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Chair

Mr. Bill Casey

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● (0835)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Good morning. Welcome, everybody, to meeting 66 of the Standing Committee on Health. I'm looking forward to an interesting day today.

Our first panel is on household cultivation of plants. It's one of the more interesting and controversial topics we have on this subject, so we certainly welcome our panellists to help us through this.

Our guests today are, from Anandia Labs, Jonathan Page, who is the chief executive officer; as an individual, John Conroy, a barrister; and from the Canadian Federation of Apartment Associations, John Dickie, who is its president.

We'll ask you to make a 10-minute opening statement, and limit it to 10 minutes, after which we'll ask several questions.

I'm going to start with Mr. Page, to open with a 10-minute statement.

Mr. Jonathan Page (Chief Executive Officer, Anandia Labs): Thank you, Mr. Chair. Thank you to the committee for the invitation to speak on this important topic. It's really an honour for me to be here.

I'm a scientist who has worked on the cannabis plant for more than 18 years. My research is mainly on the biochemistry and genetics of this very fascinating plant, and I'm very familiar with its cultivation, both in a scientific context and then in the new commercial industry we have in Canada. I'm also an adjunct professor in the botany department at the University of British Columbia and am the founder and CEO of a cannabis testing and biotechnology company in Vancouver called Anandia Labs.

There's a lot to speak about, but I've confined my comments specifically to the subject of cultivation of cannabis, hopefully to educate and eventually answer some of your questions.

I think it is fundamentally important that this legalization include the ability to grow cannabis for personal use. I was happy to see that Bill C-45 included some provision for this. The cultivation of plants is a foundational aspect of human culture. In fact, the advent of agriculture via the domestication of plants has been one of the key forces in the creation of human societies.

Cannabis has been grown by humans for thousands of years as a source of food, fibre, and drug. Given the long-standing relationship between humans and cannabis and the fact that we will soon be allowing adults to consume it legally, it is important that the cannabis act allows Canadians to grow the plant. The absence of personal cultivation from the act, as for example might occur if the provision were stripped from Bill C-45 in response to pressures from law enforcement, would surely lead to Canadians facing fines or charges for the simple act of planting seeds.

I also think we are dealing with a relatively small number of people who may choose to cultivate, since most consumers of cannabis would rather purchase from a store. This is the same situation as with the home-brewing of beer or making wine. I suspect we will not see apartment buildings overrun by cannabis gardens.

The fact that Bill C-45 includes allowances for personal cultivation doesn't mean everything is fine. There are a number of points that cause me concern. Bill C-45 restricts the number of plants that can be grown for personal use, with a limit of four plants per household. I see the purpose of this restriction in that the ability to grow larger numbers of plants might result in diversion into an illicit commercial market. Indeed, all the limits of plant cultivation, including plant height, plant number, and seed possession limits, appear to have reduction in diversion as their main goal. However, these limits expose the awkwardness of applying strict legal definitions to a living organism, a plant, and might criminalize Canadians who are simply gardening.

The proposed limit of four plants per dwelling doesn't take into account the practical challenges in growing plants or the biological characteristics of cannabis. As I think every gardener or farmer knows, plants are difficult to grow and might fail to thrive or might succumb to disease. In growing tomatoes, one might sow a dozen seeds on a windowsill and select the foremost robust plants to transplant to the garden.

Cannabis plants may be male or female, with the male plants unusable as a drug. Without cross-seeds, which are a proportion of the seeds that are available, 50% of the plants will be males and therefore discarded. In many cases, cannabis cultivators maintain so-called “mother plants” to be used as a permanent source of cuttings, producing so-called “clones”, which are vegetatively propagated cuttings to be used for growing, and then have one or two plants in flower at one time. In my opinion, the cultivation limit should be adjusted to account for these non-flowering and non-producing plants required for normal cultivation practices. In fact, Bill C-45 already distinguishes between non-flowering and flowering plants. Therefore, I would propose that the act be amended to allow adults to grow perhaps 10 plants in total, of which four may be in flower. This allows cultivators the flexibility to grow for personal use without running afoul of the law.

I also want to address the limit on plant height of 100 centimetres, or about three and a half feet. Cannabis is a highly variable species, and I have seen plants of 30 centimetres that are flowering, and others that are several metres tall. The limit of 100 centimetres is potentially problematic from the perspective that cultivators might break the law simply by providing fertile soil and water and then going away for a week's vacation. Their plants might grow from 95 centimetres to 105 centimetres during that time. I wonder what the goal of the 100 centimetre limit is, which was also contained in the legalization task force report. Is it to reduce the amount of cannabis that each Canadian is capable of growing so they don't go on to sell it, or is it to reduce the visibility of plants grown on private property?

If it is the latter, I think this is best dealt with by municipal bylaws. If it is the prevention of diversion to the so-called black market, I would suggest that achieving this through enforced pruning is quite silly, and that the 100-centimetre height limit should be removed.

I also wanted to comment on the awkward treatment of cannabis seeds in Bill C-45. Cannabis seeds are individually smaller than a peppercorn, weighing about 15 milligrams each and are devoid of cannabinoids such as THC. Yet schedule 3 of Bill C-45 indicates that one seed is equivalent to one gram of dried cannabis. One gram of dried cannabis may contain up to 250 milligrams of THC and is fully usable as a drug.

Bill C-45 proposes that this is equivalent to a single small seed that is not useable as a drug at all. The possession limit in public is therefore 30 seeds or about a thimbleful. Since there will be limits on the number of plants that can be grown, this equivalency factor seems very arbitrary. Cannabis seeds for the purposes of personal cultivation should not be restricted at all.

The cannabis act also makes a distinction between illicit and licit products, which also applies to seeds and plants. Under the ACMPR, our current medical regulations, patients and licensed producers may only purchase seeds and clones from licit sources, yet most of the patients choose to source their seeds and clones from the Internet, store displays, and trade with other growers. All of these are considered illicit.

Licensed producers are also under very tight restrictions on the access to cannabis genetics used for starting their commercial operations. As any plant breeder will tell you, genetic diversity is important. The genetic diversity of cannabis is important for its future breeding and improvement.

We need to make sure that the regulations—I respect the fact that this may not be in the act itself but in regulations arising from it—need to allow broader access to sources of cannabis genetics without criminalizing growers who use their own heirloom seeds as starting materials.

On the commercial side, licensed producers also need to access a rich supply of cannabis genetics, which now exists in Canada and around the world.

I have a brief comment on quality-control testing. My laboratory in Vancouver does a lot of this work. Cannabis can be safely grown at all scales, and the cannabis produced by home-growers is no more dangerous than the tomatoes, basil, and lettuce that others grow at home. There are always hazards inherent in gardening, and careful application of fertilizers, manure, and pest control products is always advisable. That said, allowing everyone access to accurate quality-control testing by certified testing labs will help to ensure the safety of the product. This is currently the case for patient growers under the ACMPR, and access should be continued and expanded under legalization.

The last point I'd like to make is from my perspective as a scientist who has done research on cannabis for many years. My request to the government as legalization and regulations are crafted is to allow our scientists to work on cannabis. Cannabis is a plant that in many ways has been left out of mainstream science because of prohibition and restrictions on research. As far as I know, there are currently no Canadian university labs licensed to grow drug-type cannabis or marijuana. So we have more than 200,000 authorized patients as well as 56 or 58 licensed producers, and yet our universities are lagging behind.

On Monday in this panel, Dr. Mark Ware made a strong statement about Canada's leadership in cannabis research from plant science to clinical trials and epidemiology. I echo his thoughts and add that if we allow cannabis to be grown in our homes and sold in our stores while keeping it out of our university, government, and private-sector labs, then we will not maximize the benefits and reduce the negatives arising from legalization.

Mr. Chair, I conclude by saying that I support this bold policy move. The time for legalization has come. Bill C-45 is not perfect, but I am sure your committee will recommend changes for improvement.

Thank you very much.

● (0840)

The Chair: Welcome, Mr. Conroy. We're anxious to hear your opening remarks.

Mr. John Conroy (Barrister, As an Individual): Good morning. As a lawyer, it's always hard to confine oneself to 10 minutes; I'll do it.

To use the metaphor yesterday of travelling on the plane, I've been on this plane for almost 45 years. There have been a number of times when I thought we were going to run out of gas, with various other proposals that have come up in that 45 years, but I think we are coming in for a good landing. It's certainly not a perfect landing, from my point of view, but I think it's going to be a safe landing. We will have some bumps, obviously, along the road.

My experience with this started not long after I was called to the bar in 1972, when the interim Le Dain commission report was tabled. It recommended that the government hybridize, create summary conviction and indictable offences for trafficking back then. It's only just being proposed now, some 45 years later. It recommended the maximum penalty be five years imprisonment, not 14, as you are proposing now, some 45 years later.

In terms of the public education issue, there are studies that go back to 1894, the Indian hemp drugs commission, and you can take seven or eight royal commissions that led up to Le Dain before that. There is more information out there about cannabis than any other drug, if you want to use it for public education, which I understand is one of the concerns.

I was born in Montreal, but after a couple of years, my father, who got a degree in agriculture from McGill, went out to the colonies, so I grew up in central Africa. It wasn't long before I realized that some of the Africans smoked something called dagga, which was cannabis. Years later, my father told me that if he saw a marijuana plant up in around the tobacco plants, he would pull it up and throw it on the ground, as he was a consultant on the growing of tobacco.

I grew up in a situation where there wasn't this concern about cannabis as a problem. When I came back to Canada and started practising law in the early seventies, it wasn't long before I was in front of judges who would drink booze after court and pop Valium, but they would actually sentence people to prison for simple possession of cannabis and lecture them about it. The hypocrisy of what was going on, at that period of time, was something that certainly motivated me, in terms of the cases I was doing.

In those early days, we didn't have people growing marijuana. The market was coming in from Los Angeles, as Arlo Guthrie said, or we used to get it from Thailand, Colombia, and so on. They were all big import cases. It was only over time, with the ingenuity of Canadians, people figured out how to grow it indoors and create something called B.C. Bud, which became popular. We became an export economy after we had been an import economy for years.

I can remember one of my first growing cases was a young man who decided to grow a few plants out in his yard in Clearbrook, B.C. The police didn't know how to operate their own camera, so he helped take the pictures for them. When we went to court, they were actually dragging the plants along the floor and people were scooping up the material behind them. That was in the mid-seventies. That was the nature of what was going on, in terms of the production of cannabis in those early days, which has of course changed substantially ever since.

In those early days, I used to have drug squad, other police officers, and fellow lawyers come up to me and tell me I was trying to ruin a good thing by speaking out and that saying it was crazy for us to use prohibition on this subject. Now, at least I have the police coming up to me often, saying that they hope we win. Things have changed considerably since those old days.

I was counsel in R. v. Malmo-Levine and R. v. Caine, which was the challenge to prohibition, which went to the Supreme of Canada in about 2003. I incorporated the BC Compassion Club Society about 20 years ago and it's had senators, members of parliament, and many others go through it and compliment it on the way it operates, including the recent task force. I was also counsel in Allard.

● (0845)

You should have a five-page summary that I put together, as well an appendix, which are the excerpts from the court on the issue that you've asked me to address, which is the household cultivation.

I should step back and give you history, which some of you are probably aware of. When the BC Compassion Club Society first started, the patients had an authorization under section 53 of the narcotic control act, which at that time authorized practitioners to give, sell, administer, or prescribe any narcotic to a patient for a medical condition that they were treating them for. That was the basis for the Compassion Club, which was checked out by the police and everything in those days, and allowed to continue.

