Addictions & Mental Health Ontario | Dépendances & santé mentale d'Ontario

CANNABIS: PUTTING HEALTH FIRST

Submission to Ontario's Legalization of Cannabis Secretariat

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EXCUTIVE SUMMARY

Canadian governments have a once-in-a-generation opportunity to place public health at the center of cannabis policy. Governments also have access to a body of evidence that demonstrates how this can be achieved. AMHO's main message to government is straightforward: use evidence to address the demonstrated harms associated with cannabis use, including cannabis dependence.

The most compelling argument for cannabis legalization is the opportunity to treat cannabis-related harms as a health issue rather than of a criminal issue. This argument is made stronger when governments commit to using a portion of the revenue derived from cannabis sales to address cannabis-related harms. Whether cannabis legalization will lead to increased rates of use and dependence is unclear, and should be evaluated. But cannabis is *already* the presenting drug dependence issue in about one-third of the cases that are reported by Ontario's specialized addiction treatment services. The capacity of these services is currently severely strained by the absence of any cost-of-living increase in years. Wait lists for residential services are already as long as a year in some parts of Ontario. Rapidly increasing rates of opioid dependence have added to the strain on Ontario's addiction services. That is why the Government of Ontario should commit to using a portion of cannabis-related revenue to build capacity in the addiction service system, while also applying restrictions on commercialization and marketing of cannabis.

Cannabis is *already* the presenting drug dependence issue in about one-third of the cases that are reported by Ontario's specialized addiction treatment services.

AMHO appreciates the Government of Ontario's commitment to broad consultation as part of its response to federal legislation to legalize cannabis, under the leadership of the Attorney General. AMHO is pleased to provide specific advice on the issues identified by the Attorney General. In some cases this is based in the specific experience of AMHO members; in all cases, it is supported by evidence that suggests how cannabis-related harm may be reduced.

Minimum age – While there is strong evidence for restricting use to those under 25, AMHO recognizes the practical challenges of a legal age that is not harmonized with alcohol and that may lead to illegal sales. The choice of 19 as the minimum age in Ontario should be accompanied by rigorous enforcement, monitoring, minimum pricing and advertising restrictions.

Where people can use cannabis – AMHO believes that a ban on public cannabis consumption would minimize exposure to young people.

Keeping our roads safe – Ontario needs public education and enforcement efforts that reinforce the message that drug-impaired driving is dangerous and unacceptable.

Regulating cannabis sales – Ontario should commit to using a portion of revenue derived from cannabis sales to addressing cannabis-related harm, including cannabis dependence. The government should transparently report on all revenues derived from cannabis sales, and document corresponding investments directed at reducing cannabis-related harms. A similar entity to the Liquor Control Board of Ontario should be responsible for cannabis sales.

Public education – Everyone, but particularly young people, need access to evidence-based drug education programming. Long-term planning and stable funding is critical.

Ontario has extensive experience with the regulation of tobacco, alcohol and gambling. Each of these products is heavily regulated – in many cases delivered – by governments. We have a much greater empirical understanding of cannabis-related harms than we did of tobacco, alcohol and gambling when each of these products entered the legal marketplace. We clearly have an opportunity to regulate cannabis – as a legal substance – in a manner that promotes health, and guards against commercialization and aggressive marketing of the substance, especially targeted at young people.

INTRODUCTION

Addictions and Mental Health Ontario (AMHO) appreciates the opportunity to participate in the Government of Ontario's consultation on the legalization of cannabis. AMHO commends the Ministry of the Attorney General for providing Ontarians with an opportunity to participate in the practical implementation questions associated with this important public policy change.

AMHO represents over 220 community addictions and mental health care organizations across Ontario. Our members provide services and supports that help Ontarians with their recovery, including counselling and case management, peer support and family support, employment services, residential treatment, withdrawal management, supportive housing and hospital based programs.

As the collective voice of our members, we provide leadership and engage partners to build a comprehensive and accessible system of addiction and mental health care, and improve the well-being of individuals, families and communities in Ontario. We do this through policy work, advocacy initiatives, service development, knowledge exchange, education offerings and quality improvement work.

AMHO values its partnership with the Government of Ontario. We are a member of the Mental Health and Addictions Leadership Advisory Council (MHALAC), helping to lead action on key strategic questions on the sector's future. AMHO has also been engaged in other government initiatives that affect addiction and mental health, such as the development of Ontario's Long-Term Affordable Housing Strategy and the Ontario Poverty Reduction Strategy.

AMHO members have a significant stake in drug policy generally, and cannabis policy in particular. AMHO members provide residential and non-residential treatment services for cannabis dependence, which is a significant problem. Many cannabis users also have a mental illness, and cannabis use in adolescence has been linked to increased risk of psychotic disorders, such as schizophrenia. Virtually every one of AMHO's 200+ members encounter the impact of cannabis use every day.

