Centre for Addiction and Mental Health

Submission to the Ontario Legalization of Cannabis Secretariat

August 11, 2017

The Centre for Addiction and Mental Health (CAMH) has long advocated for reform of Canada's system of cannabis control. In 2014 we released a Cannabis Policy Framework[1] recommending a public health approach to cannabis policy. We examined the evidence around the risks and harms associated with cannabis use and concluded that legalization, combined with strict health-focused regulation, provides an opportunity to reduce those risks and harms. For these reasons we are pleased that the federal government's legislation to legalize cannabis cites public health and safety as its central purpose, and that the province of Ontario has indicated that public health is a key component of its approach to the aspects of legalization under its jurisdiction.

One of the fundamental principles of public health approaches to psychoactive substances is that they must not be bought and sold like regular consumer goods. Since cannabis use comes with health risks, evidence-informed regulations – most importantly, controls on availability – must be put in place.[2]

CAMH's recommendations to the Ontario Legalization of Cannabis Secretariat follow. Among the most important are that the province:

1) set the minimum age for cannabis use at 19;
2) establish a public monopoly on distribution with the Liquor Control Board of Ontario (LCBO) at its centre;
3) ensure a ban on marketing, promotion, and advertising, with products sold in plain packaging;
4) apply to public cannabis smoking and vaping the same restrictions governing public use of tobacco / nicotine under the *Smoke-Free Ontario Act;*
5) enable / introduce A) the use of oral fluid testing for provincial driving offences and B) zero tolerance for driving after drug use for those with a graduated license and/or those under 21;
6) prohibit home cultivation.

An effective public health approach will embed these regulations in a comprehensive strategy that includes prevention, treatment, research, and evaluation. A portion of government revenues from cannabis should be formally dedicated to these activities.

Retail and distribution

From decades of alcohol and tobacco research we know the population-level interventions that can reduce health harms. The most effective measures include controls on availability, e.g. controls on pricing, retail outlet locations and density, and hours / days of sale, as well as minimum age requirements.[3] Evidence also suggests that such policy tools are more effectively implemented and maintained when the retail system is government-run (i.e. via a control board) than where it is privately operated; notably, jurisdictions with public monopolies on alcohol sales tend to have less alcohol-related harm than those with private systems.[4] In Ontario the LCBO, which has social responsibility as part of its mandate, carries out these functions. Though there are areas of social responsibility where the LCBO can improve, in many ways it is exemplary in its approach to alcohol sales and control.[*] We believe that the LCBO, because of its social responsibility mandate and its expertise in alcohol distribution, is best positioned to handle cannabis sales.

CAMH recommends that the province:

- **Establish a public monopoly on distribution**.
    - **Storefronts operated by the LCBO** should be the main point of purchase. This might, but need not necessarily, involve co-location of cannabis and alcohol. (See the third bullet below.)
    - Storefront sales should be conducted from **behind the counter** (i.e. not off the shelf), by **trained staff**. Staff should be trained in challenge-and-refusal protocols and to offer information about the relative risks of various products, formulations, and modes of delivery.
    - If cannabis and alcohol are sold in the same retail location, they should be displayed separately, with no cross-promotion; separate transactions at different checkouts should be required for cannabis and alcohol. (This is analogous to the Wine Shop outlets found in some Ontario grocery stores.) Information on the risks of co-use should be actively provided.[**]
    - **Secure online sales**, as currently conducted by the licensed medical cannabis producers, should continue. This will be necessary to ensure distribution in some rural, remote, or otherwise unserved areas.
    - About 20% of cannabis users account for a majority of the cannabis consumed.[5] It is unclear whether, or to what extent, these frequent users would be willing purchase their cannabis from LCBO, yet their participation is essential for Ontario's legalization regime to succeed. There may be a need to allow for a **small, fixed number of privately owned/operated but government-licensed dispensaries**. These stores would be subject to the same regulations (pricing controls, hours of operation, etc.) as government-operated outlets. The regulations governing the sale of beer, wine and cider in a limited number of grocery stores could serve as a model for this outlet type.[***]

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[*] For a brief discussion see this CAMH submission. For more detail see Giesbrecht & Wettlaufer (2013), Reducing alcohol-related harms and costs in Ontario: a provincial summary report

[**] Note that co-use of alcohol and cannabis heightens impairment, but there is no evidence as to whether selling cannabis and alcohol alongside one another would encourage or facilitate co-use.

[***] For these regulations see https://www.ontario.ca/laws/regulation/160232

- **Place oversight and enforcement of cannabis regulations under the Alcohol and Gaming Commission of Ontario**. Relevant regulations include retail location and density; required distance between cannabis storefronts and sites such as schools, community centres, and other cannabis storefronts;[*] hours of operation; and staff training. The AGCO already plays a similar role for alcohol and gambling.