Subsequently, there was the Parker case here in Ontario, which determined that a medically approved patient had to be given reasonable access. When the government of the day ultimately determined that the marihuana medical access regulations, MMAR, was the way to do that, and that compelled people to.... The only source was for them to grow for themselves or have someone grow for them.

While we attempted to convince the government in those days that they should allow somebody to grow more so we would have fewer grows, they said you can grow for two, instead of one. We went back to court to say we should be able to have more in one place than just one or two grows, and they said you could have four. We did make efforts to try to have people grow for more people so we'd have fewer home-grows, but the number of home-grows went to some 38,000 by March of 2014.

That was the situation we were faced with when a new government decided it would introduce the marihuana for medical purposes regulations and take away that right to grow or the designated grower, which had existed for some 10 years. We went to court and got an injunction from Justice Manson in March of 2014. That basically allowed those who had a grow licence under the MMAR to continue to do so, as long as it was valid on September 30, 2013, and their authorization to possess had to be valid on the date of the injunction, which was March of 2014.

We then continued with the case, and ultimately Justice Phelan, in the Federal Court, ruled that indeed the new regulations were unconstitutional because they failed to provide reasonable access. The evidence from the patients was that they would go to a licensed producer, maybe get what they wanted the first time, and then get on a waiting list and be waiting to receive, in the mail, their medicine, which they needed. It wasn't working.

The evidence established that the patients voted with their feet and went to the dispensaries. There were only a few of those in the early days, the Compassion Club being one of them. However, suddenly there was a huge increase in the number of dispensaries, because those people in the business of trying to sell cannabis and make money out of it figured out that this was where to go. The same then happened here in Ontario, particularly in Toronto. The surge in dispensaries occurred, and it established—I think as Jonathan Page said earlier—that most people don't want to grow for themselves or have somebody grow for them, they want to be able to go to a store to purchase and get information and not just wait to get it in the mail. That's the current situation.

I have a minute, so I'll just jump to the topic.

In the context of that case, which deals with the entitlement of medically approved patients to have reasonable access and includes their ability to grow, we were faced with the police, Corporal Holmquist, and Chief Len Garis from Surrey, vocal opponents of home-grows, going on about fire, mould, public safety, and so on. We established, as we do in trials after examination and cross-examination of the witnesses, that they lacked credibility totally. Justice Phelan found that Holmquist was totally biased and not to be credited, as was Chief Garis. We clearly established that all of these things in a legal market can be reasonably and safely done. All of the evidence they relied upon was from the illicit market, where people were cutting corners, staying underground, and not complying with anything.

● (0850)

Today, the inspectors I deal with in local government tell me that the last thing they want is to go back to those old days.

The big issue nowadays is not a great problem in terms of fire, electrical safety, mould, and so on. They're very easy to deal with. The most common complaint is smell, so stinking out the neighbourhood or not impacting your neighbours is the critical thing that needs to be addressed.

I want to very quickly, then, close by saying that Mr. Dickie and I managed to chat a bit before coming in. He represents the apartment owners and I support what he says in the sense that, again, you don't want to allow people to do things where they may put their neighbours at risk or impact negatively on their neighbours. But you can't just sit back and say, well, then, we're going to prohibit it, because that will not work. It hasn't worked for as long as I've been practising.

I think you're going to have to look at Washington state community gardens, or something. Most people don't have a dwelling-house, as the act defines it, with some land surrounding it, and so on. You're going to have to figure out something so that they'll be encouraged to do it in a safe place. We do have bloom boxes, which are engineered solutions, but most people can't afford them and they'll take up most of the apartment.

I think reasonable regulation is what we want, but we're heading in the right direction.

Thank you.

● (0855)

The Chair: Thank you very much.

Now we have, from the Canadian Federation of Apartment Associations, Mr. John Dickie.

Mr. John Dickie (President, Canadian Federation of Apartment Associations): Thank you, Mr. Casey. I appreciate being invited to speak here, and I'm glad to do so.

As the president, I'm really the executive director of CFAA. I'm also their housing policy analyst and their government relations specialist.

Our association represents the owners and managers of close to one million rental homes across Canada. The total rental sector across Canada consists of close to four million rental homes. They range from close to one million apartments in high-rise buildings, a little under two million apartments in low-rise buildings, and then various other low-rise rental units—duplexes, triplexes—and some 525,000 single-family homes that are rented. You can drive down a street in a city and think it consists of owner/occupiers, but, in fact, depending on your city—in Toronto six or seven of those homes may be rented even though they're single-family homes, and in other cities it may be one or two or three or somewhere in between.

Let me give you a bit about me, as well, as Mr. Conroy did. I'm 61. I grew up in Montreal, and I remember the Le Dain commission. I remember how remarkable it was that the government had given Mr. Le Dain, they hoped, the job of condemning marijuana and what the young people were doing, and Mr. Le Dain and his commission came back and said that non-medical use of drugs was not the biggest problem, and that it was alcohol. It was a little bit shocking to a number of people at the time. As I've grown up, I certainly have experienced people using marijuana, and some of them use it and there's absolutely no harm whatsoever. I know a fine young man who uses it in that way, smokes it once a week, and he's fine. My daughter, on the other hand, also dated a person who was also a fine young man, except that he is now afflicted with schizophrenia, and that may have been brought on because of his smoking marijuana as a teen. There's a whole range of reaction to this and the way it works.

One other bit of personal background is that besides representing CFAA, I am by profession a lawyer. I, in fact, am one of the experts on residential tenancies law in Ontario, and with my law partner I've written one of the leading texts on that subject. So Ontario residential tenancies law I know extremely well. The residential tenancies law of the other provinces I know reasonably well as well.

I'll go back to multiple-dwelling units. Multiple-dwelling units are a living environment that is different from single-family homes. In a single-family home essentially what you do really affects only you and your family. It doesn't affect other people, whereas in an apartment, what you do very much affects other people, and affects your neighbours. That has to do with noise. It has to do with anything that produces smells in your apartment, and certainly safety in your apartment. If as a homeowner you break the rules and don't have a smoke alarm, the people you're going to kill are you and your family. If you don't have a smoke alarm in your apartment, you may very well kill half a dozen people in a building. Landlords are empowered to stop those activities that are safety hazards or that interfere with the neighbours.

It used to be that second-hand smoke fell into the category of an interference that no one could address. People just had to put up with it, but that's not the case anymore. I know we're not here to talk about smoking, so I'll leave that subject, but it is certainly a concern for our members and neighbours of people who will be consuming marijuana by smoking it as opposed to ingesting it.

The various provinces have a number of bans on smoking tobacco. I would certainly hope that they would ban smoking marijuana in those same locations, such as the common areas of apartment buildings in Ontario. But that's a provincial matter and this whole business is very complicated because of the provincial-federal interface.

Our position, as an organization, is that we would like to see more restrictive limits on growing in rented dwellings in order to protect the owners' interests and the neighbours' interests.

● (0900)

At best, we would see a federal ban. It probably doesn't need to be an offence subject to a term of 14 years of imprisonment, but a federal ban would be our first preference. That is because of the fire safety issues with electrical overloads, the humidity—and so, safety to the building—and certainly the smell through cultivation and its impact upon the neighbours.

That would be our first preference. However, I'm here, and all of that is set out in the submission, with information that comes from the website ilovegrowingmarijuana.com. Until 12 months ago I wasn't much of an expert on marijuana, but I certainly went to that site and found it extremely informative. I found what in law one would say are admissions contrary to interest. If the marijuana proponents say there's a problem, well, there's a problem, and they say there's a problem with smell and a problem with electrical, and they say there can be a problem with humidity.

There are ways to address those things, but they all involve changing the physical building, whereas our buildings are not built to do that, and we are not mandated typically to change our buildings to address those things, other than in the case of accommodation under the Human Rights Code for the medical users. For the medical users we may have to do certain things, but for recreational users we're not required to make those changes. At least, we never have been before this law came forward.

In terms of compromises or suggestions, as a kind of fallback position I think our members would be willing to see a regime in which growing was allowed in rented dwellings with the consent of the landlord. Then you could have landlords who had smaller buildings or weren't worried about the ventilation or had good electrical systems who could allow it. Tenants who want to grow would be able to find their accommodation there. On the other hand, landlords who aren't able to deal with this situation, who aren't willing to invest the money, and who aren't willing to disturb their other tenants could decline consent.

Beyond that, the federal legislation could enable the provinces to establish a regime to make that a practical reality. One regime would be a regime the provinces could establish in which the landlord's consent could be dispensed with. In other words, a tenant could come forward and say, “Well, landlord, you're refusing your consent unreasonably. Your building has good electrical, there is no humidity problem, there isn't this problem. My neighbours on both sides of me say it'll be fine.” Presumably, the landlord and tenant board would say they were going to dispense with consent and then provide a solution dovetailing with that. The person could then legally grow marijuana in his or her apartment, subject to size limits.

The flip—again, it could be left to the provinces to decide which way to do it— could be that the provinces establish a regime whereby, if a landlord wished to prohibit growing marijuana in his or her building, the landlord could apply, presumably to the landlord and tenant board, to say, “Listen, my building can't cope with this”—the electrical system, etc., ventilation, a petition of the tenants in the building—“so I should be allowed to prohibit marijuana”.

Again, it'll be a little trickier to do, but we have some pretty smart people in this room and pretty smart people working on this bill. I'm sure a set-up in which the provinces were able to do that fine tuning to address the problems that really do exist and that the Allard decision found would be a positive outcome.

The last thing I'd like to suggest by way of a compromise is this. We are concerned that the four-plant limit is not a sufficient limit. We've heard from Mr. Page that people should perhaps be allowed more than four plants. My concern is that if they're allowed four plants or whatever number and they go to ilovegrowingmarijuana.com, they'll soon find that you can use a screen-of-growth technique. You can put a screen across the top of your plant; as it grows up you can nip it at the top. You can bring it out and you could be filling an area from the end of this desk to past where Mr. Page is sitting or to the end of the table, full of marijuana leaves—off four plants.

Surely that's not a good thing. Surely when the government is thinking and Parliament is considering four plants, you mean four plants—a plant here and here and here—you mean about a cubic yard. We would suggest that as well as whatever plant limit there is, whether it be four, six, or whatever, there be an area-of-growth limit.

● (0905)

We would suggest a cubic metre because that would pretty much cover it. One, it would address Mr. Page's concern about a higher plant; and, two, it would cover a higher plant, two plants in mid-stage, and a small plant. It would admittedly be a little more difficult to administer, but no one is going to be charged with an offence with possibly 14 years of imprisonment if they're growing 1.2 cubic metres. It's going to be pretty clear, if it's more than 1.5 cubic metres, how big it is. The police can take a metre stick, put it there, and take a photograph of the plants as they're growing, and then at the end of the day you can prove in court, whoa, they had a grow area of four cubic metres, or six cubic metres, and that's way beyond the limit.

That would be my suggestion in terms of limiting the amount that is grown.

Thank you very much.

The Chair: Thank you very much.

All right, this is going to be interesting.

We're going to go now to the question period. We'll start with Mr. McKinnon for a seven-minute round.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Mr. Page, you indicated that height might not be a good restriction, but you understand our desire to limit possible diversion. What would a good restriction be?

