CMA Submission

Legalization, Regulation and Restriction of Access to Marijuana

Government of Canada – Task Force on Marijuana Legalization and Regulation

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is helping physicians care for patients.

On behalf of its more than 83,000 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 Canadian Medical Association (CMA) is pleased to make this submission in response to the consultation led by the federal Task Force on Marijuana Legalization and Regulation, which has the objective of providing advice to the government on the design of a new framework for marijuana for non-medical, or recreational, purposes.

The CMA has over 83,000 physician-members. Its mission is helping physicians care for patients and its vision is to be the leader in engaging and serving physicians, and the national voice for the highest standards for health and health care.

The Government of Canada has made a commitment to legalize, strictly regulate and restrict access to marijuana in response to the high rates of marijuana use among Canadians, particularly youth[a] [1] [2], despite its current illegal status. The existing approach to drugs has resulted in high rates of criminal records for non-violent drug offences each year[b] [3], affecting disadvantaged groups disproportionately. Organized crime is supported by these high levels of use. This situation has resulted in considerable harm to society.

Public opinion in Canada and internationally has risen steadily in support of the removal of criminal sanctions for simple marijuana possession, as well as for the legalization and regulation of marijuana.

The federal Task Force has developed a discussion paper, *Toward the Legalization, Regulation and Restriction of Access to Marijuana*[4], which includes the following objectives for the new regime for legal access to marijuana:

- Protect young Canadians by keeping marijuana out of the hands of children and youth;
- Keep profits out of the hands of criminals, particularly organized crime;
- Reduce the burdens on police and the justice system associated with simple possession of marijuana offences;
- Prevent Canadians from entering the criminal justice system and receiving criminal records for simple marijuana possession offences;
- Protect public health and safety by strengthening, where appropriate, laws and enforcement measures that deter and punish more serious marijuana offences, particularly selling and distributing to children and youth, selling outside of the regulatory framework, and operating a motor vehicle while under the influence of marijuana;
- Ensure Canadians are well-informed through sustained and appropriate public health campaigns, and, for youth in particular, ensure that risks are understood;
- Establish and enforce a system of strict production, distribution and sales, taking a public health approach, with regulation of quality and safety (e.g., child-proof packaging, warning labels), restriction of access, and application of taxes, with programmatic support for addiction treatment, mental health support and education programs;
- Continue to provide access to quality-controlled marijuana for medical purposes consistent with federal policy and Court decisions; and
- Conduct ongoing data collection, including gathering baseline data, to monitor the impact of the new framework.

[a] Marijuana is the most commonly used illegal substance in Canada. 43% of Canadians claim to have used marijuana at some point in their life, despite almost a century of prohibition. Canadian youth has the highest rate of marijuana use among 29 developed countries. Almost a quarter of the population aged 15 to 24 years reported past-year use.

[b] According to a Stats Canada report, there were 73 thousand marijuana-related criminal offences (67% of all police-reported drug offences) in 2013.

Context

The CMA has longstanding concerns about the health risks associated with consuming marijuana, particularly in its smoked form.[5] [6] Children and youth are especially at risk for marijuana-related harms, given their brain is undergoing rapid, extensive development.

Our understanding of the health effects of marijuana continues to evolve.[c] [7] [8] [9] Marijuana use is linked to several adverse health outcomes, including addiction, cardiovascular and pulmonary effects (e.g., chronic bronchitis), mental illness, and other problems, including cognitive impairment and reduced educational attainment. There seems to be an increased risk of chronic psychosis disorders, including schizophrenia, in persons with a predisposition to such disorders. The use of high potency products, higher frequency of use and early initiation are predictors of worse health outcomes.

The lifetime risk of dependence to marijuana is estimated at about 9%[d], increasing to almost 17% in those who initiate use in adolescence.[10] In 2012, about 1.3% of people aged 15 and over met the criteria for marijuana abuse[e] or dependence[f] – double that of any other drugs – due to the high prevalence of marijuana use.[11]

Another area of great concern is that of impairment and the operation of vehicles, as well as the performing of work in an unsafe manner. There is an increased risk of motor vehicle collisions up to 6 hours after use, depending on method of use, dose and tolerance. As well, experience in the U.S. and even in Canada has shown that there can be an increased risk of unintentional overdoses in children due to marijuana edibles.

