AMHO SUBMISSION TO THE TASK FORCE ON MARIJUANA LEGALIZATION AND REGULATION

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INTRODUCTION

Addictions and Mental Health Ontario (AMHO) is pleased to present its submission to the Government of Canada’s Task Force on Marijuana Legalization and Regulation. AMHO represents more than 200 not-for-profit organizations providing mental health and addictions care in Ontario. Our membership includes community-based agencies, hospitals, peer support networks and provincial agencies.

Our members have a strong interest in drug and alcohol policy. Addiction treatment providers see the consequences of drug-related harms, as we help our clients to gain greater control over their health, and their lives. Many of our mental health treatment providers care for people with concurrent disorders, whose mental health treatment is made more difficult because of problems related to substance use and gambling.

This submission is structured to align with the key themes described in the government’s discussion paper, Toward the Legalization, Regulation and Restriction of Access to Marijuana.

SUMMARY

Marijuana is a controlled substance used broadly for both recreational and therapeutic purposes. Yet its recreational use and growth as a medical agent must not obscure the fact that marijuana use is empirically linked to significant risks and harms. These harms should be addressed thoughtfully. The government’s intention to change the legal status of marijuana is a very strong signal that – first and foremost – comprehensive policy will be approached as a health issue, rather than a criminal issue.

The legalization of marijuana presents Canadians with two important opportunities:

- To use best evidence to develop policies that specifically address the documented harms associated with marijuana use.
- To direct resources generated by the distribution of marijuana to the documented costs of marijuana use, most notably to support clinically-proven treatment programs.

In pursuing these opportunities, Canadian policy-makers at all levels can learn from other jurisdictions, as well as the experience with other addictive products. American states that have legalized marijuana present one example; these experiences have been the subject of
extensive analysis.\(^1\) The Canadian experience with alcohol\(^2,3\) and gambling\(^4\) presents another important series of case studies. This submission makes use of these examples to describe how marijuana legalization may be pursued in a way that addresses both public health concerns and the need for adequate access to treatment, services and supports.

**It is critically important that Canadians with substance use problems are able to access addiction prevention and treatment services. The revenue from the sale and distribution of marijuana should be allocated to increase the capacity of addiction prevention and treatment programs.**

**MINIMIZING HARS OF USE**

A central issue in marijuana legalization is to “identify those system features that will best reduce the risks of health and social harms associated with use.” And, as the discussion paper points out, our collective experience with alcohol provides useful evidence for a public health approach. Among the key harms to be addressed are the following:

**Addiction**

There are very significant health care resources attributable to the use of marijuana. Each year in Canada, 76,000–95,000 people undergo cannabis addiction treatment.\(^5\) It is the presenting drug dependence issue in about one-third of the cases that are reported by Ontario’s specialized addiction services.\(^6\) (This does not include screening, identification and brief treatments offered within primary care settings.) The human cost of addiction must not be underestimated. About 2% of Ontario students 12 to 18 years old report using cannabis daily –


an estimated 20,000 students. This puts them at risk for poor educational outcomes, increased physical injury and other health problems, as well as involvement with the justice system.

When Canadians with addictions seek treatment for a substance use problem they are often confronted with a waiting period for the service they need. In Ontario in 2016 the wait time for residential treatment is, on average, over two months. In large parts of the province, the wait exceeds six months. Yet we know that treatment works, and helps many thousands of Canadians to gain greater control over their health, and their lives.

One of the great benefits of the legalization of marijuana is that profits associated with its sale and distribution will no longer benefit organized crime. Both the provinces and federal government stand to gain significant revenue from the sale and distribution of marijuana. The Prime Minister has indicated that the government's policy shift is not motivated by the desire for financial gain, and that the government's proceeds resulting from marijuana legalization should be directed toward mental health and addictions services. It is entirely appropriate that this revenue should be directed toward the prevention and treatment of mental health and addiction problems. This could be done by provincial governments, which could derive significant revenue from sales and distribution. The federal government could also direct marijuana-derived revenue to addiction services within its jurisdiction, including services provided to First Nations, veterans, and federal correctional inmates.

Use by young people

Restricting access of young people to marijuana should be a fundamental objective of the public policy framework for legalization and regulation of marijuana. Young people with addictions requiring treatment tend to be poly-drug users who make use of multiple substances. But marijuana is reported by many front-line addiction workers as the drug of choice for young people. Early use and heavy use are associated with a range of social problems, such as downward social mobility, financial troubles such as debt and cash flow, intimate partner

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10 Information available from ConnexOntario on request

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violence and abuse, severe truancy and juvenile offending.\textsuperscript{14, 15} Additionally, early onset cannabis users are at increased risks of later substance use behaviors, conduct/oppositional disorders, anxiety, depression, and suicidal ideation.\textsuperscript{16}

In recent years there has been growing evidence of a link between marijuana use and psychotic illness, including schizophrenia. This research has been reinforced by neuroscientific evidence that brain development takes place over a longer period than previously believed, challenging conventional definitions of youth and adolescence. The scientific argument for the benefits of delaying any use until adulthood is very strong.

To restrict access of young people to marijuana, the following public health measures can be borrowed 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.

Young people also 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 is extensive. Effective, long-term planning 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 funded by revenue that government derives from the sale and taxation of marijuana.

\textit{Impaired driving}

One key harm associated with the use of marijuana is drug-impaired driving. Changing attitudes and behaviours associated with alcohol-impaired driving has – to a significant extent – been a remarkable success. We need a comprehensive strategy to ensure that drug-impaired driving is recognized as anti-social and dangerous. 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 use.

