# CMA Submission:

## Bill C-45: The *Cannabis Act*

**Submission to the House of Commons Standing Committee on Health**

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Association Médicale Canadienne
Canadian Medical Association
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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is empowering and caring for patients, with a vision for a vibrant profession and a healthy population.

On behalf of its more than 85,000 members and the Canadian public, the CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and over 60 national medical organizations.

# Introduction

The CMA is pleased to provide this submission to the House of Commons Standing Committee on Health on Bill C-45, the *Cannabis Act*.

The CMA has long-standing concerns about the health risks associated with consuming cannabis,[i] particularly in its smoked form.[1,2] Children and youth are especially at risk for cannabis-related harms, given their brains are undergoing rapid and extensive development.

The CMA's approach to cannabis is grounded in broad public health policy. It includes promotion of health and prevention of drug dependence and addiction; access to assessment, counselling and treatment services; and a harm reduction perspective. The CMA believes that harm reduction encompasses policies, goals, strategies and programs directed at decreasing adverse health, social and economic consequences of drug use for the individual, the community and the society while allowing the user to continue to use drugs, not precluding abstinence.[3,4]

Specifically, the CMA recommends a multi-faceted cannabis public health strategy that prioritizes impactful and realistic goals before, and certainly no later than, any legalization of cannabis.[5] We propose that the first goal should be to develop educational interventions for children, teenagers and young adults. Other goals relate to data collection; monitoring and surveillance; ensuring a proportionate balance between enforcement harms and the direct and indirect harms caused by cannabis use; and research.

There is an ongoing need for research into the medicinal and harmful effects of cannabis use. As noted by the Lower-Risk Cannabis Use Guidelines, [6] there is limited evidence on such subjects as synthetic cannabinoids; practices like "deep inhalation" to increase the psychoactive effects of cannabis; and the combination of risky behaviours, like early-onset and frequent use, associated with experiencing acute or chronic health problems.[6]

Since 2002, the CMA has taken a public health perspective regarding cannabis and other illegal drugs. More recently, the CMA endorsed the Lower-Risk Cannabis Use Guidelines, and we submitted 22 recommendations to the Task Force on Cannabis Legalization and Regulation ("the Task Force").[7]

# Overview

According to the recent Canadian Tobacco, Alcohol and Drugs Survey, cannabis is the most used illicit drug in Canada.[8] In particular, 25%–30% of adolescents or youth report past-year cannabis use.[9] This concerns the CMA. The increasing rate of high usage, despite the fact that non-medical use of cannabis is illegal, coupled with cannabis' increased potency (from 2% in 1980 to 20% in 2015 in the United States),[10] the complexity and versatility of the cannabis plant,[ii] the variable quality of the end product, and variations in the frequency, age of initiation

[i] The term cannabis is used, as in Bill C-45: that is, referring to the cannabis plant or any substance or mixture that contains any part of the plant.

[ii] The plant contains at least 750 chemicals, of which there are over 100 different cannabinoids. Madras BK. *Update of cannabis and its medical use*. Agenda item 6.2. 37th Meeting of the Expert Committee on

and method of use make it difficult to study the full health impacts and produce replicable, reliable scientific results.

The CMA submits, therefore, that any legalization of cannabis for non-medical use must be guided by a comprehensive cannabis public health strategy and include a strong legal-regulatory framework emphasizing harm reduction principles.

Given that the Task Force employed a minimizing of harms approach[11] and given how the proposed legislation aligns with the Task Force's recommendations,[12] the bill addresses several aspects of a legal-regulatory framework "to provide legal access to cannabis and to control and regulate its production, distribution and sale."[13] This work provides the starting point for creating a national cannabis public health strategy. The CMA has long called for a comprehensive drug strategy that addresses addiction, prevention, treatment, enforcement and harm reduction.[3]

There are, however, key public health initiatives that the Canadian government has not adequately addressed and should be implemented before, or no later than, the implementation of legislation. One such initiative is education. Education is required to develop awareness among Canadians of the health, social and economic harms of cannabis use especially in young people.

**Supporting a Legal-Regulatory Framework that Advances Public Health and Protection of Children and Youth**

From a health perspective, allowing any use of cannabis by people under 25 years of age, and certainly those under 21 years of age, is challenging for physicians given the effects on the developing brain.[1,3,14] The neurotoxic effect of cannabis, especially with persistent use, on the adolescent brain is more severe than on the adult brain.[15,16]

Further, neurological studies have shown that adolescent-onset cannabis use produces greater deficits in executive functioning and verbal IQ and greater impairment of learning and memory than adult-onset use.[17,18]

This underscores the importance of protecting the brain during development. Since current scientific evidence indicates that brain development is not completed until about 25 years of age,[19] this would be the ideal minimum age for legal cannabis use.