The CMA's overarching recommendation to the federal government is that the government must take a broad public health policy approach to address the legalization and regulation of marijuana for non-medical use. A public health approach would place an increased focus on: preventing drug abuse and dependence; the availability of assessment, counselling and treatment services for those who wish to stop using; and harm reduction to increase the safety for those who are using.

This approach seeks to ensure that the harms associated with enforcement are not out of proportion to the direct harms caused by substance abuse. Individuals with drug dependency should be diverted, whenever possible, from the criminal justice system to treatment and rehabilitation. Monitoring, surveillance and research of marijuana use are essential to better understand the short and long term harms as well as to develop policy options to address prevention, treatment, harm reduction and enforcement.

There are huge economic pressures at play that need to be considered in a new regime and it is essential that public health objectives be central to the process of legalization and regulation. A recent report[12]

[c] Unlike pharmaceuticals, marijuana is a complex combination of more than 100 different chemicals. The main psychoactive component is delta-9-tetrahydrocannabinol (THC), but other components, such as cannabidiol (CBD), also act on the central nervous system and may modify the effects of THC. The concentration of these compounds can vary substantially, making it difficult to characterize the specific positive or negative health effects of marijuana, especially in uncontrolled and epidemiological studies. As well, the average content of THC in marijuana has increased substantially in the last 30 years. For these and other reasons, research and attribution of harm and benefit are challenging.

[d] Similar estimates for other substances are 15% for alcohol, 23% for heroin and 32% for nicotine.

[e] Abuse is characterized by a pattern of recurrent use where at least one of the following occurs: failure to fulfill major roles at work, school or home, use in physically hazardous situations, recurrent alcohol or drug related problems, and continued use despite social or interpersonal problems caused or intensified by alcohol or drugs.

[f] Dependence is when at least three of the following occur in the same 12 month period: increased tolerance, withdrawal, increased consumption, unsuccessful efforts to quit, a lot of time lost recovering or using, reduced activity, and continued use despite persistent physical or psychological problems caused or intensified by alcohol or drugs.

estimates that it could create a $10 billion a year industry in Canada, including production and distribution. As well, legalizing marijuana will bring in considerable tax revenue, and governments could collect as much as 50% or more of that if the rate of taxation is high, as in the 'sin' tax on the sale of alcohol and tobacco. As well, legalization could also lead to substantial savings in enforcement and incarceration. Given these pressures by private corporations, governments and other lobby groups, it is essential that the federal and provincial/territorial governments be held accountable to public health objectives of decreasing harms of marijuana use, particularly in children and youth.

The CMA's submission does not address the question of whether marijuana should be legal; the current federal government has already made it clear that this is their intent. Instead, this submission focuses on specific recommendations from physicians as they apply to the regulatory framework, with the objective of protecting individual and public health. It is based on input from CMA's members, discussions with key stakeholders and experts from specialty societies, a review of reports on the experience in jurisdictions that have legalized marijuana for non-medical use, such as Colorado, Washington and Uruguay[13] [14] [15] [16] [17], as well as expert literature[18] [19].

The Task Force's discussion paper presents the potential elements of a new system, which were grouped into five themes: 1) minimizing harms of use; 2) establishing a safe and responsible production system; 3) designing an appropriate distribution system; 4) enforcing public safety and protection; and 5) accessing marijuana for medical purposes. Each theme includes questions on specific concerns for which the Task Force is seeking input. Presented below are the CMA's recommendations to the federal government for each section of the discussion paper. A summary of all recommendations is listed at the end of the brief.

RECOMMENDATION:

The CMA recommends that the federal government take a broad public health policy approach in legalizing marijuana for non-medical purposes, and that it be held accountable to these public health objectives.

1. MINIMIZING HARMS OF USE

1.1. Do you believe that these measures are appropriate to achieve the overarching objectives to minimize harms, and in particular to protect children and youth? Are there other actions which the government should consider enacting alongside these measures?

Legalization and strict regulation of marijuana for recreational use seeks to reduce health and social harms, particularly in higher risk groups; however, with the increased access, there could be an inverse effect, with the potential that harms could be intensified. There is also the considerable risk that the degree of "normalization" of use that already exists could increase.