Mr. Jonathan Page: I've given this some thought. Is it that 1.5 metres or two metres would encompass the majority of plants grown now? I think that is the case, so we could double or increase that grow limit by 50%. That would likely catch or encompass more of the typical growing, including outdoor cultivation.

One of the issues is that cannabis is, in a technical term, photoperiod-sensitive, which means that it flowers when it is exposed to short days. If you're growing cannabis inside, you can make those short days occur just by the flick of a timer or a light switch and force it to flower at 60 centimetres, or 80 centimetres, or a metre or more.

Outside, on the other hand, the day length is, of course, determined by the season. With outdoor cannabis production in Canada now, the flowering starts in August and it might continue through September. Depending where we are in the country, in fact, harvest might be some time around Thanksgiving. What's happening during those long Canadian summers is that the plant is getting quite tall. If we allow outdoor cultivation for typical climates in Canada, we might be approaching a two-metre plant height, or even a little taller, by the time flowering occurs.

Of course, as I said, you can enforce pruning, and people can bend their plant down, or something. However, in general, if you have a limit, a plant number limit, if it's four flowering plants and a few more to tidy up the gardening issues as I suggested, that can be the limit. In terms of what people do within those four plants, if it's 1.5 metres or two metres, or even 2.5 metres, I'm not sure we should be that concerned also about the 100 centimetres or a height limit.

The task force came up with the suggestion of 100 centimetres and I was puzzled why that was. I think it had a lot to do with screening plants in cultivation in people's backyards. The height of a typical fence in Canada is about four feet, by city bylaw, and that would screen out those plants at 100 centimetres. As I indicated in my submission, allow the cities to enact those bylaws. I would just toss out the plant height restriction.

● (0910)

Mr. Ron McKinnon: Even though I remember the sixties, I don't know much about the growing of pot. What kind of life cycle is involved here with the plants? How long does it take to grow a typical plant?

I keep hearing about smell as a problem. We keep hearing about potential problems with mould and property damage. I've heard that growing pot is like growing tomatoes. That doesn't seem to cause a problem with mould and property damage. Maybe you could expand on this area.

Mr. Jonathan Page: There's a lot of variability in the approach. If you're an indoor cultivator, you're sort of force-flowering the plants, so to speak. It might be a cycle where you would plant a seed or establish a cutting, and it might grow for four weeks, or something, and then you would trigger flowering, and then there would be a flowering period of about eight weeks. It's about three months in total, sort of seed to harvest, in typical terms.

Outdoors, that might be longer, because you would potentially plant in May, when you would plant tomatoes, around the Victoria Day long weekend, and be harvesting later in September. That would stretch out that growing season to more than three months, or a little bit longer.

In terms of the smell, cannabis has a very distinct odour, whether it is smoked or grown. This is not due to THC but rather due to the terpenes, the sort of volatile components of the plant. They are the same chemicals that give mint, lavender, and basil their smell; those are also terpenes. They have quite a powerful odour. In terms of indoor cultivation, they can be controlled with appropriate ventilation or appropriate filtration. You can have charcoal filters to remove the smell. It is a little bit more complicated than tomatoes, in the sense that tomatoes don't smell as much.

Some of the issues are that people are pushing larger numbers of plants into closets in their apartments or dwellings, and that smell, in that intense light, in the indoor confined space, is difficult to control.

Mr. Ron McKinnon: Is it possible to tell if a plant is male or female before you see flowering? How soon might you see flowering in a plant?

Mr. Jonathan Page: There are a few options there. One is that, if people are growing from clones, the plants are cloned from female plants. That's one thing. Feminized seeds are also available. These are seeds that are produced to only give female offspring.

There are more molecular methods to determine males and females. For example, my lab offers a test that you can test at a very early seedling stage. Generally—and again it's all about the sort of light regime—you can detect males within several weeks of the triggering of flowering, and then they start to produce a different floral structure that can be identified and they can be removed or....

Mr. Ron McKinnon: If I walk into a home that has a number of green things, if I'm a police officer, I don't necessarily know if they are male plants or female plants.

Mr. Jonathan Page: No. At the seedling stage, in plants that are grown from seed and are 40 centimetres high or something, the males and females would be virtually indistinguishable.

● (0915)

Mr. Ron McKinnon: In terms of controlling the numbers of plants—we're not counting seeds, necessarily, but a seed becomes a plant. What would be a good determinant for saying this is a plant and this is not a plant? If you had a bunch of small shoots coming out of the ground, is that something you want to control by numbers, or do you need to have a minimum size to say that this is a plant that we're counting?

Mr. Jonathan Page: At this point I think everything counts as a plant under the Controlled Drugs and Substances Act. Seeds are cannabis plants, and they are restricted. Importation is restricted; sale is restricted. I believe it's the case that under the current laws if you take a cannabis plant, and take cuttings from that plant, and they start rooting, those are also considered plants from the perspective of being charged with plant numbers.

That's that the current case. If an organism has leaves and it's growing beyond the seed stage, it probably is a plant.

The Chair: Okay. Now we go to Ms. Gladu.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair.

My first question is for you, Mr. Page.

Are you familiar with the type of testing and quality control that the medical marijuana operations, the larger facilities, do?

Mr. Jonathan Page: Very familiar. My lab offers that as a service.

Ms. Marilyn Gladu: Can you describe some of the things in terms of testing for potency, contamination from fertilizer, mould, and that sort of thing?

Mr. Jonathan Page: There are five or six core tests within the ACMPR quality control measures. As you mentioned, potency; the presence of heavy metals; aflatoxins, which are fungal toxins produced through spoilage; bacteria and mould; and pesticides. The sixth area in the case of extracts and oils is residual solvents. It's an add-on measure.

Ms. Marilyn Gladu: Okay. What kind of quality control testing do home growers typically do?

Mr. Jonathan Page: At this point under the current medical regime under the ACMPR and since last August patient growers are able to access Health Canada certified labs in order to have their product tested. However, it's not required so it's their option to access those labs and pay for the tests.

Ms. Marilyn Gladu: Okay. Very good.

I have a question for you, Mr. Dickie. I see this article. There was a 2010 RCMP report on medical marijuana grow operations that shows fires are 24 times more likely to occur in homes with grow operations than those without, so I would think there is a huge concern about fire damage.

I also know when we talk about second-hand smoke, in the U.S. there are an estimated 34,000 premature deaths from heart disease due to being exposed to second-hand tobacco smoke, and they report that marijuana smoke provoked even bigger effects than tobacco in their lab studies.

My question has to do with the rights of the person who owns the property. If I own a property, and I'm worried that I'm going to be more likely to have fires, or maybe somebody's renting the basement from me, and I don't want to have the second-hand smoke problem, does the homeowner have the right to prohibit people from smoking cannabis with this current legislation?

Mr. John Dickie: That is a question that would vary by the province. Let me rephrase that slightly. Across Canada, landlords on first renting could impose a ban on cultivating and/or smoking. However, enforcing that ban would be relatively easy in the Atlantic provinces and in the west from Manitoba west.

In Quebec and Ontario, it would be difficult to enforce because in Ontario, where I have the most familiarity with the law, it is very clear law that a landlord cannot.... The way a landlord enforces a termination of the lease is by giving a notice and then bringing eviction proceedings. You don't necessarily want the tenant to go. You want them to stop doing what they shouldn't be doing, and the way you do it is with a notice of termination. It is not possible in Ontario to give a notice of termination for merely breaking the term of a lease. Merely to prove the smoking when it's banned in the lease, the growing when it's banned in the lease, will not get a landlord what they want. The tenant can basically flip them the bird.

To enforce the term in the lease, the landlord needs to demonstrate a substantial interference with the reasonable enjoyment of other tenants, or with the lawful rights and interests of the landlord. The first one is easier to do, although it's not easy to do. It requires bringing other tenants as witnesses to the landlord and tenant board to give their evidence about how they have been impacted.

You can understand people don't want to do that because they are living right next to this person, they are going to see them in the hallway, the person may crank their TV at night as the least of what they might do in retribution, and they are just uncomfortable doing it. They don't want to do it.

Ninety per cent or 95% of the steps landlords take to address tenant behaviour is, in fact, to protect other tenants in the building. In Ontario, thanks to Ontario's landlord and tenant law, it would be much easier to enforce against an illegal act than to enforce a lease term.

● (0920)

Ms. Marilyn Gladu: Right. If I understand correctly, it means if we allow home-grow under this legislation, then in Ontario and Quebec landowners will essentially lose the rights over their own property to keep people from home growing and smoking it there.

Mr. John Dickie: The only way they would not do that would be if the provinces added violations of those terms or that behaviour as a ground for termination under, for example in Ontario, the Residential Tenancies Act. Again, Ontario might do that because they look like they want to drive everything in the sales by the LCBO—heaven help us all—but that would be very much contingent on what Ontario and Quebec did.

Ms. Marilyn Gladu: It's good to know.

Mr. John Dickie: And it would also be contingent—in some of the other provinces, in the Atlantic provinces or the west—on how the boards reacted to this. It's certainly the case law that for mere trivial breaches of the lease, the landlord cannot terminate. So if the view is taken that, oh well, the federal government has made this legal, so it's legal, it's trivial.... Say someone is growing five plants. I doubt that even in Atlantic Canada or the west a landlord would get a termination for five plants, perhaps even six plants if the limit is four, because it would be regarded as a kind of minor breach, a minor violation.

Ms. Marilyn Gladu: It's concerning to me because apartment 801 here in Ottawa smokes so much marijuana that I get second-hand smoke exposure every time I come home, so it is a concern.

I have a question for Mr. Page.

Are most people growing plants inside or outside in their home-grows?

Mr. Jonathan Page: I think in general it's inside, partly because of security, and the fact that, if it's a medical grow, they're worried about people taking that, and if it's an illicit grow, they're worried about police or others seeing it. So I would say indoors, but it's very hard to get statistics on a very grey, nebulous world.

The Chair: Time's up.

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you.

Thank you to the witnesses for being here.

Dr. Page, in your submission to the committee, you pointed out that among the task force's six specific recommendations was promoting “environmental stewardship by implementing measures such as permitting outdoor production with appropriate security measures.” Despite these clear directions, as of yet there has been no indication from the federal government that outdoor production of cannabis will be part of the new cannabis regulations.

So my question is, is that the case? It's unclear from Bill C-45 whether outdoor production will be permitted, and if so, is it your opinion that it should be allowed, and why?

Mr. Jonathan Page: I'm not clear on whether Bill C-45 restricts indoor or outdoor.

Mr. Conroy.

Mr. John Conroy: The definition of a dwelling-house in the cannabis act includes the land contiguous surrounding the premises and any outbuilding on the property.

Under the medical regulations, you can only grow indoor or outdoor. They won't let you do both, which actually doesn't make sense in some cases where people want to start indoor and go outdoor and then come back indoor, especially if you live in the west coast rainforest, but it appears you can do it outdoors under this bill.

Mr. Don Davies: Would that include community gardens?

Mr. John Conroy: No, it doesn't. That's why I think there's this problem with apartments that don't have an area where somebody could do it besides their apartment, so you need to give them the carrot to be able to do it somewhere else, rather than do it in the apartment, by creating the community garden.

● (0925)

Mr. Jonathan Page: Back to your question about outdoor and sustainability, the submission you referred to is one that I did as a team, not the one I'm doing as a witness here.