Youth and young adults are among the highest users of cannabis in Canada. Despite non-medical use of cannabis being illegal in Canada since 1923, usage has increased over the past few decades.

The CMA recognizes that a blanket prohibition of possession for teenagers and young adults would not reflect current reality or a harm reduction approach.[3] Harm reduction is not one of polarities rather it is about ensuring the quality and integrity of human life and acknowledging where the individual is at within his/her community and society at large.[5]

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Drug Dependence, Department of Essential Medicines and Health Products, World Health Organization; 2015. Available: www.who.int/medicines/access/controlled-substances/6_2_cannabis_update.pdf (accessed 2017 Jul 27).

The possibility that a young person might incur a lifelong criminal record for periodic use or possession of small amounts of cannabis for personal use means that the long-term social and economic harms of cannabis use can be disproportionate to the drug's physiological harm. The Canadian government has recognized this disproportionality for over 15 years. Since 2001, there have been two parliamentary committee reports[iii] and two bills[iv] introduced to decriminalize possession of small amounts of cannabis (30 g). It was recommended that small amounts of cannabis possession be a "ticketable" offence rather than a criminal one.

Given all of the above, the CMA recommends that the age of legalization should be 21 years of age and that the quantities and the potency of cannabis be more restricted to those under age 25.

**Supporting a Comprehensive Cannabis Public Health Strategy with a Strong, Effective Education Component**

The CMA recognizes that Bill C-45 repeals the prohibition against simple possession while increasing penalties against the distribution and sale of cannabis to young people, but this is not enough to support a harm reduction approach.

We note that the Federal Tobacco Control Strategy, with its $38 million budget, is intended to help reduce smoking rates and change Canadians' perceptions toward tobacco.[20] Similarly, there are extensive education programs concerning the dangers of alcohol, particularly for young people.[v]

The government of Canada has proposed a modest commitment of $9.6 million to a public awareness campaign to inform Canadians, especially youth, of the risks of cannabis consumption, and to surveillance activities.[21]

A harm reduction strategy should include a hierarchy of goals with an immediate focus on groups with pressing needs. The CMA submits that young people should be targeted first with education. The lifetime risk of dependence to cannabis is estimated at 9%, increasing to almost 17% in those who initiate use in adolescence.[22] In 2012, about 1.3% of people aged 15 years and over met the criteria for cannabis abuse or dependence — double the rate for any other drug — because of the high prevalence of cannabis use.[23]

The strategy should include the development of educational interventions, including skills-based training programs, social marketing interventions and mass media campaigns. Education should focus not only on cannabis' general risks but also on its special risks for the young and its harmful effects on them.

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[iii] House of Commons Special Committee on the Non-Medical Use of Drugs (2001) and the Senate Special Committee on Illegal Drugs (2002).

[iv] *An Act to amend the Contraventions Act and the Controlled Drugs and Substances Act* (Bill C-38), which later was reintroduced as Bill C-10 in 2003.

[v] For example, the Substance Use and Addictions Program (SUAP), a federal contributions program, is delivered by Health Canada to strengthen responses to drug and substance use issues in Canada. See Government of Canada. Substance Use and Addictions Program. Ottawa: Health Canada; 2017. Available: www.canada.ca/en/services/health/campaigns/canadian-drugs-substances-strategy/funding/substance-abuse-addictions-program.html (accessed 2017 Jul 27).

This is critical given that for many, the perception is that (i) legalization of possession for both adults and young people translates into normalization of use and (ii) government control over the source of cannabis for sale translates into safety of use. Complicating this has been the fear-mongering messaging associated with illegal drugs.

The evidence shows that fewer adolescents today believe that cannabis use has any serious health risks[24] and that enforcement policies have not been a deterrent.[25] Having an appropriate education strategy rolled out before legalization of possession would reduce the numbers of uninformed young recreational users. It would also provide time to engage in meaningful research on the impact of the drug on youth. Such strategies have been successful in the past; for example, the long-term[vi] Federal Tobacco Control Strategy has been credited with helping reduce smoking rates to an all-time low in Canada.[26]

The Lower-Risk Cannabis Use Guidelines were developed as a "science-based information tool for cannabis users to modify their use toward reducing at least some of the health risks."[6] The CMA urges the government to support the widespread dissemination of this tool and incorporation of its messages into educational efforts. Other strategies must include plain packaging and labelling with health information and health warnings.