Colorado has seen an increase in marijuana-related traffic deaths and an increase in the use of health care due to intoxication, burns and cyclic vomiting syndrome, as well as overdoses in children due to marijuana in edibles.[20] [21] [22]

Many of the regulatory interventions used in reducing tobacco normalization and rates, as well as controlling the harms of alcohol at a population level, are proposed in the Task Force's discussion paper as part of a framework for marijuana legalization and regulation. These include:

1) Minimum age for legal purchase with the objective of protecting children and youth, particularly since the risks of marijuana use are higher in ages where the brain is still in development.
2) Advertising and marketing restrictions to minimize the profile and attractiveness of products, seeking to prevent or at least reduce the "normalization" of use in society, particularly among children and youth.
3) Taxation and pricing to discourage use and provide the government with revenues to offset related costs (such as substance abuse services, law enforcement and regulatory oversight).
4) Restrictions on marijuana products, particularly with regards to the THC component, given higher concentration products have added risks and unknown long term impacts, with most impact on children and youth. Restrictions would include maximum THC limits and prohibition of high-potency products.
5) Restrictions on types of marijuana products, particularly edibles, to prevent accidental or unintentional ingestion, particularly by children. Limits would be placed on dosing and potency.
6) Limitations on quantities for personal possession, with the objective of helping to reduce demand and to minimize opportunities for resale of legally purchased marijuana on the illicit market (particularly to children and youth).
7) Limitation on where marijuana can be sold in order to minimize harms.

Despite the merit of each of the proposed measures, collectively these may not adequately protect children and youth. A pathway to better implementation would require:

- Taking the time to adequately prepare for the implementation, including developing the capacity to meet demand, administer the system, enforce regulations and deal with adverse effects. A phased-in approach or pilots in certain jurisdictions should be considered before going nationwide.

- Learning from the lessons gained in jurisdictions that have made changes in drug policy, including the U.S. states of Colorado and Washington, Uruguay, the Netherlands and Portugal.

- Learning from successes and failures in the regulation of tobacco and alcohol, with respect to the objectives of reducing or eliminating use for all Canadians (tobacco) and promoting responsible use among adults, while prohibiting use in youth (alcohol).

- Developing the capacity to carry out a rigorous national-level evaluation of the impact of legalization of marijuana on the health and safety of Canadians. Data collection and analysis cannot be conducted if national surveillance systems do not exist. Important data to be monitored include marijuana-related emergency room visits and hospitalizations, rates of drug-impaired driving, recreational injuries, unintentional poisonings, product contamination, overconsumption and food-borne illness from edible products.[23]

- Support for a research agenda to better understand harms of marijuana, particularly among vulnerable groups such as children and youth, pregnant women, people with mental illness and chronic diseases. Research should also support policy interventions, including those to address second hand smoke, harm reduction measures, treatments and effective education strategies.

The CMA is supportive of the regulatory interventions proposed by the government to reduce the harms, regarding:

Marketing and advertising: The CMA recommends that the marketing and advertising of marijuana be prohibited, as is currently the case for tobacco and cigarettes. Measures such as plain packaging, prohibition of appealing flavours and shapes, adequate content and potency labelling, as well as health warnings, should be incorporated to discourage experimentation. A package insert should outline health risks and supporting references, the need for securing the product in the home, preventing access by youth and children, and recommendations not to drive or work with hazardous chemicals or equipment. The insert should include information detailing the health and social consequences, including legal penalties for providing marijuana to those under a designated minimum age for purchasing.

Taxation and pricing: Taxation and pricing levers should be used to discourage use, with revenues clearly earmarked for covering the health and social costs of legalization. In Colorado, for example, revenue is used in substance abuse programs, regulation of marijuana and for public school construction. However, as with tobacco, final pricing must be such as to discourage the illegal production and trafficking of marijuana. Most of future tax revenues should be redistributed to the provinces and territories. This is because they will feel the impact of legalization directly as they have jurisdiction over health care, education, social and other services, as well as responsibility for enforcement.

Restrictions on the potency of marijuana products: Experience in jurisdictions where marijuana has been legalized has shown that restrictions on the potency of products (i.e., THC limits) are necessary, given the higher risks of harm associated with higher potencies. Prohibition of high potency products is important. However, there is a risk that the prohibition could lead to an illicit market of more potent marijuana preparations.

Restrictions on types of marijuana products: It is essential that restrictions be placed on the dosing of products, particularly of edibles, given the incidence of accidental overdoses of children. Content in a package should not be sufficient to cause an overdose. Because of these incidents, child proof packaging should also be required.