A significant advantage of legalization is the opportunity for cannabis users to obtain credible product information. Those who use cannabis stand to benefit from legalization to the extent that there is reliable information about the characteristics of the product (e.g. THC and CBD content) as well as the associated risks and how to moderate them (e.g. by following Lower-Risk Cannabis Use Guidelines [see "Public education" below]). But a firm distinction must be drawn between factual product information on one hand and, on the other, advertising and branding. The link between exposure to advertising and consumption behaviour is well established: exposure to alcohol marketing is associated with earlier initiation of alcohol use, increased consumption and alcohol-related harms (especially among young people) as well as normalization of alcohol use and unrealistic expectations about the effects of alcohol.[6] For these reasons:

- **There should be a total ban on marketing, promotion, and advertising outside of retail locations**. As per the recommendations of the Task Force on Cannabis Legalization and Regulation, limited **in-store** promotion such as that allowed by the *Tobacco Act* should be the only exception to this rule.[7]
- **Products should be sold in plain packaging**[**] with clear product information and warnings about health risks.

The federal government is expected to place restrictions on cannabis advertising. If federal regulations or guidelines do not rise to the standard outlined here, we strongly recommend that the province fill the gap.

Two objections to these recommendations can be anticipated – and easily rejected.

- First, one might argue that cannabis sales should not be held to a higher standard than alcohol – a riskier substance in terms of health outcomes. But the way alcohol is promoted in Canada is far from a public health approach, with higher levels of alcohol-related harm as a result. With cannabis we have a chance to avoid this, creating a market in which public health prevails to the largest extent possible.
- Next, some in the cannabis industry have claimed that in the absence of branded products, consumers will have no way to learn about legal cannabis or distinguish it from black market cannabis, thus undermining the former to the benefit of the latter.[8] But in the system we propose – and towards which Ontario seems to be progressing – there will be no mystery as to where legal cannabis can be obtained. Even in plain packaging, legal cannabis will be recognizable by the simple fact of where it is sold: in government-licensed stores (or online channels).

Under legalization, cannabis production will occur in a commercial, for-profit context. But the industry and its activities must be tightly regulated in order to avoid undue increases in use. **By definition, a public health approach to cannabis sales will place health considerations ahead of profits**. Looked at from this perspective it becomes clear that cannabis advertising must be prohibited, and products must be sold in plain packaging.

[*] See for instance the distance requirements developed by Vancouver's city council for cannabis dispensaries.

[**] See this description of plain packaging measures under consideration by Health Canada for tobacco.

Minimum age

Research confirms that cannabis use can harm the developing brain, which continues to develop into one's early to mid-20s.[9] It does not follow, however, that the minimum age should be 21 or 25.[*] Most notably:

- Early use – especially early *frequent* use – is risky. A recent review cites 18 as the age below which cannabis use is associated with a higher risk of dependence, mental health problems, poorer cognitive and executive functioning, and other problems.[10] A minority of early-onset users will experience these negative health outcomes.
- As we have stated elsewhere, "The evidence suggests clearly that the risks for health harms from cannabis use among young people is, proportionally, not greater than other psychoactive substance [use] and other activities in which young people commonly engage…"[11] These include consuming alcohol and even playing hockey, which both appear to be riskier to developing brains.[12]
- One of the benefits of legalization is that it allows us to approach cannabis use as a health issue and not one to be addressed through law enforcement and the court system. In Ontario around 30% of current cannabis users are aged 19 to 24;[13] setting a higher minimum age would thus leave a sizable proportion of cannabis users – and of young adults – criminalized and dependent on the black market, with all the social and health harms this entails.[14]

Regulation in this area should be guided by rational analysis of the risks of cannabis use, in absolute terms and relative to other substances. With this in mind, and recognizing that some youth will use cannabis regardless, **we recommend that the minimum age for cannabis use be set at 19 in Ontario** – consistent with the other legal psychoactive substances. This will allow young adults who do use cannabis to access the advantages of the legal cannabis market, notably reliable information and regulated, safer products.[**]

Impaired driving

Motor-vehicle accidents due to impaired driving are one of the main contributions of cannabis to Canada's burden of disease and injury.[15] This is not a new or emerging problem: for several years already, rates of cannabis-impaired driving have equaled or exceeded rates of alcohol-impaired driving among high-school students and among young adults aged 18 to 29.[16]

The federal government recently introduced legislation reforming the impaired-driving regime of the *Criminal Code*. Ontario has also shown leadership by introducing legislation to ensure that drug-impaired driving sanctions for provincial offences parallel those for alcohol-impaired driving. We recommend that Ontario also:

- **enable the use of oral fluid testing for provincial driving offences,**
- **introduce zero tolerance for driving after drug use for those with a graduated license and/or those under 21,** and
- **provide funding for public education, research and enforcement in this area.**

[*] For a discussion see Fischer & Rehm (2017), Cannabis use, legalization and youth health – a response to Kelsall

[**] As we have recommended elsewhere, pricing policy should be used to steer users from higher-harm to lower-harm products, e.g. A) from products higher in THC to those that are lower and B) from combusted products to smokeless ones.