It really highlighted the issues around the carbon footprint of indoor cultivation on a commercial level, but less regarding the four-plant, personal production area. That is, when you put a large cannabis production facility in a concrete bunker, put it under intense lighting, and have HVAC and all the air control to do that, you have significant power needs. You've built a concrete structure maybe on farmland or something, so there's an ecological footprint to that industry, and you know, cannabis is a plant. It doesn't need intense sunlight. It can grow in a greenhouse. It can grow in the field as hemp does now with sunlight, and so the argument would be that the regulations arising from Bill C-45 should allow outdoor growing as well.

Mr. Don Davies: Oh, I see. So you mean for production, for producers who apply to the federal government for a licence to produce cannabis, you're saying that it should be explicit that outdoor growing would be permitted.

Mr. Jonathan Page: Right, exactly, and currently, under the ACMPR and the MMPR before that, outdoor production is prohibited for commercial purposes under the medical cannabis regime.

Mr. Don Davies: Thank you.

I want to get your thoughts on labelling, Dr. Page. We haven't had a lot of testimony on this. As someone who understands the properties of cannabis, what aspects of cannabis do you think are properly of interest to consumers? I'm thinking beyond just THC levels, or CBD levels. What other things might a consumer want to know about the product?

Mr. Jonathan Page: THC and CBD levels, of course, are the main drivers of the pharmacological activity. That's what we label for medical cannabis at this point.

Other aspects would be the terpenes I referred to before, so those would be the smell and flavour components. One can see that labelling might, in a limited way—because we don't want to get into a list of a hundred chemicals that have to be parsed by a consumer—give us some information around the terpene composition of the product.

There are also other cannabinoids also present. THC and CBD are the two main ones, but we often see large amounts of cannabigerol, CBG, or cannabichromene, CBC. I would suggest also including information on the presence of some of the other cannabinoids that in certain products might be higher than a baseline.

There is also this whole focus in the cannabis world on strains and genetics and the origin of the material. There is a widespread classification between *sativa*-type plants and *indica*-type plants, which hasn't really stood up to scientific scrutiny at this point, but there could be labelling around the sort of genetic type of plant as well.

Mr. Don Davies: Thank you.

I'll turn to Mr. Dickie.

I come from Vancouver. Another high irritant for people is the smoking of cigarettes and tobacco inside apartments. Interestingly, this bill, if passed as is, does not legalize edibles, so it will be promoting the smoking of marijuana in apartments.

Is it your view that it would be better from a multiple dwelling point of view that people have the opportunity to consume their cannabis in a non-smokable form?

Mr. John Dickie: Yes, absolutely, especially for medical users, but for everyone we would strongly support that. There are some health concerns in terms of children getting at it but, hopefully, that would be a limited problem and could be addressed in a careful way. To avoid second-hand smoke would be huge for all kinds of people.

It's ironic, the extent to which we are now being pushed, as landlords, to limit smoking, and the non-smokers' rights people are after us constantly to make our buildings tobacco smoke-free, yet this is kind of opening the whole thing up to smoking marijuana.

● (0930)

Mr. Don Davies: Thank you.

Mr. Conroy, I want to turn to you. To both Mr. Dickie and Mr. Conroy, thanks for bringing up the Le Dain commission. The NDP has been actively pushing for decriminalization for the last 40 years, since the Le Dain commission, so it's nice to see that we're finally here.

I want to talk about pardons a bit. Mr. Conroy, your whole career has been spent looking at the stigmatization and negative impacts of criminalization on people's lives and this bill will actually continue to criminalize people, and we're criminalizing people right now.

What is your advice to this committee on how we might approach pardons for Canadians who are maybe carrying around convictions today for things that this bill will now render legal?

Mr. John Conroy: I clearly feel that if you're going to make conduct legal that in the past was illegal, you should also then address eliminating those prior criminal records, and so on. You certainly are making a mistake, I think, in not looking at the existing industry and saying we're going to regulate them as opposed to trying to push them out and create a whole new group of people doing it, such as in the Ontario liquor stores.

The whole idea, as I understand it, is to try to eliminate the black market. That's what legalization is. Home-grows will reduce the black market, but stores reduce both home-grows and the black market. Just because somebody has a criminal record or has been convicted in the past, it should not be a bar, in my submission, to their being able to participate in this market. We should take steps to enable them to eliminate things.

The Criminal Records Act is what governs the pardon situation and there have been recent decisions that have pointed out that the ability to get a pardon is determined by the date of the offence. As a result, we've ended up now with a situation where, depending on how old your offence is, different rules apply under the Criminal Records Act compared to what's in the current version of the act.

Mr. Don Davies: Thank you.

The Chair: Thanks very much.

Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

I would like to thank our three witnesses for being here.

One of the advantages of living in a country like Canada is that there are three levels of government. Co-operation among the governments is always a challenge, but it is also a great advantage.

The federal level being what it is, and the provincial and municipal levels being what they are, our challenges and advantages are precisely that we can trust each other and work together to improve legislation. The federal government provides a framework, based on a vision to be able, in this case, to legislate on cannabis. When this new legislation applies more locally, provincial autonomy is particularly important.

Mr. Dickie, you said that eastern Canada, western Canada, Ontario and Quebec were facing different challenges. Isn't it true that they can legislate according to the will of the province in order to adjust this legislation in terms of the number of plants, particularly for dwellings? Already some apartment owners prohibit their renters from having pets or from smoking. Some cities prohibit ownership of pitbulls. There has been some heated debate about pitbulls recently in Quebec.

There is municipal autonomy and provincial autonomy. I would like to hear what you have to say in this regard. Do you think that this autonomy could help to solve more specific problems?

● (0935)

[*English*]

Mr. John Dickie: Well, it seems to me that the federal government is legislating in this area, in part because of its power over criminal law. I realize that with respect to criminal procedure, there are differences in the different provinces, but with respect to criminal law, for the most part, it is uniform.

I think there is some value in uniformity on the basic prohibitions, in part because people do move around Canada quite a bit, and it seems to me it would be quite onerous for someone who grows up in one province where they're allowed, say, eight plants, who then takes a job somewhere where they're only allowed four plants, and to grow five plants risks 14 years of imprisonment, yet they don't know. I think that on the basic prohibition there should be uniformity.

With respect to procedures for allowing consent to be given or to be dispensed with, for example, I think that could well be a provincial issue, because it is already. That issue comes up with respect to other aspects of landlord and tenant law.

Mr. Ramez Ayoub: That's why I said, "*C'est un cadre*." They can go lower, but they can't go higher than the maximum.

Mr. John Dickie: I see.

Well, in that respect that might be a partial solution. Certainly, as I understand it, the provinces, under their power with respect to civil property and civil rights, could in fact ban the home production. They could ban various forms of cultivation. They're being given the power, I think, to regulate the production and distribution system, so they could be given the power to make more restrictive rules.

[*Translation*]

Mr. Ramez Ayoub: Thank you, Mr. Dickie.

Mr. Page, I would like to take advantage of your expertise on growing marijuana plants. In short, there are two opposing points of view.

On the one hand, we do not want to regulate the number of plants. The intention is to permit the cultivation of cannabis in the same way as there is no limit on the number of tomato or tobacco plants. There is no limit on the allowable quantities. It can be grown as long as there is land or soil, no matter where. On the other hand, we want to ban the individual cultivation of cannabis completely.

Is there no middle ground? Isn't there an intermediate solution where people can grow cannabis? Is it too complicated to legislate on the height? These are rather complex details to manage. I must admit, managing the cultivation of cannabis has a certain complexity.

How does it work between these two extremes? I would like your opinion.

[*English*]

Mr. Jonathan Page: I do think that we can strike a balance between a free-for-all, wide-open "You could plant 10 acres of cannabis if you wanted to," and very restrictive limits. What I was getting at before was that I do agree that some plant limits for personal production are appropriate. We do see those in, say, U.S. states like Colorado and Oregon, where cannabis legalization has occurred. It is often six plants, not four.

I guess where I was going is that we want to have a limitation that also takes into account the cultivation realities of cannabis, the idea that you could have a limit on the number of plants in flower, which are really the producers of the drug. If that were to be four plants in flower, I think I could support that. There should be some sort of leeway so that you could have these additional four or six plants in a vegetative state, a non-flowering state.

● (0940)

Mr. Ramez Ayoub: I have just one more question. I don't have a lot of time.

Is it easy to cultivate cannabis? I have never grown cannabis in my home. Is it as easy as tomatoes?

Mr. Jonathan Page: Yes, it's as easy as tomatoes, though a lot of growers make all sort of complexities with cuttings, hydroponics, and all this kind of stuff.

In general, it's like a weed. It grows easily.

Mr. Ramez Ayoub: It grows like that.

Mr. Jonathan Page: Where I was going though was my recommendation around plant height: that's a hard one to regulate. The plant does grow. Limit the number of plants and maybe the number of flowering plants, but after that, do not get into this idea that if we hit 100 centimetres, that's suddenly illegal.

Mr. Ramez Ayoub: How can you regulate that? Is there a way to regulate that?

Mr. Jonathan Page: As your colleague asked before, could you expand that to 150 centimetres or 200 centimetres and encompass more of the typical growing that might occur, and therefore Canadians wouldn't be offside if their plant has sort of inched up in those directions?

I would say that police carry guns and all sorts of handcuffs and things; do they have to have tape measures as well? That's sort of where we're going with 100 centimetres. Just count the number of plants, and don't worry about how tall they get.

Mr. Ramez Ayoub: Thank you.

The Chair: The time is up. Thanks very much.

Now we're going to our five-minute round.

Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): We'll go with Mr. Carrie. I'll go next time.

The Chair: Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair.

Again, you are fascinating witnesses. I wish I had more time. I have a lot of questions for you.

There are a lot of things we've agreed upon, I think, with some of the witnesses coming forward, but home cultivation is one that there's not a lot of agreement on. I think it's important to point out that cannabis isn't tomatoes. It's not aloe vera. It's not carnations or roses. According to the CMA and the Canadian Paediatric Society, it is potentially dangerous, especially for our young people.

Like you, Mr. Dickie, somebody close in my life developed schizophrenia and lifelong psychological problems that have been attributed to cannabis use. I'd like to bring it down to talking and listening to my constituents, who have concerns about these. I have mostly talked to individuals and small business people—or as the Liberals call them, tax cheats—but one lady came in to see me and identified herself as a former drug user. She identified herself as addicted to marijuana and it took her many years to get off it. She lives in an apartment, an older building, and she is concerned about the smell. She's concerned about how it's going to affect her. This is an extremely difficult situation because now with the government legalizing it, we have the rights of one group, recreational users, and then the rights of others, owners and neighbours who may be in apartments.

Mr. Dickie, I was wondering if you could maybe give us an example. How are governments going to manage the competing interests of the rights of one group versus another group, and historically how has that played out?

Mr. John Dickie: Typically it's a question of this test of substantial interference with reasonable enjoyment. There has to be not just an interference with the other person's enjoyment, but a substantial interference. Medical problems will meet that test. If someone has asthma, someone's affected, or if someone coughs when they smell smoke; it's those kinds of things. Then the question is about the reasonable use. In other words, say if someone is playing the piano loudly at 7 p.m., or playing the bagpipes, God forbid—although I'm a Scotsman, by heritage at least, so everyone should love the bagpipes.... I'm sorry, I'd better go back to the piano, because the bagpipes probably would be a substantial interference; but with the piano, if someone wants to sleep at 7 p.m., it's kind of too bad. People get to play the piano at 7 p.m., but they don't get to play the piano after 11 p.m. Now with smoke, it's not that easy because smoke you can't adjust. You can't separate the interests by the time of the day. What typically happens now is that smokers are required to take steps to minimize their interference. Maybe it's to smoke on the balcony. Maybe it's to smoke on the side of the apartment that's away from the person who has the problem. Maybe it's to run a fan to push the smoke out of a window.