Limitations on quantities for personal possession: Placing maximum limits on quantities that can be purchased would help to reduce the opportunities for illegal distribution and sale, especially to those below the established minimum age limit.

The proposed measures related to **minimum age for legal purchase** and **limitation on where marijuana can be sold** are discussed in Sections 1.2 and 3, respectively, below.

In addition to the regulatory interventions proposed in the “Minimizing Harms of Use” section of the discussion paper, others are equally fundamental, including:

> **A clear process for identifying, testing and charging individuals who are driving under the influence of marijuana** should be in place prior to legalization (see further discussion under Section 4).
>
> **Public education:** The use of public education tools to inform youth and families of the risks and harms of marijuana use is necessary. Awareness of Canadians of the harms of marijuana is generally low.[24] [25] [26] Youth tend to emphasize the drug’s ability to help them focus, relax, sleep, reduce violent behaviour and improve creativity. There are also many dangerous myths, such as

that marijuana can counter the harmful effects of smoking tobacco by preventing cancer or that marijuana makes people better drivers. There is also a perception amongst some that marijuana is not an addictive substance because it is "natural".

However, traditional public campaigns and educational programs for youth have been shown to be minimally effective. There is a need for more effective programs, including those that incorporate skills-based training that teaches youth how to handle situations that involve drugs and/or alcohol.

Harm reduction measures, such as those outlined in the *Lower Risk Cannabis Use Guidelines for Canada*[g] [27] should be discussed, particularly with teens, in an effort to minimize harm, even if they choose to continue to use.

It is important that these education programs be designed by governments and health professionals, and not marijuana producers or distributers. However, costs of such programs could come from the profits of such industries.

Expanded access and immediate availability of substance use, mental health and social stabilization services is another very important measure to minimize harm. These services are currently difficult to access in the community and have long wait times; in many parts of Canada they are simply unavailable. A plan to expand training programs in addiction medicine and access to treatment should be in place prior to legalization.

Enforcement of regulations: Licensed producers and retail outlets should be held accountable in their compliance with policies, guidance and good practices to prevent contaminants that may cause additional health issues if consumed, particularly by minors (See also Section 3).

1.2. What are your views on the minimum age for purchasing and possessing marijuana? Should the minimum age be consistent across Canada, or is it acceptable that there be variation amongst provinces and territories?

In order to achieve the first objective of legalization, i.e., to protect young Canadians by keeping marijuana out of the hands of children and youth, a minimum age for its purchase and possession must be adopted. This has been an important measure in tobacco and alcohol regulations. Existing evidence on marijuana points to the importance of protecting the brain during its development. Since that development is only finalized by about 25 years of age, this would be an ideal minimum age based on currently accepted scientific evidence, although knowledge on brain development is still evolving.

However, marijuana use among youth (ages 15 to 24) is still double that of the general population, at 20%, even though there has been a slight decrease in use in recent years.[28] A 2011 report on student alcohol and drug use in Canada showed that of those youth who had used marijuana in the past 3 months, 25% had used it daily. The average age of initiation was 16.1 years. In some provinces, about 50% of students in grade 12 have reported using marijuana in the past year.[29]

[g] These include delaying use until early adulthood; avoiding frequent use; preferring smokeless delivery systems; using less potent products; not driving after use; and abstaining from use when at higher risk of cannabis-related problems (people with a personal or family history of psychosis, cardiovascular problems and pregnant women).

A minimum age lower than 25 years should be considered in order to deter youth from seeking marijuana from organized crime groups, where they are exposed to other more dangerous drugs, sometimes even laced into marijuana.

In jurisdictions where marijuana has been legalized, the minimum age has been set at the same minimum age for purchase of alcohol, i.e., 21 years. In Canada, the age limits for acquiring alcohol and tobacco are either 18 or 19 years of age, depending on the province or territory. In a survey carried out with a sample of the CMA membership, 25.4% recommended age 21, 20.3% age 25, 19.7% age 18, and 14.2% age 19.

The CMA recommends that the minimum age should be set at 21, and that quantities and the potency of marijuana be more restricted to those under age 25 to discourage use and sharing with underage friends. The CMA recommends that the minimum age be established at the national level, and federally regulated, to avoid differences at the provincial/territorial level. This would reduce problems with enforcement in areas near provincial/territorial borders.