\textsuperscript{14} Cerdá et al. (2016). Persistent Cannabis Dependence and Alcohol Dependence Represent Risks for Midlife Economic and Social Problems A Longitudinal Cohort Study. \textit{Clinical Psychological Science}, 2167702616630958.


ESTABLISHING A SAFE AND RESPONSIBLE PRODUCTION SYSTEM

Legalization of marijuana presents an opportunity to ensure that products meet minimum standards for safety. This is an area where lessons from the regulation of alcohol are applicable. The labelling of alcohol content by volume, for example, is an important measure that allows individual drinkers to know how much alcohol they are consuming. In recent years there has been a move toward the definition and labelling of a standard drink, as recommended by the National Alcohol Strategy.\(^\text{17}\) When such labelling is aligned with public messaging about lower-risk drinking guidelines, consumers of alcohol are supported in following evidence-based advice on reducing alcohol-related risks and harms.

Whether used for recreational or medicinal purposes, the production system should be designed in a manner that effectively limits diversion, particularly to young people. This requires restrictions on packaging, particularly for edible products that may be attractive to children.

DESIGNING AN APPROPRIATE DISTRIBUTION SYSTEM

Canada has extensive experience with alcohol distribution systems that are regulated, controlled, and operated by governments. In Ontario, the primary retail agent for alcohol – the Liquor Control Board of Ontario (LCBO) – is a crown corporation whose mandate includes protection of public health and safety. Provincial governments derive significant revenue from the sale of alcohol. The government’s public safety and revenue generation objectives may come into conflict.

The evidence linking increased harms to increased retail access is unequivocal.\(^\text{18}\) Higher minimum legal drinking ages, greater monopoly controls over alcohol sales, lower outlet numbers and reduced outlet densities, and limited hours and days of sale has not only been found to reduce alcohol sales and use, but also related problems.\(^\text{19}\) Public regulation and control of the distribution system provides the government the authority to restrict density of outlets and marketing, as well as the ability to rigorously enforce age restrictions. In Ontario the LCBO’s record in the area of refusing under-age drinking is strong.\(^\text{20}\)

AMHO is not in a position to determine whether the LCBO should be the entity charged with the distribution of recreational marijuana, or what the precise approach should be in other provinces. We note that the evidence on harms related to the combination of alcohol and


\(^{20}\) In 2014-15, LCBO staff refused service to more than 439,000 individuals; 88 per cent for reasons of age – From LCBO website, http://www.lcbo.com/content/lcbo/en/corporate-pages/about.html#V7NNw5X6upo
marijuana suggests that their availability in the same premises may be problematic. Pharmacies, licensed dispensaries, or other hybrid models may offer greater public protection and promote health more effectively. Any mechanism should be subject to evaluation based on the basis of public health objectives.

We strongly encourage governments to establish and maintain strong control/regulation of the distribution system, and to enshrine public health and safety objectives into legislation and policy governing the distribution mechanisms. We believe that provincial governments – given their history with alcohol – are generally well-placed to assume responsibility for governing the distribution of recreational marijuana.

**ENFORCING PUBLIC SAFETY AND PROTECTION**

Many of the issues relating to public safety and protection are covered in other parts of this submission (see Minimizing Harms of Use). AMHO believes that enforcement must be adequately resourced to address drug-impaired driving, restrictions on marketing and advertising, and purchase and diversion to young people. The evidence supports strong actions against media depictions of drug use and assisting parents of children and young teenagers to restrict access to adult media venues with excessive substance use exposure.21

The experience with alcohol sales would suggest that the retail distributor of recreational marijuana must be required to report to a regulator on key health and safety considerations. For example, provincial governments should place restrictions on the density of retail outlets, and these policies must be monitored, enforced, and be subject to public reporting.

Ultimately, the failure of punitive approaches to substance use has demonstrated that enforcement alone will fail. The most effective approaches to addressing marijuana-related harm require a comprehensive approach that effectively targets the demand for drugs. Investment in enforcement, where successful, may reduce supply of drugs (for example, to young people); but enforcement is no substitute for effective, evidence-based public education and prevention programs that provide clear information on the risks associated with use.

**Accessing marijuana for medical purposes**

Canadian courts have recognized the right of Canadians to use marijuana for medical purposes, provided such access has been authorized by a qualified health practitioner. Changes to the legal status of marijuana for recreational use must not jeopardize access to medical marijuana.

Medical marijuana access provisions must be designed and implemented with regard to public health and safety. As we have learned from the experience with prescription opioids, diversion from authorized medical use may constitute a significant source of inappropriate access to

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drugs, particularly for young people. Data from a team of Colorado-based researchers indicates that 41.4 percent of the study participants with a medical marijuana card had sold or provided free access to the marijuana they received for medical purposes.\textsuperscript{22} Strict labelling, product safety assurance and limited volumes per prescription are required in order to reduce opportunities for diversion.

It is also important that health practitioners who authorize the use of medical marijuana are in a position to adequately assess the potential for adverse drug interventions. This is particularly important for those who depend on psychiatric medication.

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\textbf{ABOUT ADDICTIONS AND MENTAL HEALTH ONTARIO}

Addictions and Mental Health Ontario (AMHO) represents over 200 community based, not-for profit addictions and mental health service providers in Ontario. As the collective voice of our members, we provide leadership and engage partners to build a comprehensive and accessible system of addictions and mental health care, and improve the well-being of individuals, families and communities in Ontario.

AMHO would be very pleased to provide any further information that would be helpful to the Task Force in developing its recommendations to government.

For more information on this submission please contact Gail Czukar, CEO of AMHO at gail.czukar@addictionsmentalhealthontario.ca.

More information on AMHO may be found at http://www.addictionsandmentalhealthontario.ca.
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