● (0945)

Mr. Colin Carrie: For somebody who's a former addict, for example, the onus would be on her, then, to get out there. If one of her neighbours is growing marijuana, and the smell is maybe triggering her, she was really concerned about falling back into—what she said—her addiction.

Mr. John Dickie: Yes. She could certainly address the issue herself, but that takes a certain fortitude to do. She can, I think, in most of the provinces go to the landlord and say, "Look, the neighbour's interfering with me; will you please do something about it?"

Mr. Colin Carrie: Can you see landlords—

Mr. John Dickie: But that's when it gets into whether the landlord has the right, because remember that 90%—well, hell, it's 99% right now—of leases do not prohibit marijuana smoking or marijuana growing. They didn't have to, because it was in the law.

Mr. Colin Carrie: Yes.

Mr. John Dickie: Effectively, the legal regime of today is going to be turned on its head. Gradually landlords can take it back through a lease prohibition, but again in Ontario and largely in Quebec, you cannot impose a new lease term on a tenant. So there will be all those grandfathered leases where the landlord doesn't have any right under the lease.

Mr. Colin Carrie: Again, some of my constituents are retirees who are renting out. Could you foresee landlords, then, being hit with huge bills to comply with these conflicts? I know that Ontario just rolled out its plan, and a lot of people thought that landlords could simply prohibit homegrown marijuana in leases. What you've said is that, for some of these grandfathered leases, this is going to be very problematic for certain people. Did Ontario put anything in its plan, that you're aware of, that will help in settling these issues for home cultivation?

Mr. John Dickie: As to the second question, no. I don't think Ontario has focused on this either. People tend not to get this distinction between rental dwellings with these other competing interests and detached homes. As to the first question, the question of damage, yes, Ottawa, for example, has a marijuana grow op remediation bylaw, and there is within it no test.

Any grow op could trigger a report by the police to the city, which then triggers the city to go to the owner and say, "you had marijuana growing in your unit or in your dwelling that you own. Prove to us that there's been no damage." One would hope the police would not go with six plants or eight plants or 10 plants or 12 plants or whatever. But if the police go with that, then that owner is basically looking at $10,000 of expert reports from engineers, air quality control, and electrical safety to prove there's been no damage to the unit. Plus they're on this registry, which might knock $10,000 or $20,000 off the value of their house.

Mr. Colin Carrie: So these small-business owners most likely will be negatively affected by these changes in the law. That's what you're saying?

Mr. John Dickie: Absolutely.

Mr. Colin Carrie: These "tax cheats", I should say. We have to keep that type of thing straight.

The Chair: Time's up.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Chair.

Yesterday we heard that home cultivation would make it easier for you to access cannabis.

Mr. Page, could you explain to us what would be the impact on children or youth of eating the raw leaves of a cannabis plant?

Mr. Jonathan Page: That's a good question.

The leaves of the cannabis plant are not typically consumed by someone who wants to get high. It's the flowers that are rich in THC and other cannabinoids. The reason they're not consumed by people interested in getting high is that they contain very low levels of cannabinoids. So the classic sort of pot leaf that you see on people's T-shirts and things like that doesn't have a lot of THC or CBD cannabidiol in it.

With regard to the impact on children—and I'm a plant scientist, not a medical doctor—I'm going out on a limb a little bit, but just on the basis of the plant chemistry, if kids eat cannabis leaves or a small cannabis plant, not a lot of cannabinoids are going to get into their system and affect them.

On the other hand, if the plant is flowering and it is that THC-rich material or CBD-rich material, they could ingest it and receive a dose of that. It gets a little technical here. The plant actually doesn't make THC. It makes an acidic form of THC. So tetrahydrocannabinolic acid is the form the plant makes and you actually have to heat it to form THC, which is why smoking a joint or baking a brownie or something is required.

If a child were to eat the raw bud of cannabis, they'd get mainly the acidic form, which is non-psychoactive. The fresh material is not capable of getting you high. You need to bake it or heat it or smoke it to get there.

● (0950)

Ms. Sonia Sidhu: Thank you.

Presently, the illicit market is 100% controlled by criminals, with an estimated $7 billion in income annually for organized crime. Furthermore, the cannabis being sold today is unregulated, untested, and often unsafe. How has allowing homegrown fought this illegal market? Can you explain that?

That's for Mr. Conroy or for both.

Mr. John Conroy: How has homegrown helped to eliminate the black market?

Ms. Sonia Sidhu: Yes.

Mr. John Conroy: Well, it's because people are growing it for themselves instead of being consumers of something that somebody else is producing. You're eliminating the market; you're not buying into the market. That's why these stores are the most important thing in terms of reducing the black market because most people don't want to grow for themselves. However, home-grows will reduce the demand that's out there. With regard to tobacco, for example, under the tobacco control act you can grow 15 kilograms of tobacco for anybody over the age of 18 in your premises. We don't have a demand for illicit tobacco anymore, that I know of. I've never had anybody charged with that in my career in any event. It is the same with alcohol. You can make as much beer, wine, and spirits as you want. You can share it with your neighbour, but you can't sell it. We used to have bootleggers and stills and so on in the old days, certainly in the area where I live, and we don't see much of that anymore.

Flooding the market, in my view, is what we need to do so that we can regulate it and control it. We have the tobacco act, and we have tobacco regulations under that act. Presumably we're going to see federal cannabis act regulations, and presumably we're going to see provincial cannabis acts with regulations. So I say, as I think Dr. Page was saying, that many of these issues can be dealt with in those regulations without federally saying four plants 100 centimetres tall. You can allow the feds, as they do for tobacco and alcohol, to control manufacturing, but you can allow the fine details to be controlled in those regulations, and particularly in the provinces. Human ingenuity being what it is—which keeps some of us lawyers busy—people will do things in order to get around what you come up with. You have to anticipate what may occur, but, as I say, make an opportunity for it to be done in a way that hopefully doesn't impact others.

The Chair: Mr. Webber.

Mr. Len Webber: Thank you, Mr. Chair.

Thank you, presenters, for being here today.

Dr. Page, your submission to the committee here I found quite interesting. You talked about the environmental considerations of indoor cultivation, and you say that:

> ...the statistics are staggering. According to a report by the Northwest Power and Conservation Council in Oregon (where recreational marijuana has been legal since 2014) an indoor grow system for only four plants consumes as much energy as 29 refrigerators.

You say:

> The carbon emissions of this energy use are likewise staggering. It has been estimated that one average kilogram of final product is associated with 4600kg of C02 emissions. Looked at another way, embedded in an average indoor-grown plant is the energy equivalent of 265 litres of oil. From the perspective of individual consumers, a single marijuana joint represents about 4.6 kg of C02 emissions, or an amount of electricity equal to running a 100-watt light bulb for 75 hours.
>
> In addition to the environmental and economic cost of the energy intensive nature of indoor cultivation, the legalization of marijuana has also placed strains on some individual utilities and local grids in US states where marijuana has been legalized.

It is clear to me that there is quite an environmental impact to growing four or however many plants in a household, yet you propose that we allow even more than four plants, which is the proposed legislation. Is it because you're not concerned about the environment, or is it because you believe that we have the right to grow more plants?

● (0955)

Mr. Jonathan Page: No, I think, in general, what that submission is getting at is mainly the large-scale commercial production, which currently under the medical regime allows indoor production and greenhouses, but not outdoor production. The idea is that either personal production—four or 10 plants or what have we for personal use—could also include outdoor production. In the apartment situation, this could be on someone's balcony, carefully monitored so as to not be exposed to public view. In the larger-scale commercial industry that we've seen now with medical cannabis and we'll see with recreational cannabis, that would also allow secure facilities with appropriate fences, cameras, and alarms to have outdoor production as part of the spectrum in order to have a more sustainable industry.

Because we're talking about personal cultivation here, I guess where I would go with that is that regulations would encourage the outdoor possibility to reduce that carbon footprint.

Mr. Len Webber: Okay, thank you.

I can see with the effects here why Mr. Dickie and his association are concerned with tenants growing indoor plants, and the cost to our environment.

Mr. Dickie, I owned a condominium in Edmonton. I lived there for a number of years in the past, though I don't anymore. I had to deal with a neighbour in a high-rise beside me who would have their morning toke and their evening toke before bedtime. I had to deal with the second-hand smoke coming into my apartment. It was frustrating. I did talk to the landlord about it. They indicated that it was for medicinal use and they had legal documents stating that they can grow and smoke, so there was not a hell of a lot I could do about it, other than to try to sell my condo.

It's up for sale now, and if anybody here is looking for a condo in Edmonton, come and talk to me.

Mr. John Dickie: With added second-hand smoke as kind of an amenity.

Mr. Len Webber: Yes, exactly. I do understand your concerns and the concerns of your association.

Now, with the government going forward and allowing recreational marijuana, I can see more and more apartments, and more and more people like me out there dealing with more and more second-hand smoke from neighbours who live in multi-dwellings.

Mr. John Dickie: Yes, it's certainly a concern.

One of our suggestions today is to attempt to achieve a compromise in which a landlord's consent is required, and with different levels, which the provinces could choose, of ability to refuse or not refuse consent. That would allow us to take into account these safety features in the buildings. It would allow for a diverse market, a diverse supply of apartments, some buildings where cannabis is used, and if you're going to rent them, you know you're going to get some second-hand smoke but you can use it yourself, or other places where you will not get second-hand smoke and you will not be smoking cannabis.

The medical users need to go in the first set, so that could solve the problem in terms of creating these two sectors of the market. There would probably be a little middle ground in which a few people use it occasionally and no one freaks out about that. However, certainly there are many, many people who rent apartments who do not want second-hand tobacco smoke and second-hand marijuana smoke, as well as the fire safety issues and the humidity, and all of those issues.

Mr. Len Webber: Yes, interesting.

The Chair: Time is up.

Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you very much.

Thank you very much for your testimony today.

One of the goals of the legislation is a public health goal to ensure that cannabis is produced in a way that's safe and there are no contaminants, and that it's a licensed production facility. We've heard from some witnesses that growing marijuana at home sort of reintroduces those risks.

I am curious, and I guess the fundamental question is, can you grow safe cannabis at home? Are there any general increased risks that would be a contaminant which would be unhealthy for people, and that as part of public health we should be addressing with this legislation as part of education or messaging to the public?

● (1000)

Mr. Jonathan Page: I absolutely think that people can grow safe cannabis at home. There is nothing inherent about home production that would say there's an issue with mould contamination or something that is different, say, from what licensed producers would do. Of course, they are professionals, and presumably the home cultivators are more hobbyists or amateurs, but some of them get really good at this.

One of the things we haven't had good statistics on is the quality control analysis of home cultivation under the medical regime, so I can't refer to a statistic that says only 2% of it showed signs of mould or something. We don't have those numbers. However, there's really nothing to indicate that there are inherent problems, whether it's a backyard cultivation set-up, or indoor in your garage or basement.

That said, there have been indications of concerns around things like heat and wiring and, as Mr. Conroy has said, I think those were well refuted in the Allard trial. In both aspects, the plant itself and then the sort of infrastructure for the plant, we don't have a lot of information to say home cultivation is absolutely bad and people shouldn't do it, from the public safety aspect.