SECTION 1 RECOMMENDATIONS:
The CMA recommends that the federal government incorporate the following measures to support improved implementation of the legalization of marijuana:

a) **Ensure sufficient time to adequately prepare for the implementation of the legalized regime, including a phased-in approach and piloting legalization in smaller regions prior to national roll-out;**

b) **Assess international experience with legalization and incorporate lessons-learned from other jurisdictions into Canada's approach;**

c) **Assess the domestic experience in the regulation of tobacco and alcohol against meeting the national objectives for each substance and incorporate lessons-learned from those experiences; and,**

d) **Develop capacity for national surveillance to ensure rigorous national-level monitoring and evaluation.**

e) **Support for a research agenda.**

The CMA recommends that the federal government prohibit the marketing and advertising of marijuana and that packaging requirements include plain packaging, potency labelling and health warnings. The CMA further recommends that the federal government prohibit flavouring and shapes.

The CMA recommends that the federal government employ taxation and pricing levers to discourage consumption and that the revenues of this taxation be allocated to the provinces and territories and clearly allocated for health and social services.

The CMA recommends that the federal government establish potency restrictions to reduce the harms associated with higher potencies.

The CMA recommends that the federal government establish dosing restrictions on marijuana products, notably edibles.

The CMA recommends that the federal government establish maximum limits on quantities of marijuana that can be purchased.

The CMA recommends that the federal government employ effective public education tools, including skills-based training, to inform youth and families of the risks and harms of marijuana usage.

The CMA recommends that the federal government expand access and availability of substance use, mental health and social stabilization services simultaneously to the legalization of marijuana.

As part of this initiative, the CMA recommends that the federal government implement a plan to expand training programs in addiction medicine.

The CMA recommends that the federal government set the minimum age of purchase and consumption at 21 and that quantities and potency be restricted for those under the age of 25.

The CMA recommends that the federal government establish the minimum age at the national level to ensure consistency across all jurisdictions.

2. ESTABLISHING A SAFE AND RESPONSIBLE PRODUCTION SYSTEM

2.1. What are your views on the most appropriate production model? Which production model would best meet consumer demand while ensuring that public health and safety objectives are achievable? What level and type of regulation is needed for producers?

There will be no perfect production model, with each one having its risks and benefits. The CMA would support a tightly regulated competitive model. A set number of licenses should be granted to producers, who are part of a competitive system, and there should be a reasonable cost associated to offset regulatory expenses. Producers would have to comply with policies and guidelines set by Health Canada, and be subject to inspections.

It is fundamental that commercialization is rigorously controlled through taxation, regulation, monitoring and advertising controls.

2.2. To what extent, if any, should home cultivation be allowed in a legalized system? What, if any, government oversight should be put in place?

The CMA does not recommend home cultivation in a legalized system for non-medical purposes, as it presents many challenges to municipal, enforcement and public health authorities, particularly given the potentially high number of homes that could seek to cultivate marijuana.

There are many health and safety hazards in cultivation, such as high humidity and temperatures, risk of fire, as well as the use of hazardous chemicals, including pesticides used for the control of fungi, bacteria and insects. There is little quality control regarding contamination and potency of the product. As well, home cultivation has an enhanced risk of abuse, if individuals use the production for sale rather than exclusively for personal use. Access to marijuana by children and youth is also a serious concern with home cultivation.

In the present marijuana for medical purposes system, where some users have been allowed to continue to grow for personal use, there is great difficulty in monitoring and inspecting these properties. However,

this has been allowed given the *Allard v Canada* court decision, to not hinder access for medical purposes.

Washington has not permitted home cultivation, but Colorado has allowed the growth of a small number of plants for personal use (up to 6 plants, with a maximum 3 mature ones, in an enclosed, locked space).

2.3. Should a system of licensing or other fees be introduced?

Should limited home cultivation for non-medical purposes be an option, a system of registration and licensing would have to be set up to allow for tracking and inspections of home production. It would also allow penalties for non-registered producers as well as larger scale operations. This would be a system that would require intense government regulation, oversight and tremendous resources to be effective.

2.4. The MMPR set out rigorous requirements over the production, packaging, storage and distribution of marijuana. Are these types of requirements appropriate for the new system? Are there features that you would add or remove?

The requirements for production, packaging, storage and distribution of marijuana set out by the MMPR are appropriate for the new system. However, a rigorous review of the MMPR should be conducted to determine if there are weaknesses that need to be corrected before expanding to a non-medical market. Ongoing evaluation will be warranted as well. Distribution would have to expand beyond the mail service.