DETAILED RESPONSES TO THE ISSUES IDENTIFIED IN THE GOVERNMENT'S CONSULTATION PAPER

MINIMUM AGE

What the evidence tells us

The federal government's cannabis task force recommended a national minimum age of 18 for the legal sale of cannabis. They noted that provinces and territories could establish a higher minimum age, possibly harmonizing with their minimum age for alcohol consumption. Among the considerations they cited were the desirability of a common minimum age to prevent *border shopping*.

From a health standpoint, a "safe" age of onset is a contested subject, but many Canadian health authorities agree that the minimum age should be higher than 18 (Canadian Medical Association, 2016, Canadian Psychiatric Association, 2017). In the USA, states that have legalized cannabis have set the minimum age equal to their minimum drinking age – 21. That being said, there is evidence to suggest that age prohibition may not impact the onset of cannabis use (Centre for Addiction and Mental Health, 2014).

With regard to brain development and cognition, brain maturation does not end until mid-20s, during which the brain is particularly susceptible to developing mental illness (CPA, 2017). Daily or near-daily use beginning in adolescence is associated with a wide range of poor psychosocial outcomes (Camchoung, Kumra, & Lim, 2016). Cannabis use before the age of 18 can increase the risk of developing schizophrenia or psychotic disorders in those who are vulnerable (CPA, 2017).

When compared to alcohol and tobacco, cannabis use has the fastest rate of transition to substance use disorder among adolescents. Young people who are regular cannabis users are more likely to use other illicit substances (Canadian Centre on Substance Abuse, 2015).

Additionally, the federal task force recommends that criminalization of underage youth should be avoided where possible. Research consistently shows that increasing sanctions on youth does not reduce crime, and instead has a deleterious impact not only on the youth involved, but their families and communities. Moreover, the issues of criminalization and equity are closely tied. In 2016, there were approximately 55,000 cannabis-related offenses, with 81 per cent for possession (Statistics Canada, 2017). It is estimated that there is an arrest for cannabis possession approximately every nine minutes in Canada. According to the Honourable Bill Blair, Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, a disproportionate number of

those arrests are among “Minority communities, Aboriginal communities, and those in the most vulnerable neighbourhoods” (Larsen, 2016).

Recommendations

Focusing on the health of young people, 18 years of age could be too young to engage in cannabis usage. The evidence has shown that cannabis usage has an impact on the developing brain up until the mid-twenties, around age 25. However, the trade-offs between the risks cannabis imposes on brain development and the risk a high minimum age would preserve the illicit market must be balanced. Restricting access of youth to marijuana should be a fundamental objective of the public policy framework for legalization and regulation of marijuana. Marijuana is reported by many front-line addiction workers as the drug of choice for youth. Early use and heavy use are associated with a range of social problems, cognitive, psychological and financial problems (Cerda et al., 2016; Fergusson, 1996). Additionally, early onset cannabis users are at increased risks of later substance use behaviors, conduct/oppositional disorders, anxiety, depression, and suicidal ideation.

For practical reasons, a legal minimum age that is harmonized with the minimum age for alcohol and tobacco (in 2017 in Ontario, that age is 19) would be defensible, provided the government also adopts public health measures to reduce early use learned from alcohol and tobacco:

- Rigorous enforcement of restrictions on under-age purchase.
- Monitoring of under-age use to identify the source of marijuana.
- Significant restrictions on advertising and marketing that target young people, as well as prohibitions on products designed for adolescents (e.g. flavoured product).
- Taxation and minimum pricing regimes.

To promote equity, AMHO recommends that youth offenses of small quantities of cannabis possession should be decriminalized. Criminal sanctions should be replaced with alternatives such as community service, education, fines, peer support programs, and community addiction and mental health services and supports. In the interim period prior to legalization, decriminalization of personal possession of cannabis in small quantities for all individuals should be implemented.

WHERE CANNABIS MAY BE USED

What the evidence tells us

Of the six states that have legalized cannabis (Alaska, California, Colorado, Maine, Massachusetts, Nevada, Oregon, and Washington), all have banned smoking cannabis publicly, with contextual exceptions regulated by each state.

In the case of tobacco, public and workplace bans on tobacco have produced documented improvements in community health outcomes, including reductions in heart attacks (Eagan, Hetland, & Aaro, 2006), improvements in cardiac health (Cesaroni, et al., 2008), improvements in workplace air quality and increase in worker pulmonary performance (Goodman, Agnew, McCaffrey, Paul, & Clancy, 2007). Similar research has been conducted regarding alcohol. Research from Australia suggests laws prohibiting public drinking can increase public perception of safety, despite having little effect on rate of consumption or hospitalization (Pennay, et al., 2013).

The federal task force recommended that existing restrictions on public smoking and vaping should be extended to include the public consumption of cannabis. Its advice to ministers includes permits for dedicated places to consume cannabis. Co-consumption with alcohol, underage use and the protection of health and safety were also cited as concerns.

Recommendations

From a health perspective, a ban on public cannabis smoking would minimize exposure of cannabis to young people. Similar to how tobacco smoking bans have reduced the normalization of smoking culture, a ban on cannabis smoking would have similar impact. This would also align well with current tobacco smoking regulations and alcohol consumption regulations.