Mr. John Oliver: Thank you.

I'm Googling here. Four marijuana plants under a 60-watt HPS lamp, whatever that is, will produce about 150 grams per plant, or about 600 grams from the four plants.

We've heard from many witnesses that they are concerned about increased exposure of children, of youth, to marijuana because of home-grown plants. Again, one of the goals of legislation is to reduce access to marijuana for Canadian youth.

Do you have any reflection on that? I heard you say that when the plant is growing, unless you heat it or do something, it doesn't actually release the THC components, but once it's dried and you have 600 grams of it sitting around somewhere in jars, what's your feeling about children's exposure to it at home?

Mr. Jonathan Page: Being in the same room as a jar of cannabis, obviously, doesn't mean that THC is wafting around. Children—and I guess I would define them as being younger than 13—are not smoking anything. They're not interested in that. As they become teenagers, that becomes something of an issue.

It's not a very attractive thing to be eating. Toddlers are not going to reach into a jar of dried cannabis and start nibbling on it. It's sticky. It's stinky. It tastes bad. It's dry and crispy. It's not something like a cookie, or whatever, that's going to be more attractive, so I don't think we're looking at a massive problem.

Mr. John Oliver: It does seem harder for a parent to control 600 grams of dried product versus 30 grams of dried product, in terms of someone getting into it or not. There does seem to be a greater quantity at home under the home-growing operations.

Mr. Jonathan Page: Right, but I think secure storage is secure storage, and 600 grams is not like a bale of hay, so to speak. It's a smaller amount that can still be locked up, the same as a 30-gram amount. I have kids at home—9 and 13—so I think about these things as well.

Mr. John Oliver: Okay.

Mr. John Conroy: We've had people doing it for now over 12 or 13 years, and we don't have any bodies.

Mr. John Oliver: Under the recommendation, Mr. Dickie, I'm a bit concerned about there being prohibitions on rented dwellings. I don't know this, but I would suspect that some of the more vulnerable communities are renters, not homeowners. It's sort of putting them more out into the market versus being able to do this at home. If the legislation permitted it, would the landlord-tenant things allow collective growing in a storage area, say, in apartment buildings? I don't think the legislation permits that right now, but would that be a way around the concerns of each apartment having its own four plants and the odours that come with it?

● (1005)

Mr. John Dickie: Yes, it would be an improvement if that could be done.

Again, that would be a way for the demand to be met by.... Landlords are certainly in this business. We provide housing for people, and we do it very cost effectively. But the motivating factor is, frankly, to make money. If the customers want to be able to grow, and the landlord has unused space in the basement or can throw a chain-link fence around a plot on the outside, in many areas of Canada, then that would be a way to allow it to be done at the building without being done in the unit and bothering the neighbours.

Again, it's come up today. Mr. Conroy raised it with me before we began. Yes, I like the idea.

The Chair: Your time is up.

We're moving now to our three-minute round, with Mr. Davies.

Mr. Don Davies: Thank you.

Dr. Page, my research indicates there are three basic strains of marijuana: *indica*; *sativa*; and *ruderalis*, or hybrid.

Interestingly, *sativa* is the strain that grows tall and thin. *Indica* is the type that tends to be shorter and bushier. My research indicates that it's the *indica*, the shorter bushier one that produces the higher yield than the *sativa*, which grows tall and thin. Ironically, it seems that by putting a 100-centimetre limit on a plant, we are actually enshrining the type of plant that will produce more yield, based on this arbitrary notion of height, than the *indica* plant, which will grow taller and produce less. Am I missing anything there?

Mr. Jonathan Page: I hadn't thought of it that way. Yes, in general, as I mentioned before, the science is still out on this *indica-sativa* split and how it relates to the effects of the plant. Generally, yes, this taller, lankier, open-flowering *sativa* type can be lower potency than the dense, squat, wide-leaved *indica* type.

Mr. Don Davies: There seems to be a pretty clear connection between height and yield. I'm just talking about yield.

Mr. Jonathan Page: Yes, and *indica*—that type of short, squat plant—is the backbone of the commercial cannabis industry, legal or otherwise. So yes, by enforcing a height limit, there will be potentially a higher yield in that area than these taller plants, though you can get high-yielding *indica* types as well.

Mr. Don Davies: I thought you gave very interesting testimony on the issue of research. We're restricting home cultivation to four plants. I've got your testimony that you think it should be more than that, perhaps 10. Then we have the producers who will be applying for licences, I presume for commercial growing. But in terms of researchers at universities who may want to be growing plants for research and experimental purposes, would you suggest that we amend this legislation to provide a clearer section on that, to make sure researchers can actually get access to grow the kind of cannabis they need to do the research we all want done?

Mr. Jonathan Page: Yes, adding that to the legislation would be beneficial. Some of these things have been treated in regulations. Currently, under the narcotic control regulations, licensing and exemptions for research are delineated, but it has been the case that we just don't have the research that we need. Dr. Mark Ware indicated the same thing around clinical studies.

Enshrining it in legislation and being very clear in the act that access to the cannabis plant, be it for the plant science side or the constituents for research purposes or trials, is necessary. I agree it should be amended; that would be beneficial.

Mr. Don Davies: The last word to you, Mr. Conroy. Is there anything you would like to add?

Mr. John Conroy: We don't have time for anything I'd like to add.

As I say, where are the bodies? After all these years we don't have any of these problems that many people have talked about. For a long time now, we've had many people producing for medical purposes. We've managed to iron out some of the kinks as we go along, and that's what we're going to have to do here.

Certainly, the act doesn't address all of the issues, and you have a problem in terms of source regarding the 12- to 17-year-olds, even though I agree completely that it is a good thing in order to avoid them being stigmatized for the rest of their lives as a result of cannabis.

If you look at the big picture in terms of how many people have been involved in this over the years, sure, we have a legitimate basis to be concerned about certain things, but we don't have many of these problems occurring on the ground. We've been able to sort them out, and I think we can sort them out in the future.

● (1010)

The Chair: That completes our official round, but we have 20 minutes left. We have time for a first round with five-minute questions if that's the wish of the committee. Is that the wish of the committee? All right. We'll start again with four questions, and the questions will be five minutes, starting with the Liberals. Is there any Liberal who is ready for questions? Everybody's good? Okay.

We now go to the Conservatives, to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

I have a couple of questions. I share the concern that Mr. Oliver raised earlier about the potential of having 600 grams in a home-grow operation. I'm not so concerned about kids eating. I'm more concerned, especially with the 12- to 17-year-olds, that they're going to try to dry it, roll it, and smoke it.

There are no provisions that I can see in Bill C-45 about protected storage. Mr. Page, are there best practices in terms of how you would recommend storing this material to keep it out of the hands of children?

Mr. Jonathan Page: One of the things about the experience Mr. Conroy referred to in medical cannabis is that people have now been receiving cannabis or producing it themselves and there are lock boxes and other sorts of small safes that can be put in people's houses. Certainly, with the opiate epidemic that we hear so much about, there has been a move in households to make sure teenagers can't get access to pharmaceutical drugs in medical cabinets. The same thing may apply to alcohol and liquor cabinets in someone's home, that there should be some control over them. I think cannabis is very similar to those two areas that we already deal with. I think it's up to each family, and the age of the children in the household, how they deal with security. Certainly, best practices could include a small safe with a combination or a key to make sure, and there's also childproof packaging.

Outside of personal cultivation, receiving samples, whether it's LCBO or online via producer, in packages—the same as a pill bottle—obviously a teenager can open childproof packaging but younger kids can't.

Ms. Marilyn Gladu: My second question is for Mr. Conroy. It is about the time it will take for the provinces to introduce legislation. We've heard concerns today that in Ontario and Quebec, the landowner or landlord will not have any right to prohibit somebody from having a grow-op or smoking marijuana on their property if the provinces don't introduce legislation.

Similarly, if we talk about trying to make sure there are regulations that keep the smoking of cannabis in the same light as the smoking of tobacco, where it's allowed and not allowed, how long do you think it will take provinces to get that kind of legislation in place, if they started today?

Mr. John Conroy: It shouldn't take them very long. Unfortunately, the bureaucratic process in terms of passing regulations.... You don't need to go through the legislature or Parliament to pass regulations. It's always a puzzle to me how long it takes for them to do things. We heard them go on about how they're not going to be ready and they need more time. The provinces have said the feds have to tell them more about road safety. I know you're talking about that next week in terms of the impaired. On taxation, we have examples of how we tax tobacco and alcohol, HST, GST, and so on, so I don't understand what the difficulty is.

The training of distributors, they said. Well, we've got existing distributors who know what to do, and that's why we need to bring them in and regulate the existing market instead of trying to reinvent it.

Public education was the other one the provinces raised. As I said, there's more information about cannabis out there than any other drug in history, given all of the royal commissions of inquiry and other things that we've had, as well as evidence in court cases. In R. v. Malmo-Levine; R. v. Caine, the Supreme Court of Canada heard all the evidence that came from three cases that went all the way up, and there were findings of fact by judges after hearing expert witnesses, like you've heard, and them being examined and cross-examined, and made findings of fact, one of them being that marijuana is not addictive. That's because of the scientific definition —

● (1015)

Ms. Marilyn Gladu: I think I've got the answer on the amount of time. It'll take a lot of time.

Mr. John Conroy: But it shouldn't take a lot of time. The defect or the problem is in the process as opposed to the subject matter.

Ms. Marilyn Gladu: Very good. That's it for me, thanks.

The Chair: Mr. Davies.

Mr. Don Davies: Dr. Page, I want to ask you your opinion on what production policy would look like in an ideal world. I've heard concerns from a number of people that they don't want to see production limited to so-called “big weed”, big, mass, corporate growers, but that they want to see space in the production world for the small growers, the boutique growers, the craft growers, as it were, to make an analogy to craft beer. As a person who has done a lot of research into the different kinds and strains of cannabis, what's your view on that?

Mr. Jonathan Page: Some of the information we have around this is from the current medical system, where we have some very large producers licensed and also some small mom-and-pop-style producers under licence. There's a general feeling that the illicit world, which includes many small growers, primarily in British Columbia but elsewhere, has been excluded. The fact is that they don't have the wherewithal to produce the security or they have legal issues that have been held against them, and there have been delays in licensing that have led mainly to the large producers with very deep investment funds to build facilities.

What we need to do in the commercial sense, outside the personal cultivation subject of this hearing, is to have an ecosystem in the same way we have with beer or wine, where you can have Molson and that type of thing as big ones and also have smaller producers that are equally well regulated, with testing applied and securities around there, that we also have regulations and legislation that encourage those small ones to get involved in this industry and not make the cost of start-up so steep or the regulations so strict that we exclude those small producers.

Mr. Don Davies: Thanks.

Mr. Conroy, we're calling this bill the legalization of cannabis, but what we're really doing is making it less illegal.

Mr. John Conroy: It's a little bit of legalization.

Mr. Don Davies: If you have more than 30 grams in your possession, you'll be criminally charged. If you have more than four plants, you'll be criminally charged. There are penalties of up to 14 years of imprisonment. If you have more than five grams as a youth, you face some sort of penalty.

In clause 7, one of the purposes of this bill is to reduce the burden on the criminal justice system. Do you see that happening?