2.5. What role, if any, should existing licensed producers under the MMPR have in the new system (either in the interim or the long-term)?

The CMA's policy position does not extend to whether the existing licensed producers should be suppliers to the recreational market. The experience in Colorado, however, showed that having the industry set up for medical purposes first allowed a smoother transition, in contrast with Washington, which did not have an industry.

SECTION 2 RECOMMENDATIONS:
The CMA supports a tightly regulated competitive model wherein production and distribution is heavily regulated and includes strict oversight.

The CMA recommends that the federal government prohibit home cultivation in the legalized system for non-medical use.

The CMA recommends that the federal government evaluate the requirements established by the MMPR system for production, packaging, storage and distribution to introduce improvements for implementation in the new legalized system for non-medical use.

3. DESIGNING AN APPROPRIATE DISTRIBUTION SYSTEM

3.1. Which distribution model makes the most sense and why?

There is the need to continue mail availability for patients accessing marijuana for medical purposes to ensure nationwide access, however, a distribution system based exclusively on mail service would probably not meet the objectives of a recreational system.

When a sample of our membership was asked about distribution models, first preference was given to existing non-health care structures, such as liquor stores. In some provinces, they would have the additional benefit of having a tightly regulated government monopoly by control board entities with a social responsibility mandate. Restrictions could be placed to limit the acquisition of both alcohol and marijuana. As stated earlier, marketing should be prohibited. Staff in these stores receives training and hours can be limited.

A close second preference was given to legal storefronts, similar to the independent dispensaries. Several municipalities have been in varied degrees of discussion on the regulation of the presently illegal dispensaries, and those regulations could be looked at as models in a legalized environment.

When asked about health care settings, such as pharmacies, respondents to the survey did not support this model. Almost 60% disagreed or strongly disagreed. A reason for this lack of support could be that placing marijuana in pharmacies could lend it credibility as a pharmaceutical medication, whereas placing it in liquor stores would send the message that it needs strict and formal controls.

As per previous discussion, the creation of private industries for production and distribution would have to be very tightly controlled to avoid commercialization. As we have learned from the alcohol and tobacco industries, private companies have an interest in recruiting customers and encouraging high levels of ongoing consumption. It is important that the regulatory framework be protected from these commercial and fiscal interests.

Regardless of the actual point of sale, storefront densities should be federally set and restrictive. There is good evidence from the regulation of alcohol that the less restrictive retail outlet density is, the more harms associated with alcohol use occur. Restrictions would also be placed on distances from schools, parks, playgrounds, colleges and universities, as well as on hours of sale. Regulations would lay out standards, including for the control of product sources, proof of minimum age required for purchase and restrictions on quantities sold.

3.2. To what extent is variation across provinces and territories in terms of distribution models acceptable?

In the CMA's survey of our members, there was not a consensus among respondents as to whether provincial and territorial governments should decide on their own distribution mechanisms. Many comments stated that a federal standard is warranted due to the need for initial close oversight and the ability to make effective changes more quickly. The CMA position is that there is an important role for the federal government to play in ensuring consistency across the country and avoiding provincial/territorial variation.

3.3. Are there other models worthy of consideration?

The CMA recommends a phased in approach to the roll out of the system of distribution. Several pilot locations could be considered before going nationwide. Given the novelty and impact of this new legislation, particular caution is absolutely necessary from a regulatory and public health perspective.

SECTION 3 RECOMMENDATIONS:

The CMA recommends that the distribution model should occur outside health care structures, for example, in liquor stores, and that storefront densities should be federally set and restrictive.

The CMA recommends that the distribution model should be established at the federal level and be consistent across jurisdictions.

The CMA recommends a phased implementation approach prior to national availability.

4. ENFORCING PUBLIC SAFETY AND PROTECTION

4.1. 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?

The severity of punishment for simple possession and personal use of marijuana should be eliminated with the removal of criminal sanctions. The CMA recommends that resources currently devoted to combating simple marijuana possession through the criminal law be diverted to public health and education strategies, particularly for youth. Having a criminal record limits employment prospects, and the impact on health status is profound, disproportionately among marginalized populations. Laws should include such things as the facilitation of access by individuals to services to address substance use, mental health and social stabilization. Laws should be drafted in a clear fashion to minimize ambiguity and provide as much guidance and direction to users, health care providers, enforcement authorities, producers, distributors and others.

