per se level;
- implement mandatory roadside testing for alcohol and drugs; and
- implement a robust education campaign for youth and adults advising how they can determine whether they are in excess of the legal per se level.

Advertising, Marketing, Promotion and Sponsorship (Demand Drivers)

When psychoactive substances like heroin and fentanyl can be purchased on the internet, it is clear that the solution to problematic substance use is not going to be on the supply side. Supply will always rise to meet demand. The solution will be through demand reduction. And the antithesis of demand reduction is branding, advertising, marketing, and promotion.

In 2011 The Health Officers Council of BC in a discussion paper regarding the regulation of psychoactive substances said this:

"One of the most important lessons learned from the commercialization of tobacco and alcohol is that product promotion is a significant driver of consumption and consequent increases in population harms. Therefore all promotion of substances will be prohibited. Promotion comes in many forms and includes advertising, branding/naming, sponsorship, gifting, product association with film, leading personality recruitment, associating use with attractive activities such as sporting, socialization, sex, and vacations; pricing reductions (i.e. loss leaders); labelling suggestive of pleasure, enhanced performance, over stated benefits; creating similar products for children (i.e. chocolate cigarettes) or youth attractive products (e.g. alcopops, flavoured cigarettes and cigars); and other information presentations suggestive of performance enhancement. Branding of substances products is critical to promotion, and once branding is allowed promotion is very difficult to prevent. Therefore, to prevent branding from occurring, substances should only be available in generic packaging."[12]

There are already images of Snoop Dogg wearing a Tweed T-shirt on the internet. We suggest this image is not aimed at the older generation. Psychoactive substances sell themselves. There is no justification for allowing the advertising, marketing, promotion or sponsorship of psychoactive substances in a public health model. With respect to cannabis, approximately 30% of users will develop cannabis use disorder[13]. Dependence will develop in 5%-9% of adults and 17% of adolescents[14]. It is reasonable to assume that, as with alcohol and gambling, the majority of the profits of the cannabis industry will be derived from, and at the expense of, consumers with problematic use who will be targeted by the industry.

Youth are particularly vulnerable to advertisements and marketing and they will see any ads intended for adults only. FAR recommends that, to the extent possible under our laws, there should be a complete ban on branding, advertising, and marketing of

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[12] The Health Officers Council of BC*. Public Health Perspectives for Regulating Psychoactive Substances (2011)* at p.30.
https://healthofficerscouncil.files.wordpress.com/2012/12/regulated-models-v8-final.pdf

[13] Hasin DS, Saha TD, Kerridge BT, et al. *Prevalence of Marijuana Use Disorders in the United States Between 2001-2002 and 2012-2013. JAMA Psychiatry*. 2015;72(12):1235-1242. doi:10.1001/jamapsychiatry.2015.1858.
http://www.ncbi.nlm.nih.gov/pubmed/26502112

[14] Canadian Centre on Substance Abuse (2015).*The Effects of Cannabis Use During Adolescence*.(p.48) http://www.ccsa.ca/Resource%20Library/CCSA-Effects-of-Cannabis-Use-during-Adolescence-Report-2015-en.pdf

cannabis products and on the cannabis industry sponsoring events or entertaining politicians.

We recommend warning labels stating:

- cannabis should not be used prior to driving (ideally an evidence-based length of time to wait before driving would be indicated);
- impairment and risk of harm will increase if cannabis is used with other psychoactive substances such as alcohol; and
- cannabis use can become addictive (ideally addiction rates for adults and adolescents would be stated).

Distribution Model

The danger is that where there is a profit to be made in the sale of psychoactive substances, public health will suffer. It is imperative to try to avoid the mistakes of the past with respect to alcohol and tobacco.

The Liquor Control Board of Ontario (the "LCBO") provides an example of how government regulation and control of a psychoactive substance does not necessarily equate to a public health approach. The LCBO reports to the Ontario Minister of Finance and its Board Members are appointed by the Lieutenant-Governor on the recommendation of the Premier and the Minister of Finance. The current backgrounds of the sitting board members are in business and government relations; none have a public health or medical background or expertise. None of the profits from the LCBO are required to be used to reduce the harms to public health and safety from the consumption of alcohol.