Places of use

The main health concerns with regards to places of use are A) the harm of second-hand smoke and B) the potential harms of exposure to second-hand vapour. Medical use of cannabis should be accommodated but smokeless options are available and in fact preferable. It is critical that regulations in this area not undermine the gains of the *Smoke-Free Ontario Act* or municipal bylaws governing public use of e-cigarettes, waterpipes, etc. It should further be noted that, at this time, public consumption remains illegal in all five American jurisdictions that have legalized recreational cannabis (Alaska, Colorado, Oregon, Washington state, and Washington, DC).

- **Public cannabis smoking and vaping should be subject to the same restrictions applied to public use of tobacco / nicotine under the *Smoke-Free Ontario Act***,[*] regardless of whether the cannabis use is considered medical.
- Public use of smokeless or vapourless cannabis for medical reasons may be permissible. **This should be the only exemption for medical cannabis from rules governing public use.**

Home cultivation

From a public health perspective there are several concerns with home cultivation of cannabis. These include 1) environmental hazards, 2) the absence of safety / quality regulations, 3) the risk of diversion, and 4) children being exposed to cannabis. Although it is true that some personal production of wine and beer is allowed, cannabis is much more prone to diversion; home cultivation, even under the parameters proposed in federal legislation (four-plant limit, maximum plant height of 100 cm, etc.), would likely undermine the legal market. It is also not clear that the proposed restrictions are realistically enforceable. Therefore **home cultivation should be prohibited.**

Public education / Youth and young adult prevention

In June 2017, an international team of experts released an updated version of the Lower-Risk Cannabis Use Guidelines (LRCUGs).[**] Based on a rigorous scientific review, these evidence-informed recommendations enable cannabis users to reduce their exposure to health risks.[17] The LRCUGs have been endorsed by CAMH, the Canadian Society of Addiction Medicine, Canadian Centre on Substance Use and Addiction, the Canadian Medical Association, the Canadian Public Health Association, and the Council of Chief Medical Officers of Health. **The province should broadly disseminate and promote the Lower-Risk Cannabis Use Guidelines**, including alternate versions for different populations.

As discussed above, youth are at higher risk of cannabis-related harms. There are many strategies and programs designed to reduce, delay, or prevent substance use among youth. Not all are effective, however. It will be important that the government initiatives in this area be evidence-informed.

[*] See https://www.ontario.ca/page/smoke-free-ontario

[**] For a summary of the recommendations see this brochure

There is good evidence that family-based programs in middle childhood and early adolescence (e.g. Strengthening Families, which addresses parenting skills) impact alcohol use and self-reported drug use; there are also school-based approaches focusing on strengthening coping and resilience in middle childhood, early adolescence, and later adolescence that have shown promising effects on substance misuse prevention.[18]

We recommend that Ontario **study evidence-informed prevention programs** with a view to introducing non-punitive prevention programs from middle childhood to the post-secondary level and leveraging existing effective substance misuse prevention initiatives for youth and young adults to support cannabis efforts. In addition, **youth and young adults with lived experience should be included in planning and implementation of prevention initiatives**.

Responsible economic development

Very different models for legal cannabis markets are possible based on the types of regulation and their implementation. The health impact of cannabis legalization will vary accordingly. We understand that legalization will, naturally, spur some economic opportunities and development. This is not negative in itself. But while a public health approach does not rule out profit, it does subordinate it to population health considerations. **It is critical that cannabis regulations be designed – and maintained – with public health as the primary and overriding objective.**

Ontario needs an approach to cannabis that protects health and mitigates the risks of cannabis use. We believe that the regulations outlined above – carefully implemented, diligently maintained, and thoroughly evaluated – can help us achieve that.

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camh The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital and one of the world's leading research centres in this field. CAMH is committed to playing a leading role in transforming society's understanding of mental illness and substance use and building a better health care system. To help achieve these goals, CAMH communicates evidence-informed policy advice to stakeholders and policymakers.