Mr. John Conroy: I live in the cocoon of British Columbia, where people haven't been charged with simple possession for a long time; the police just seize it. You still see a lot of charges but rarely convictions, unless it's something more than simple possession. In my practice, I don't get anywhere near as many cases as I used to in the old days, even though you haven't legalized it yet. The burden has been reduced.

However, having this maximum of 14 years, hybridized by indictment, and so on, is frankly totally unrealistic in terms of what goes on on the ground. Even in the Saskatchewan Court of Appeal, which is not known to be the most liberal court in the country, the range for trafficking, for example, is 12 to 18 months. Most sentences are up to two years. For tobacco and alcohol, all your maximums are two and three years. This 14-year thing is ridiculous, frankly, and it's problematic because it will increase the burden in the following way.

Years ago, through the sentencing commission, through Parliament here, and so on, we determined that we had to reduce the amount of incarceration because we'd just make people worse most of the time instead of really protecting the public. Therefore, why are you going to put somebody in prison, actual prison, for trafficking in cannabis nowadays? It seems ridiculous.

A judge will introduce something called a conditional sentence order. The conditional sentence order is the last step before having to put you actually in prison. Depending upon levels of denunciation and deterrence, the judge decides whether to put you in prison. A 14-year maximum, because of the 2012 amendments, prevents a judge from doing that.

What does 14 years have to do with it when the court is sitting there saying we think that up to two years is a fit sentence, but we also think you're not a danger to the community, you don't have any violence in your history or anything such as that, so we think you can serve it in the community? The judge can't do it. What do judges do, faced with that now? They'll give probation with conditions to try to structure it like a conditional sentence order.

I really encourage you to listen to what Le Dain said at least 45 years ago and reduce that to five years if you're going to keep a hybridized system.

My hope and expectation is that the cannabis consumers who I have now watched over a long period of time are going to demonstrate to you that they will be able to live under this existing proposed beginning, if I can call it that, and will not create a lot of problems, hopefully, for the criminal courts and others, that we will effectively, in practice, legalize and demonstrate to all of you that you don't need many of these limits that you're worrying about.

● (1020)

The Chair: All right. That concludes our session on the household cultivation of plants. We appreciate the information you've given us. We continue to learn. I think we've all learned a lot today from your input, so I thank you very much for taking the time to come and participate.

I suspend this meeting now until 10:45 in this room.

● (1020)

(Pause)

● (1045)

The Chair: Welcome back to the 66th meeting of the Standing Committee on Health, where this afternoon we're going to have a panel on the age of legal possession and impact on young Canadians, which is certainly one of the controversial discussions and part of this.

I should tell all our witnesses that some of the questions will be in French. We have translation here, so you should just be ready for that and be prepared.

One of our witnesses this morning is the Canadian Drug Policy Coalition, with Scott Bernstein, senior policy analyst, by video conference from Vancouver.

From the Canadian Public Health Association, we have Ian Culbert, executive director. From the Canadian Paediatric Society, we have Christina Grant, member of the adolescent health committee. From Educators for Sensible Drug Policy, we have Judith Renaud, executive director, and Paul Renaud, communications director. From Portage, we have Peter A. Howlett, president, and Peter Vamos, executive director.

Each organization will have 10 minutes for an opening statement, and then we'll go to questions.

We'll start with the Canadian Drug Policy Coalition, by video conference. Welcome.

Mr. Scott Bernstein (Senior Policy Analyst, Canadian Drug Policy Coalition): Thank you.

Good morning, honourable members. Thank you for the opportunity to make comments on Bill C-45 this morning on this important panel.

I'm representing the Canadian Drug Policy Coalition or CDPC, a non-governmental organization comprised of over 70 organizations and 3,000 individuals working to support the development of a drug policy in Canada that is based in science, guided by public health principles, and respectful of human rights.

CDPC supports the passing of Bill C-45 and the legal regulation of non-medical cannabis as a way to minimize the social and individual costs of prohibition while ensuring the cannabis policy supports public health and human rights to the fullest extent possible.

Legalizing and regulating cannabis will ensure there is adequate oversight of the complete market of non-medical cannabis including control over dose, quality, potency, marketing, and access. From decades of prohibitionist drug policy in Canada, evidence clearly and unequivocally demonstrates that criminalizing people for possessing and using drugs leads to great social and individual harms. As such, CDPC supports the legal regulation of all drugs within Canada as a route to retaking control of a dangerous, unregulated market for drugs that supports criminal organizations and puts countless Canadians at risk of criminal sanction.

We believe this is the path to minimizing infectious disease such as hepatitis C and HIV, reducing overdose and social stigma, and promoting public health and safety objectives. Similarly, we believe that evidence strongly supports decriminalizing all drugs and further improved public health and public safety.

I would like to make comments this morning on recommendations that CDPC has put forward to this committee in our submitted brief.

First, I'll address the minimum age of access. The cannabis act establishes a federal minimum age of 18 years to access cannabis with provinces having the ability to raise the minimum age as Ontario has done to align with its alcohol age. CDPC supports maintaining the federal minimum age of 18 years in the legislation.

Despite the existing system of cannabis prohibition that has been in place in Canada for decades, there remains a consistent one in three people in the 16 to 25 age range who are active users. In a UN study it was shown that youth cannabis use was lower in countries with more liberal drug policies than in Canada, demonstrating that strict enforcement policies are not a deterrent for young people.

It is unrealistic to conclude that all youth will completely abstain from consuming cannabis regardless of set age limits and sanctions against consumption. Having a minimum age that's too high will maintain the illegal market and put numerous young Canadians at greater risk than the risk to them of consuming cannabis. That approach should be rejected in favour of a public health approach that looks at the entire spectrum of risk to young people from not only the substance itself but the policies as well. Protecting youth must consider the harms to youth of engaging with illegal markets as well as the harms of consuming cannabis, a policy balance that supports a lower minimum age of access.

Second, regarding criminal penalties in youth, the cannabis act prohibits possession of dried cannabis of more than five grams by a young person, creating either an indictable or summary conviction offence, and if convicted, a sentence under the Youth Criminal Justice Act. Notably, the Province of Ontario has chosen to close even the small gap and create provincial crimes for a young person carrying any amount of cannabis.

Seeming to recognize the harms of a criminal record, the cannabis act provides in some circumstances allowances for a peace officer to issue ticketable offences to both adults and organizations. Such allowances, though, are not available to young people.

It is now well documented that a criminal record contributes to considerable social harms from limiting international travel, diminishing career and volunteer opportunities, exacerbating poverty, and leading to poorer health outcomes, creating stigma, and consuming scarce public resources.

As mentioned, evidence also supports the fact that the potential for criminal sanction is not a deterrent for adolescent use of cannabis. Instead, as was recommended by the task force, achieving the public health and safety goals of the cannabis act with respect to youth should be addressed through education and soft approaches to discourage use as opposed to criminal punishment.

● (1050)

Overwhelmingly, respondents to the task force took the view that the criminalization of youth should be avoided, and that criminal sanctions should be focused on adults who provide cannabis to youth, not on the youths themselves. One such approach might be found in the state of California, where the regulatory scheme provides that young people found possessing cannabis will receive non-criminal infractions, and must attend mandatory education or counselling and perform community service. CDPC recommends that youth not be subject to criminal penalties at all, and that the cannabis act be amended to substitute similar soft approaches to youth drug use, such as counselling and community service. Removing these sanctions of criminality will increase public health and safety, particularly with respect to youth, by decreasing the harm and stigma of criminalization, while still discouraging unlawful use through a balanced and realistic approach.

Additionally, social sharing, which is a common practice among young people, is something the task force recommended be allowed, but it has also been prohibited by the cannabis act through the criminalization of any form of distribution to a young person, with a draconian penalty of up to 14 years in prison. This would penalize an 18-year-old sharing cannabis with a 17-year-old friend, or a parent sharing with his or her son or daughter.

In the case of alcohol, there are clear exemptions to criminalization for adults sharing with their minor children in a private home, and all provinces regard social sharing of alcohol with far less punitive penalties than in the cannabis act. CDPC recommends that social sharing with a young person not be criminalized but rather treated in a similar manner to youth use, with counselling and community service. CDPC further recommends that adults be permitted to provide cannabis to their own minor children in a private residence, similar to alcohol.

My final point concerns social justice. Underlying the legal regulation of cannabis is the notion that our historical policies of criminalizing cannabis have led to unacceptable negative outcomes in Canadian society, including supporting a thriving illegal market for cannabis nationwide, and capturing hundreds of thousands in the criminal justice system for cannabis offences. Criminal law, though, is rarely applied equally, and cannabis prohibition has had a greater negative impact on marginalized communities, people of colour, youth, and indigenous persons. Legislation crafted to repair past policies should also aim to repair the damage done to those punished under an unjust system, including creating opportunities within the new economy and clearing past criminal records.

CDPC recommends two changes to the act to better serve the social justice aims of the legislation. First, prior drug convictions should not be the sole reason for denying a licence to participate in the cannabis economy. Paragraph 62(7)(c) allows the minister to refuse to issue, renew, or amend a federal licence or permit required for participation in the cannabis industry if the applicant has contravened the Controlled Drugs and Substances Act, or committed other drug-related offenses in the past 10 years. This would of course include any drug conviction for activities that would now be legitimate under the new regime. There is no logical reason for creating a specific ground related to drug offences in this provision, compared to any number of past offences that might make a person ineligible for a licence, such as theft or fraud. A preferred approach would be one similar to California's, where prior convictions for non-violent drug offences are actually prohibited from being the sole reason for denial of a licence.

Second, there should be clear mechanisms for those convicted of cannabis-related drug offences in the past to apply for the suspension of convictions on their criminal record, or for cases where sentences are still being served, of having these cases dismissed or re-evaluated under the new legislation. CDPC recommends amendments to the cannabis act that allow for the reconsideration of ongoing sentences and record suspensions for prior convictions.

The cannabis act is a remarkable piece of legislation that forges new policy standards regulating previously illegal substances.

● (1055)

It is important that these new standards be centred on evidence, public health, and the well-being of Canadians young and old. Thank you.

The Chair: We'll be moving on to the Canadian Public Health Association with Mr. Ian Culbert, executive director, for 10 minutes.

Mr. Ian Culbert (Executive Director, Canadian Public Health Association): Good morning, Mr. Chair and committee members. Thank you for the invitation to present to you today.

I will preface my comments this morning by noting that, throughout my remarks, my references to cannabis use relate to recreational use, not the use of cannabis for medical purposes.

On behalf of the Canadian Public Health Association, I am pleased that the Government of Canada has committed itself to a public health approach to the legalization and regulation of cannabis. We are further pleased that Bill C-45 does in fact embody such an approach.

Different from the publicly funded health care system, public health is the organized efforts of society to keep people healthy and to prevent injury, illness, and premature death. As such, a public health approach is based on the principles of social justice. It pays attention to human rights and equity. It is based on the evidence, and it addresses the underlying determinants of health. A public health approach is organized, comprehensive, multisectoral, and it emphasizes pragmatic initiatives.

As a colleague recently noted, in some ways public health is like that darling child who's always asking, “Why?” In the case of cannabis, we want to know why people use it, so that we can develop policies and interventions that meet their needs. The human relationship with cannabis ranges from abstinence to a spectrum of consumption. This spectrum ranges from beneficial to non-problematic, to potentially harmful use, to the development of use disorders. At the federal level, the legal and regulatory response to cannabis needs to be sufficiently broad to encompass the entire spectrum of consumption, while at the provincial and territorial levels, the response begins to narrow to meet the particular needs of each jurisdiction. Then at the regional or local levels, the response is honed to the specific needs of particular populations.