4.2. What specific tools, training and guidelines will be most effective in supporting enforcement measures to protect public health and safety, particularly for impaired driving?

The use of marijuana is associated with an increased risk of impairment, and is incompatible with the operation of vehicles and work in safety sensitive positions due to risk of injury to oneself, coworkers or the general public.

Marijuana use is associated with an increased risk of motor vehicle crashes. Young people, particularly males, are more likely to drive after using marijuana. The Cross-Canada Report on Student Alcohol and Drug Use[30] states that 14–21% of students in Grade 12 reported having driven within an hour of using marijuana, and more than 33% of Grade 12 students reported having been a passenger in a car where the driver had used the drug. Often, marijuana is associated with alcohol use, having an additive effect.

A clear and reliable process for identifying, testing and imposing consequences on individuals who use marijuana and drive absolutely needs to be in place nationally prior to legalization. This will be complicated by the fact that a roadside test for marijuana use is not in widespread use; blood and urine testing also pose challenges. Another issue is the fact that recent use does not necessarily equate to impairment and no scientific standard for impairment exists in the literature.

All individuals charged with impaired driving should have a specialist assessment to determine whether a substance use disorder is present. Individuals with substance use disorders should have immediate access to addiction treatment, mental health services and social stabilization.

There is also a need for the development of guidelines for employers for the assessment and management of risk.

4.3. Should consumption of marijuana be allowed in any publicly-accessible spaces outside the home? Under what conditions and circumstances?

No public smoking should be permitted, due to the risk of second hand smoke. Second hand marijuana smoke contains many of the same toxins, including carcinogens, found in directly inhaled marijuana smoke, in similar amounts, if not more. There is special concern for harmful health effects, especially among children. The CMA does not recommend the exposure of children to second hand smoke in public areas or in the home. The success in the reduction of tobacco use rates is significantly related to banning of smoking in public places.

In the CMA's survey of a sample of its members, 51.7% disagreed with consumption in designated public places, such as the Dutch model of coffee shops.

SECTION 4 RECOMMENDATIONS:

The CMA recommends that the federal government reallocate resources currently dedicated to the enforcement of marijuana infractions, to public health, education and treatment programs.

The CMA recommends that the federal government ensure that a clear and reliable process for identifying, testing and imposing consequences on individuals who operate a motor vehicle under the influence of marijuana be in place nationally prior to the legalization of marijuana.

The CMA recommends that the federal government prohibit smoking of marijuana for non-medical purposes in public places.

5. ACCESSING MARIJUANA FOR MEDICAL PURPOSES

5.1. What factors should the government consider in determining if appropriate access to medically authorized persons is provided once a system for legal access to marijuana is in place?

The CMA recognizes that some individuals suffering from terminal illness or chronic disease for which conventional therapies have not been effective may obtain relief with marijuana used for medical purposes. However, clinical evidence of medical benefits is limited and there is very limited guidance for the therapeutic use, including indications, potency (levels of THC, CBD), interactions with medications and adverse effects. Health Canada does not approve of marijuana as a medicine, as it has not gone through the approvals required by the regulatory process to be a pharmaceutical.

The present system poses a serious challenge for physicians in providing the best care to patients. The CMA has long called for more research to better understand potential therapeutic indications, as well as its risks. It is important that there be support for research of marijuana in order to develop products that can be held to pharmaceutical standards, as is the case with dronabinol (Marinol®), nabilone (Cesamet®) and THC/CBD (Sativex®).

The present marijuana for medical purposes regime operates as an exception to a criminal prohibition for production, possession and trafficking of marijuana. It was developed in reaction to court challenges regarding the right to legal access of individuals to marijuana for medical purposes.

With the new legal system for marijuana for non-medical use, the requirement to maintain a separate regulatory framework would not be necessary, given court-mandated access will be provided. As well, the experience of legalization for non-medical use in Colorado and Washington has shown that two separate

regimes with distinct regulations can be very difficult to enforce given the dual standards (including different minimum ages, purchase quantities and taxation).

Provisions would have to exist within the new system to attend to legitimate medical needs of individuals who are under the minimum age for purchase of marijuana, or for those with a requirement for a more potent product than that which is legally available. Consideration might also be given to affordable access for those with low incomes.

As stated previously, the option of distribution through mail would have to continue, to facilitate access in remote areas. As well, patients or their families would be able to access marijuana through the distributors of marijuana for non-medical purposes, such as storefronts or liquor store-like entities, which would have employees trained to support patients and their needs.

