WHY AGE 21?

"If a man has never smoked by age 18, the odds are three-to-one he never will. By age 21, the odds are twenty-to-one." RJ Reynolds Memo, 1982

"These statistics confirm that **addiction is a pediatric disease**. In more than 9 out of 10 cases, addiction originates or is triggered by psychoactive substance use before the age of 21 years, a period of rapid growth and development of the brain (Denisco et al., 2011). Any use of alcohol, nicotine, or other drugs by adolescents is risky." (Searcy, 2017)

- Problem: We got it wrong for tobacco and alcohol. The evidence is that the minimum age of purchase for tobacco and alcohol should be at least 21. The Minimum Legal Drinking Age in the US is 21, and they have already started to move in that direction for tobacco (Hawaii and California). Hundreds of cities in other US States also provide for a MLA for purchase of 21.

- There is much support in Canada for raising the minimum age of purchase for tobacco to 21:

  The Ontario Tobacco Research Unit (OTRU) Update August 2015
  "Since the IOM report's release, emerging evidence indicates that raising the legal age of access in real world cases does decrease tobacco consumption among youth. Using a biennial regional survey of high school youth, researchers compared current smoking in the last 30 days in Needham, Massachusetts which had passed a local ordinance in 2005 to raise the legal purchase age to 21 with 16 surrounding communities that did not raise the age. From 2006 to 2010, larger declines in smoking were reported in Needham (13% to 7%) than in surrounding areas (15% to 12% p<.001)."

  B.C.'s Health Minister suggests raising legal smoking age to 21 (Jan. 29, 2017)
  Terry Lake believes the longer people are legally prevented from buying tobacco, the better the odds are that they won't pick up the habit. British Columbia already has the lowest smoking rate in the country at about 15.3 per cent of the population, according to figures from the B.C. Health Ministry.

  Trudeau government suggests moving the legal smoking age to 21 (March 2017)
  The idea of raising the minimum age was put forward in a Health Canada discussion paper released last week which looks at ways to reach the federal government's goal of reducing the smoking rate in Canada to five per cent by the year 2035. It currently stands at 13 per cent. The Canadian Cancer Society is supporting the idea of setting a federal smoking age of 21. Cunningham cites a 2015 study from the US-based National Institute of Medicine, which suggests raising the legal smoking age to 21 could drop the smoking rate by roughly 12 per cent, and eventually reduce smoking-related deaths by 10 per cent. About 37,000 people die in Canada each year from a smoking-related illness.

Joint response to the Federal Tobacco Control Strategy
In this document, **CAMH** and other organizations put forward recommendations for the future of tobacco control in Canada, including raising the minimum age of purchase to 21.

- Regarding alcohol, 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. (FAR's Submission to the Task Force on the Legalization and Regulation of Marijuana at p. 5-7) "Given that lowering the legal purchasing age has been found to increase youth alcohol harm each year by at least 10%, we estimate that this policy change has killed and injured more Australian youth than have our wars over the intervening four decades. Young people and others in society have a right to policies that protect them from harms such as the second-hand effects of alcohol."

  CAMH: We plan to release an updated CAMH Alcohol Policy Framework later this year. That involves our alcohol experts reviewing the recommendations we made in the 2013 framework against recent evidence and the current policy environment. As part of this we'll definitely be reviewing minimum age, though it's too early to say what our recommendation will be.

- A chart showing the relative harm to self and others of alcohol, tobacco and cannabis shows alcohol ranks first, tobacco sixth and cannabis eighth. Does this mean a lower minimum age of purchase for cannabis is justified? It is not uncommon for those who smoke cannabis to mix in tobacco. If age 21 delays initiation and reduces the harms of alcohol and tobacco, why would it be different for cannabis? Prevention of addiction is all about delayed initiation. MADD Canada says impaired is impaired is impaired. FAR says addiction is addiction is addiction.