Emblematic of the LCBO's approach is the following quote from the Media Centre section of its website:

"LCBO's focus on excellence in the customer experience, expense management and operational efficiency has contributed to another record year. LCBO's financial results for fiscal 2015-16 show net sales growth of 6.8 per cent, at $5.57 billion. The provincial agency transferred a dividend of $1.935 billion to the Ontario government (excluding HST), $130 million more than the year before. Net income for 2015-16 was $1.97 billion, an increase of 8.2 per cent."[15]

[15] http://www.lcbo.com/content/lcbo/en/corporate-pages/about/media-centre/news/2016-06-13d.html

Together with an additional $611 million in beer and wine taxes, the Ontario government made a profit in excess of $2.5 billion from the sale of alcohol in 2015-2016. Yet the Province of Ontario cannot provide timely treatment for adolescents with alcohol use disorders or other SUDs. As previously indicated, Ontario youth with alcohol use disorder and concurrent mental health disorders in need of long term residential care are currently waiting 16 months for treatment at the only long term residential facility in the province. The wait time has actually increased since the government announced that youth addiction is a priority for the government. Making matters worse, the Ontario government recently made two announcements that will increase sales and harms:

- online sales by the LCBO; and
- the expansion of retail outlets for the sale of certain alcohol products to include grocery stores and farmers markets.

The evidence is that provincial governments will be blinded by the revenues generated by the sale of alcohol (what is coming in the front door) and insensitive to the expenses incurred from a public health and safety perspective (what is going out the back door) and to the suffering of families affected by addiction. Even ignoring the staggering social costs, the sale of alcohol is likely a net economic loss to the province[16] yet the encouragement of sales (a commercial approach) and the lack of treatment continues.

In spite of this unconscionable state of affairs, FAR's position is that the distribution model that involves the least amount of risk to public health is one where the government retains control. We recommend an approach suggested by Mark Haden and Brian Emerson that the governments retain a monopoly over cannabis distribution and sales through the establishment of provincial Cannabis Control Commissions ("CCCs") to exercise regulatory oversight.[17] CCCs would have a monopoly over all cannabis sales and would control all aspects of cannabis production, packaging, distribution and retailing. CCCs would be established with a clear and explicit public health mandate; government revenue would not be a principal driver of the CCCs' policies and the CCCs would be, to the extent possible, at arm's length from the government.

Unlike the LCBO, CCCs should report to the provincial Ministers of Health given the overriding public health mandate of any CCC. Similarly, board members of the CCC

[16] Thomas, G. (2012). *Analysis of beverage alcohol sales in Canada. Alcohol Price Policy Series, Report 2 of 3.* Ottawa ON Canadian Centre on Substance Abuse

[17] Haden, M., & Emerson, B. (2014). *A vision for cannabis regulation: a public health approach based on lessons learned from the regulation of alcohol and tobacco*. Open Medicine, *8*(2), e73–e80. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4085088/

should be appointed by the Minister of Health and the majority of the board members should have relevant public health or medical backgrounds and expertise.

Given the gross underfunding of treatment for mental health disorders and addiction in all provinces, we believe all the profits of CCCs should go towards treatment. Once there is publicly-funded, timely, evidence-based treatment, we concur with Mark Haden and Brian Emerson that profits from the CCCs would be used for:

- evaluation costs (process and impact monitoring and best practice research);
- investing in demand reduction, prevention, education and treatment programs including initiatives which target the social determinants of problematic substance use; and
- supplementing general government revenues once the above costs are covered.

We recommend provincial CCCs in every province/territory. The privatization of alcohol sales in Alberta resulted in a four-fold increase in the number of retail outlets (from 300 to 1200). An increase in the number of retail outlets equals an increase in alcohol related harms.[18] It has been suggested that one of the reasons that tobacco strategies to reduce consumption have been so successful is that tobacco is kept out of sight and out of mind. Those in recovery are not triggered. The same cannot be said for those in recovery from alcohol use disorder who have to pass by alcohol retail outlets on every corner.

We recommend that Canada follow the lead of Washington and Colorado and not allow cannabis to be sold in stores that also sell alcohol.