The use of marijuana products for medical indications, through this system, should preferably be done under research protocols. This framework would contribute to the provision of more robust scientific data.

SECTION 5 RECOMMENDATION:

The CMA recommends that there be only one regime for marijuana, following legalization of non-medical marijuana, with provisions for the medical needs of those who would not be able to acquire marijuana in a legal manner, e.g., those below the minimum age or those with a requirement for a more potent product than legally available.

6. Summary of Recommendations

The CMA appreciates the opportunity to provide feedback on this important matter to physicians and the public. Legalization of marijuana for non-medical purposes is a fundamental shift in the approach to drugs. The CMA's position is that it is essential that the government consult with experts, key stakeholders and the general public not only at this phase in preparation for legislation on this matter, but throughout the process of the development of regulations and implementation.

Recommendations:

1) The CMA recommends that the federal government take a broad public health policy approach in legalizing marijuana for non-medical purposes, and that it be held accountable to these public health objectives.

Section 1

2) The CMA recommends that the federal government incorporate the following measures to support improved implementation of the legalization of marijuana:

    a) Ensure sufficient time to adequately prepare for the implementation of the legalized regime, including a phased-in approach and piloting legalization in smaller regions prior to national roll-out;

    b) Assess international experience with legalization and incorporate lessons-learned from other jurisdictions into Canada's approach;

c) Assess the domestic experience in the regulation of tobacco and alcohol against meeting the national objectives for each substance and incorporate lessons-learned from those experiences; and,

d) Develop capacity for national surveillance to ensure rigorous national-level monitoring and evaluation.

e) Support for a research agenda.

3) The CMA recommends that the federal government prohibit the marketing and advertising of marijuana and that packaging requirements include plain packaging, potency labelling and health warnings. The CMA further recommends that the federal government prohibit flavouring and shapes.

4) The CMA recommends that the federal government employ taxation and pricing levers to discourage consumption and that the revenues of this taxation be allocated to the provinces and territories and clearly allocated for health and social services.

5) The CMA recommends that the federal government establish potency restrictions to reduce the harms associated with higher potencies.

6) The CMA recommends that the federal government establish dosing restrictions on marijuana products, notably edibles.

7) The CMA recommends that the federal government establish maximum limits on quantities of marijuana that can be purchased.

8) The CMA recommends that the federal government employ effective public education tools, including skills-based training, to inform youth and families of the risks and harms of marijuana usage.

9) The CMA recommends that the federal government expand access and availability of substance use, mental health and social stabilization services simultaneously to the legalization of marijuana.

10) As part of this initiative, the CMA recommends that the federal government implement a plan to expand training programs in addiction medicine.

11) The CMA recommends that the federal government set the minimum age of purchase and consumption at 21 and that quantities and potency be restricted for those under the age of 25.

12) The CMA recommends that the federal government establish the minimum age at the national level to ensure consistency across all jurisdictions.

Section 2

13) The CMA supports a tightly regulated competitive model wherein production and distribution is heavily regulated and includes strict oversight.

14) The CMA recommends that the federal government prohibit home cultivation in the legalized system for non-medical use.

15) The CMA recommends that the federal government evaluate the requirements established by the MMPR system for production, packaging, storage and distribution to introduce improvements for implementation in the new legalized system for non-medical use.

Section 3

16) The CMA recommends that the distribution model should occur outside health care structures, for example, in liquor stores, and that storefront densities should be federally set and restrictive.

17) The CMA recommends that the distribution model should be established at the federal level and be consistent across jurisdictions.

18) The CMA recommends a phased implementation approach prior to national availability.

Section 4

19) The CMA recommends that the federal government reallocate resources to the enforcement of marijuana infractions to public health, education and treatment programs.

20) The CMA recommends that the federal government ensure that a clear and reliable process for identifying, testing and imposing consequences on individuals who operate a motor vehicle under the influence of marijuana be in place nationally prior to the legalization of marijuana.

21) The CMA recommends that the federal government prohibit smoking of marijuana for non-medical purposes in public places.

Section 5

22) The CMA recommends that there be only one regime for marijuana, following legalization of non-medical marijuana, with provisions for the medical needs of those who would not be able to acquire marijuana in a legal manner, e.g., those below the minimum age or those with a requirement for a more potent product than legally available.

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