**Supporting a One-System Approach. Alternatively, a Review of Legislation in Five Years**

The CMA believes that once the act is in force, there will be little need for two systems (i.e., one for medical and one for non-medical cannabis use). Cannabis will be available for those who wish to use it for medicinal purposes, either with or without medical authorization (some people may self-medicate with cannabis to alleviate symptoms but may be reluctant to raise the issue with their family physician for fear of being stigmatized), and for those who wish to use it for other purposes. The medical profession does not need to continue to be involved as a gatekeeper once cannabis is legal for all, especially given that cannabis has not undergone Health Canada's usual pharmaceutical regulatory approval process.

The Task Force's discussion reflects the tension it heard between those who advocated for one system and those who did not. One concern raised by patients was about the stigma attached to entering retail outlets selling non-medical cannabis. The CMA submits that this concern would be alleviated if the federal government continued the online purchase and mail order system that is currently in place.

Given that there is a lack of consensus and insufficient data to calculate how much of the demand for cannabis will be associated with medical authorization, the Task Force recommended that two systems be established, with an obligation to review — specifically, a program evaluation of the medical access framework in five years.[11]

If there are two systems, then in the alternative, the CMA recommends a review of the legislation within five years. This would allow time to ensure that the provisions of the act are meeting their intended purposes, as determined by research on the efficacy of educational efforts and other research. Five-year legislative reviews have been previously employed,

[vi] The Federal Tobacco Control Strategy was initiated in 2001 for 10 years and renewed in 2012 for another five years.

especially where legislation must balance individual choice with protecting public health and public safety.[vii] For example, like Bill C-45, the purpose of the *Controlled Drugs and Substances Act* is to protect public health and public safety.[27] Its review within five years is viewed as allowing for a thorough, evidence-based analysis to ensure that the provisions and operations of the act are meeting their intended purpose(s).[viii] Furthermore, a harm reduction approach lends itself to systematic evaluation of the approach's short- and long-term impact on the reduction of harms.[5]

The CMA, therefore, submits that if a two-system approach is implemented when the legislation is enacted, the legislation should be amended to include the requirement for evaluation within five years of enactment. Criteria for evaluation may include the number of users in the medical system and the number of physicians authorizing medical cannabis use. The CMA would expect to be involved in the determination of such criteria and evaluation process.

## Conclusion

Support has risen steadily in Canada and internationally for the removal of criminal sanctions for simple cannabis possession, as well as for the legalization and regulation of cannabis' production, distribution and sale. The CMA has long-standing concerns about the health risks associated with consuming cannabis, especially by children and youth in its smoked form. Weighing societal trends against the health effects of cannabis, the CMA supports a broad legal-regulatory framework as part of a comprehensive and properly sequenced public health approach of harm reduction.

## Recommendations

**1. The CMA recommends that the legalization age be amended to 21 years of age, to better protect the most vulnerable population, youth, from the developmental neurological harms associated with cannabis use.**

**2. The CMA recommends that a comprehensive cannabis public health strategy with a strong, effective health education component be implemented before, and no later than, the enactment of any legislation legalizing cannabis.**

[vii] Several federal acts contain review provisions. Some examples include the *Controlled Drugs and Substances Act*, SC b1996, c 19, s 9 (five-year review); the *Preclearance Act*, SC 1999, c 20, s 39 (five-year review); the *National Defence Act*, RSC 1985, c N-5, s 273.601(1) (seven-year review); the *Public Servants Disclosure Protection Act*, SC 2005, c 46, s 54 (five-year review); and the *Red Tape Reduction Act*, SC 2015, c 12 (five-year review).

[viii] The 2012 amendments to the *Controlled Drugs and Substances Act* were adopted from Bill S-10, which died on order papers in March 2011. The Senate Standing Committee on Legal and Constitutional Affairs reviewed Bill S-10 and recommended that the review period should be extended from two to five years as two years is not sufficient to allow for a comprehensive review. See *Debates of the Senate*, 40th Parliament, 3rd Session, No 147:66 (2010 Nov 17) at 1550; see also Senate Standing Committee on Legal and Constitutional Affairs, Eleventh Report: Bill S-10, *An Act to Amend the Controlled Drugs and Substances Act and to Make Related and Consequential Amendments to Other Acts, with Amendments* (2010 Nov 4).

**3a. The CMA recommends that there be only one regime for medical and non-medical use of cannabis, with provisions for the medical needs of those who would not be able to acquire cannabis in a legal manner (e.g., those below the minimum age).**

**3b. Alternatively, the CMA recommends that the legislation be amended to include a clause to review the legislation, including a review of having two regimes, within five years.**

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[12] Government of Canada. *Legislative background: an Act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other Acts (Bill C-45).* Ottawa: Government of Canada; 2017.
[13] *An Act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other Acts*, Bill C-45, First Reading 2017 Apr 13.
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[27] *Controlled Drugs and Substances Act*, SC 1996, c 19, s 9.