"The clustering of cannabis outlets would not be allowed, as an aggregate presence could have undesirable effects on neighbourhoods, and outlets would be prohibited within 500 meters of a school, playground, or alcohol retail outlet."[19]

"Outlets should, initially at least, be limited to the sale and consumption of cannabis products only. In the Netherlands, a prohibition on the sale of all other drugs, including alcohol, is a non-negotiable licence condition."[20]

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[18] Wilkinson, C., & Livingston, M. (2012). *Distances to on and off premise alcohol outlets and experiences of alcohol related amenity problems.* Drug and Alcohol Review, 31 (4), 394-401.

[19] Haden, A vision for cannabis regulation, (e75).

[20] Transform Drug Policy Foundation. *How to Regulate Cannabis a Practical Guide (Updated May, 2014)* (p. 148).
http://www.tdpf.org.uk/sites/default/files/How-to-Regulate-Cannabis-Guide.pdf

Conclusion

Canada should avoid the mistakes previously made with respect to tobacco and, particularly, alcohol. For families affected by addiction, the most important aspects of a public health approach to the legalization of cannabis are harm minimization and the provision of publicly-funded, timely, compassionate evidence-based treatment for those struggling with cannabis use disorder. Other countries and states that decide to legalize cannabis will be looking to Canada either as a model to follow or as a cautionary tale.

Summary of Recommendations

FAR recommends that:

1. The federal government immediately assists the provincial/territorial ministries of health to start to build capacity to treat youth and adults with addiction and other mental health disorders. Building capacity includes teaching and training medical students and doctors to inquire about, identify and treat SUD.

2. The federal government ensures that all the net profits from the taxation and regulation of cannabis, both federally and provincially, are used to fund the treatment of addiction and other mental health disorders in each province/territory until such spending is equal to the burden of those disorders in such province/territory.

3. The minimum legal age ("MLA") for the purchase of cannabis should be 21 years of age in each province/territory.

4. It should not be a criminal offence for an adolescent under the MLA of purchase to be in possession of cannabis for personal use; rather our laws should discourage cannabis use by adolescents, whether problematic or not, by allowing for the confiscation of their cannabis if they are found in possession, fines and allowing parents to be contacted.

5. The federal government:
   - consider altering the definition of traffic to exclude gifts or transfers for no consideration, at least with respect to cannabis; and
   - establish a task force to study, and make recommendations with respect to, the ongoing criminalization of persons struggling with addiction and other mental health disorders who should be receiving compassionate, evidence-based treatment under the health care system instead of punishment under the criminal justice system.

6. FAR recommends that the federal government expedite the research it is conducting regarding cannabis impaired driving in order to:
   - authorize the use of roadside oral fluid devices;
   - develop a per se level for THC equal to a .05 blood alcohol level ("BAC");
   - pass legislation making it a criminal offence to drive in excess of that per se level;

- implement mandatory roadside testing for alcohol and drugs; and
- implement a robust education campaign for youth and adults advising how they can determine whether they are in excess of the legal per se level.

7. To the extent possible under our laws, there should be a complete ban on branding, advertising, and marketing of cannabis products and on the cannabis industry sponsoring events or entertaining politicians.

8. Warning labels on cannabis products should be required to state that:
    - cannabis should not be used prior to driving (ideally an evidence-based length of time to wait before driving would be indicated);
    - impairment and risk of harm will increase if cannabis is used with other psychoactive substances such as alcohol; and
    - cannabis use can become addictive (ideally addiction rates for adults and adolescents would be stated).

9. The federal government ensures, to the extent possible, that the provincial/territorial governments retain a monopoly over cannabis distribution and sales through the establishment of provincial Cannabis Control Commissions ("CCCs"). CCCs would have a monopoly over all cannabis sales and would control all aspects of cannabis production, packaging, distribution and retailing. CCCs would be established with a clear and explicit public health mandate; government revenue would not be a principal driver of the CCCs' policies and the CCCs would be, to the extent possible, at arm's length from the government. CCCs would report to the provincial Ministers of Health. Board members of the CCCs would be appointed by the Minister of Health and the majority of the board members would have relevant public health or medical backgrounds and expertise.

10. In every province/territory, cannabis should not be sold in stores that also sell alcohol.