- Letter to Addiction written by a 21 year old Ontarian while in treatment. The first six years of life lost represents an addiction to cannabis alone.

- The evidence is that the minimum age of purchase for tobacco and alcohol should be 21 or higher. In choosing a minimum age of purchase for cannabis, are we going to repeat the mistake we made for alcohol and tobacco, or take this opportunity to take an evidence-based approach?

WHY NO BRANDING, PROMOTION, SPONSORSHIP OR ADVERTISING?

- These are demand drivers. There is no justification for allowing these activities.
- A public health approach requires the opposite – demand reduction. There should be a complete ban on these activities. This will lower costs overall as harms will be reduced.
- 80% of the product will be sold to problematic users. They are vulnerable and need protection.
- Youth will be exposed to any promotion, even if it is directed at adults.
- We need to work towards prohibiting these activities in the alcohol industry as soon as possible. Expect the cannabis industry to argue discrimination as their product causes less harm than alcohol (see previous chart). Possible Charter argument for infringement of freedom of expression?

WHY DEDICATED FUNDING?

- The Ontario government made a profit in excess of $2.5 billion from the sale of alcohol in 2015-2016 mostly through the LCBO. Yet the Province of Ontario cannot provide timely treatment for adolescents with alcohol or other substance use disorders. Ontario youth 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 service gap and is a priority for the government.

- 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, the Ontario Government should 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]

- 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%[2]. CAMH has estimated that this spending deficit in Ontario alone is $1.5 billion[3]. 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.

- All the net profits from the taxation and regulation of cannabis, both federally and provincially, should be used to fund the treatment of addiction and other mental health

---

[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] 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

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

disorders until such spending is equal to the burden of those disorders. This presents a perfect opportunity to achieve a central goal in regulating cannabis as set out in the "Minimizing Harms" section of the federal 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."

- Recently MP Bill Blair said this regarding the legalization of marijuana:

  "How do we reduce the harm of this drug? How do we protect our kids? Because we recognize the science that it is very, very dangerous for the developing adolescent brain. That's why we want to keep it away from our kids. We also recognize that the earlier they start to use it, the more frequently they use it and the higher the potency of what they use, then the risks increase."

  It is ironic that once our system fails, and our kids not only access marijuana but become addicted, there is little access to publicly funded treatment. How can it be that we care so much about keeping drugs out of the hands of our kids and so little about protecting our kids who are struggling with addiction?

WHY A NOT FOR PROFIT DISTRIBUTION MODEL?

- We recommend an approach suggested by Mark Haden and Brian Emerson that the government retains a monopoly over cannabis distribution and sales through the establishment of a provincial Cannabis Control Commission (CCC) to exercise regulatory oversight.[4] The CCC would have a monopoly over all cannabis sales and would control all aspects of cannabis production, packaging, distribution and retailing. The CCC would be established with a clear and explicit public health mandate; government revenue would not be a principal driver of the CCC's policies and the CCC would be, to the extent possible, at arm's length from the government.

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

[4] 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/

PROTECT OUR YOUTH AND OTHER VULNERABLE CITIZENS FROM LEGAL DRUG DEALERS

- In Cannabis Law Reform in Canada: Pretense and Perils Michael DeVillaer explains the previous shortcomings of our governments in protecting our citizens from legal drug dealers. The most egregious example is Purdue Pharma; Oxycontin and Oxyneo were both disasters.

- Once our youth succumb to addiction, there is almost no evidence based treatment available for them in Canada. We need treatment on demand, many more beds for residential treatment, educated physicians, more specialists, wraparound services and funding to make that happen. We need an anti-stigma campaign and to end the existing discrimination in funding medical services for our vulnerable youth and other citizens struggling with addiction.

- We want a seat at the table of any government task force or group regarding the regulation of psychoactive substances or the treatment of addiction especially where there are representatives of the alcohol, tobacco, pharmaceutical or cannabis industries present.