KEEPING ROADS SAFE

What the evidence tells us

According to CAMH's Cannabis Policy report (2014), about 9% of licensed drivers aged 18 to 29 and 10% of those in grades 10 to 12 report having driven within an hour of using cannabis in the past year. Rates of cannabis-impaired driving exceed rates of alcohol-impaired driving for both age groups. The accident risk associated with cannabis-impaired driving is significantly lower than that of alcohol-impaired driving.

According to CCSA's Cannabis Use and Driving report (2015), the detection and assessment of cannabis use among drivers is considerably more complex than for alcohol as blood THC levels remain far beyond the period of acute impairment, potentially contributing to a level of chronic impairment.

The federal task force recommended immediate investments in a national public education campaign to address impaired driving, and investments in research that would support a legally defined limit supported by adequate detection tools.

Recommendations

Canada's strategy to minimize impaired driving should follow a similar strategy to our alcohol impaired driving strategy. Changing attitudes and behaviours associated with alcohol-impaired driving has – to a significant extent – been a remarkable success. According to Canadian Alcohol and Drug Use Monitoring Survey (2015), driving after cannabis use among students was lower in 2015 compared to estimates from about a decade ago. We need a similar effort to ensure that drug-impaired driving is recognized as dangerous and socially unacceptable. The consequences of impaired driving should be a key element of drug education programs. Law enforcement officials need to have the resources required to detect and prevent drivers who are impaired as a result of marijuana.

REGULATING CANNABIS SALES

What the evidence tells us

In the United States, Washington and Colorado have been challenged to reconcile medical and retail markets, specifically on issues such as minimum age, purchase limits and taxation (CCSA, 2015). A lack of control on edible cannabis sales has also been a significant issue. That said, a portion of sales revenue in both states is designated to support prevention and education initiatives. However, revenue-based funding is often accompanied with delay between the initiation of sales and the availability of funding, resulting in limited resources prior to and early in the implementation stage — the period during which these initiatives are most needed (CCSA, 2015). In addition, taxation revenue in Washington that was initially reserved for cannabis-related prevention, education, treatment, regulation and research has been reallocated to the general revenue stream, which reduces the funding available for public health (CCSA, 2015).

Recently, Colorado proposed a bill that would use tax revenue generated through cannabis sales to fund opioid treatment programs (FindLaw, 2017). Oregon has proposed a similar bill to supplement funds towards mental health and addictions services (Oregon Live, 2017).

The federal task force included a range of advice to provincial ministers, based on their consultations and evidence review. They recommended that co-location with alcohol and tobacco should be avoided. There should be adequate training for retail staff, and the establishment of strict production, distribution and sales mechanisms. This would include items such child-proof packaging and warning labels.

Recommendations

One of the benefits of the legalization of marijuana is that the profits associated with its sale might be diverted from criminal enterprises. In 2016, marijuana sales produced over

$200 million and $250 million in tax revenue in the state of Colorado and Washington, respectively. The public interest would be greatly advanced by the province of Ontario directing a significant portion of revenue from marijuana sales to mental health and addiction services and supports, prevention and education. The federal government, through taxation, could also direct cannabis-derived revenue to addiction and mental health services within its jurisdiction, including services provided to First Nations, veterans, and federal correctional inmates.

The Government of Ontario should also be transparent in accounting for cannabis-related revenue and investments in programs and initiatives to address cannabis-related harms.

Sales location is a difficult issue. Dispensaries as currently operating present issues of security and regulation. Co-location with alcohol sales is perhaps not ideal, but preferable to expanding the current dispensary model. An entity similar to the Liquor Control Board of Ontario for cannabis would provide the social regulation, training and accountability needed to effectively manage the sale of cannabis on a provincial scale.

PUBLIC EDUCATION

What the evidence tells us

Research on the effectiveness of previous drug education is mixed. Particularly in the United States, evaluation of the Drug Abuse Resistance Education (D.A.R.E) program has shown low-to-no impact on substance use in young people (Clayton, Cattarello, & Johnstone, 1996). Interactive programs that focus on one particular substance and behaviour change rather than attitude seem to fare better than traditional education (Mcbride, 2003).

Recommendations

Young people in particular (but not exclusively) need access to evidence-based drug education programming, and these initiatives should continue to be evaluated. Not all drug education programs are equally effective, and the evidence about what works needs to be leveraged. Effective, long-term planning with sustained funding is critical. The most successful approaches combine universal programs in schools and communities with more targeted approaches for those young people at greatest risk. Research-based drug education programming should be initiated now, and eventually can be funded by revenue that government derives from the sale and taxation of marijuana.

The federal task force recommended that the federal government implement an evidence-informed public education campaign, and that its messages be consistent with

provincial and territorial partners. AMHO strongly advocates that such a campaign be developed as soon as possible. There is an opportunity for the Government of Ontario to work with its federal, provincial and territorial colleagues, as well as experts and stakeholders, including the community addiction and mental health sector, on a systematic campaign with shared, consistent Canada-wide messaging.

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