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[1] Centre for Addiction and Mental Health (2014), *Cannabis Policy Framework*, available at http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf.

[2] Room, Fischer, Hall et al. (2010), *Cannabis policy: Moving beyond stalemate*, Oxford: Oxford University Press; Canadian Public Health Association (2014), A new approach to managing illegal psychoactive substances in Canada, retrieved from https://www.cpha.ca/sites/default/files/assets/policy/ips_2014-05-15_e.pdf.

[3] Anderson, Braddick, Conrod et al. (2016), *The new governance of addictive substances and behaviours*, Oxford: Oxford University Press; Babor, Caetano, Casswell et al. (2010), *Alcohol: No ordinary commodity – Research and public policy*, Oxford: Oxford University Press.

[4] Anderson, Chisholm & Fuhr (2009), Alcohol and Global Health 2: Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol, *Lancet* 373, 2234-46; Babor, Caetano, Casswell et al. (2010).

[5] Room, Fischer, Hall et al. (2010).

[6] Brown & Witherspoon (2002), Mass media and American adolescents' health, *Journal of Adolescent Health* 31, 153-70; van Hoof, de Jong, Fennis & Gosselt (2009), There's alcohol in my soap: Portrayal and effects of alcohol use in a popular television series, *Health Education Research* 24, 421-29.

[7] Task Force on Cannabis Legalization and Regulation (2016), A framework for the legalization and regulation of cannabis in Canada: The final report of the Task Force on Cannabis Legalization and Regulation, retrieved from https://www.canada.ca/en/services/health/marijuana-cannabis/task-force-cannabis-legalization-regulation.html.

[8] CBC News (2017), Cannabis industry opposes call for plain packaging and bans on advertising, retrieved from http://www.cbc.ca/news/politics/marijuana-promote-brand-legislation-1.3982988; Ottawa Citizen, Joints by Snoop Dogg or white label cannabis? Government ponders ad restrictions for pot, retrieved from http://ottawacitizen.com/news/local-news/snoop-dogg-spliffs-or-cannabis-in-a-plain-white-package-government-ponders-advertising-restrictions-for-pot

[9] Squeglia, Jacobus & Tapert (2009), The influence of substance use on adolescent brain development, *Clinical EEG and Neuroscience* 40, 31-38; George & Vaccarino (2015), Substance abuse in Canada: Effects of cannabis use during adolescence, retrieved from http://www.ccsa.ca/Resource%20Library/CCSA-Effects-of-Cannabis-Use-during-Adolescence-Report-2015-en.pdf.

[10] Fischer, Russell, Sabioni et al. (2017), Lower-risk cannabis use guidelines: A comprehensive update of evidence and recommendations, *American Journal of Public Health* 107, e1-e12.

[11] Fischer, Rehm & Crépault (2016), Realistically furthering the goals of public health by cannabis legalization with strict regulation: Response to Kalant, *International Journal on Drug Policy* 34, 11-16 (quote: p. 13).

[12] Squeglia, Jacobus & Tapert (2009); Bava & Tapert (2010), Adolescent brain development and the risk for alcohol and other drug problems, *Neuropsychology Review* 20, 398-413; Kontos, Elbin, Sufrinko et al. (2016), Incidence of concussion in youth ice hockey players, *Pediatrics* 137, e20151633; Tapper, Gonzalez, Roy & Niechwiej-Szwedo (2017), Executive function deficits in team sport athletes with a history of concussion revealed by a visual-auditory dual task paradigm, *Journal of Sports Sciences* 35; 231-40.

[13] Ialomiteanu, Hamilton, Adlaf & Mann (2016), CAMH Monitor e-Report: Substance use, mental health and well-being among Ontario adults, 1977-2015; retrieved from http://www.camh.ca/en/research/news_and_publications/Pages/camh_monitor.aspx; Boak, Hamilton, Adlaf & Mann (2015), Drug use among Ontario students, 1977-2015: Detailed OSDUHS findings, retrieved from http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Pages/default.aspx.

[14] See Fischer, Rehm & Crépault (2016) under "The impact of legalization on black markets" (pp. 13-14).

[15] Imtiaz, Shield, Roerecke et al. (2016), The burden of disease attributable to cannabis use in Canada in 2012, *Addiction* 111, 653-62.

[16] Ialomiteanu, Hamilton, Adlaf & Mann (2016); Boak, Hamilton, Adlaf & Mann (2015).

[17] Fischer, Russell, Sabioni et al. (2017).

[18] United Nations Office on Drugs and Crime (2015), International standards on drug use prevention, retrieved from https://www.unodc.org/unodc/en/prevention/prevention-standards.html.