There has been considerable discussion and unfortunately a lack of consensus regarding the appropriate legal age for the possession of cannabis. The Canadian Public Health Association supports the provisions in Bill C-45 establishing the minimum legal age at 18 and allowing provinces and territories to set a higher age, as appropriate, in their jurisdictions. From a practical perspective, it is important and appropriate for provinces and territories to establish a legal age for cannabis consumption that matches the legal age for alcohol consumption. In that way, confusion should be reduced and education efforts can be better coordinated.

While we would prefer that no Canadian use cannabis or any other psychoactive substance, a public health approach recognizes that cannabis will be consumed for a number of different reasons, regardless of efforts to discourage it. You are already familiar with the statistics: 12% of the general population, 21% of youth aged 15 to 19, and 30% of young adults aged 20 to 24 reported in a 2015 survey that they consumed cannabis in the previous year. Since more than one in five youth aged 15 to 19 are consuming cannabis now and we have no reason to believe that rate will change, the responsible policy option is to create a legal and regulated market for cannabis that is accessible to adults 18 years of age and older.

Bill C-45 will establish a supply of cannabis of known potency and quality. Currently, anyone consuming cannabis is playing a game of Russian roulette, never knowing the product's quality before consuming it, or if it has been laced with other, more powerful psychoactive substances. From a public health perspective, the Canadian Public Health Association is encouraging provincial and territorial governments to limit the sale of cannabis to government-controlled entities to ensure that the focus remains on harm reduction, not profit.

The prohibition model currently in place in Canada has severely hampered health promotion and harm reduction efforts. The only message we had at our disposal was, “Just say no”, and clearly that has failed. Beyond simple health education, health promotion is the process of enabling people to increase control over and to improve their health. It is our view that legal cannabis sales must therefore be preceded by comprehensive, non-judgmental, non-stigmatizing health promotion campaigns across Canada that have a clear and consistent message. These campaigns must be supported on an ongoing basis and should be complemented by in-person health promotion and harm reduction messaging at the point of sale. We need to normalize the conversation about cannabis, not its consumption.

There are concerns that the legalization will result in significant increases in cannabis use, especially among young people. While the Canadian experience may be different, two recent reports from Washington state both indicate that youth cannabis consumption has remained stable since legalization in that jurisdiction. One of these reports, however, indicates an increase in older adults' cannabis use, while another indicates an increase in the number of people who consume cannabis daily or near daily.

● (1100)

These early reports out of Washington remind us that we need to pay attention to the entire population, with a particular focus on why certain individuals go on to potentially problematic use.

Concerns have also been raised about the impact cannabis consumption has on the developing brain. While the studies quoted are important pieces of the research puzzle, they focus on young people who are daily and heavy cannabis users. I think we can all agree that if a child is consuming a large amount of cannabis on a daily basis, there is a cause for concern. If a child were drinking alcohol heavily on a daily basis, there would be a similar cause for concern. Once again, from a public health perspective we want to know why that child is consuming heavily and daily; then we can focus our interventions accordingly.

At the moment, we lack robust data on the health impacts of casual use of cannabis and we hope that legalization will allow research on that issue to take place. Having understood that people are going to continue consuming cannabis for various reasons and in various amounts, it is crucial that our policies and interventions focus on harm reduction efforts. Harm reduction can take many different forms, including ensuring a product of known potency and quality; effective education and health promotion activities; ensuring that consumers and health and social service providers know about safer consumption methods; and adopting and promoting the lower-risk cannabis use guidelines.

I understand that you have a panel dedicated to that subject later today, so I won't go into these guidelines in detail but I will say that they are an important tool that should be adopted in all jurisdictions.

The Canadian Public Health Association does have one recommendation for an amendment to Bill C-45 that I believe one of your witnesses mentioned yesterday. As it currently stands, subclause 10(5) of the bill will result in the crime of possession for the purpose of selling becoming an indictable offence punishable by up to 14 years in prison for those convicted, including young people between the ages of 12 and 18. Clause 8 concerning possession and clause 9 concerning distribution provide similar sentencing options for people over 18 years of age, but permit referral to sentencing under the Youth Criminal Justice Act for those between 12 and 18.

The Canadian Public Health Association's viewpoint is that an option for sentencing under the Youth Criminal Justice Act for young people should also exist under subclause 10(5). In many cases these offences are related to possession for sale by young people to their peers, and the stigma established by such a conviction may cause irreparable harm to their futures, outweighing the actual offence. Care should be taken to apply the proposed rules concerning possession for the purpose of sale to reflect the severity of the crime.

You have also heard calls that we are not ready for legalization. Unfortunately, we don't have the luxury of time, as Canadians are already consuming cannabis at record levels. The individual and societal harms associated with cannabis use are already being felt every day. The proposed legislation and eventual regulation is our best attempt to minimize those harms and protect the well-being of all Canadians. Our first efforts may not be perfect, but perfection is not required as we can modify our approaches as we learn from our experiences. At the end of the day, we all want to do the right thing for the broad range of Canadians who already consume or may choose to consume cannabis for a variety of different reasons.

The Canadian Public Health Association believes that Bill C-45 and provincial responses such as Ontario's are steps in the right direction. Key lessons learned from jurisdictions that have travelled this road before us include the following: regulators must have the flexibility to adapt to changing conditions in the marketplace; upfront investments in education and health promotion are essential; law enforcement and public health need to work together; and the interests of the private sector cannabis industry are rarely aligned with the interests of public health.

● (1105)

The Chair: Thank you very much.

Now we go to Dr. Christina Grant, a member of the adolescent health committee of the Canadian Paediatric Society.

You have 10 minutes. I look forward to your comments.

Dr. Christina Grant (Member of the Adolescent Health Committee, Canadian Paediatric Society): Dear members of the Standing Committee on Health, I'm an adolescent medicine specialist and associate professor of pediatrics at McMaster University. Thank you for the invitation to speak as a representative of the Canadian Paediatric Society on Bill C-45, specifically regarding the age of legal possession and the impact on young Canadians of the legalization of cannabis in Canada.

I have submitted a summary of the CPS statement on cannabis and Canada's children and youth for your reading. My goal today is to ensure that you have up-to-date scientific information regarding the impact of cannabis use on young Canadians, including young toddlers, and to discuss our society's stance regarding the age of legal possession.

First, there can be no doubt regarding the scientific literature that cannabis use prior to the mid-20s is associated with structural, functional, and harmful effects on the developing brain, as has been borne out in many peer-reviewed studies. There are rigorous studies demonstrating a relationship between regular cannabis use in youth and the increased risk of approximately 40% of developing a psychotic episode. We know that early use, higher doses, and frequent use all contribute to this risk, in addition to other predisposing factors for developing a psychotic illness, such as family history.

There are also studies demonstrating a relationship between regular cannabis use and clinical depression, though results are not as robust as for the psychosis relationship. There are studies indicating that youth with certain anxiety disorders are at increased risk for developing problematic cannabis use that can inevitably interfere with their everyday lives.

Strikingly, one in six adolescents who experiment with cannabis goes on to develop cannabis-use disorder, a psychiatric illness similar to alcoholism, where the drug use interferes with multiple areas of functioning. This can include academics, social and family relationships, and extracurricular activities, all areas that require rich development during the teen years in order to leave them well equipped for life.

For all these reasons, there is no safe age for experimentation with cannabis, and we recommend that young people not consume it. However, adolescence is a time of experimentation. We know that Canadian youth are experimenting with cannabis at the highest rate compared with other countries around the world. The proposed legal cannabis industry in Canada has raised a dilemma regarding the most appropriate age for its legal use, which should minimize harm to children and youth, our most vulnerable population.

On the one hand, prohibiting cannabis until the mid-20s would protect adolescents during a period of critical brain development. On the other, adolescents and young adults are already experimenting frequently with marijuana. Aligning the legal age for cannabis use with that of other legally controlled substances, notably alcohol and tobacco, would help ensure that youth who have attained age of majority have access to a regulated product with a known potency. Also, they would be less liable to engage in high-risk, illegal activities to access cannabis.

Of emerging concern in the United States and in Europe is the number of accidental ingestions of edibles by the toddler age group. Perhaps we all know that edibles are marijuana-infused food products that come in various formats, including cookies and candies. These are highly attractive to young children and often indistinguishable from regular candies, chocolate bars, or baked goods. In Colorado, rates of unintentional ingestion in children less than nine rose by 34% after the legalization of cannabis. More than a third of those cases required hospitalization in a pediatric critical care unit because of overdose symptoms. Most commonly, the toddlers could not breath on their own.

● (1110)

A study from France published this month demonstrated a threefold increase in young children, mostly toddlers, requiring pediatric emergency care presenting with coma and seizures secondary to accidental cannabis ingestion.

Because of the aforementioned concerns, I would urge your committee to consider the following CPS recommendations so that as a society we are able to protect those who are most vulnerable.

First, enact and rigorously enforce regulations on the cannabis industry to limit the availability and marketing of cannabis to minors. These regulations must prohibit dispensaries from being located close to elementary, middle, and high schools, licensed child care centres, community centres, residential neighbourhoods, and youth facilities. Mandate strict labelling standards for all cannabis products, including a complete and accurate list of ingredients and an exact measure of cannabis concentration. Mandate package warnings for all cannabis products, including known and potential harmful effects of exposure, similar to cigarettes, including childproof packaging. Mandate and enforce a ban on the marketing of cannabis-related products using strategies or venues that attract children and youth, such as edibles.

Second, adequately fund public education campaigns to reinforce that cannabis is not safe for children and youth by raising awareness of the harms associated with cannabis use and dependence. These campaigns should be developed in collaboration with youth leaders and should include young opinion leaders.

Finally, send a strong message to the public that cannabis has neurodevelopmental risks by considering limiting the concentrations of THC in cannabis that 18- to 25-year-olds can purchase legally.

Thank you.

● (1115)

The Chair: Thank you very much.

Now we're going to move to the Educators for Sensible Drug Policy, Judith Renaud, executive director and Paul Renaud, communications director.

I'm not sure how you're going to spread your time. You have 10 minutes between you.

Ms. Judith Renaud (Executive Director, Educators for Sensible Drug Policy): Thank you for the invitation to speak to the House of Commons about this very important act, the issue of youth use, the age for legal possession, and the impact on our young Canadians.

Cannabis prohibition has been an abject failure. As the executive director of EFSDP, I want to see educational policy and reform come from a place of progressive change, where students, parents, teachers, health care professionals, and mental health providers work together to provide a quality of schooling that reflects a place where what is learned is lived and is based on solid scientific evidence, and where truth matters.

More and more, for a variety of reasons, it has become society's role to educate, and to provide support for parents and children. Educators have a responsibility to be esteem-builders. Bill C-45 has some good intentions, but the cannabis act will not prevent youth from using cannabis. It should not subject them to further harms from the law itself.

Educators understand that despite its increasing ubiquity, research suggests that young people's attitudes towards cannabis are ambiguous. Many have conflicting positions and negative attitudes towards its use. This is not surprising considering the complexity of the substance. Unlike alcohol and tobacco, two substances almost exclusively limited in purpose to recreational use, cannabis can be used both recreationally and medically, although the line between the two is blurred.

To increase the understanding about the issues cannabis can pose to the health and well-being of young people, drug reform educators believe we should be educating them not only about the substance's possible negative effects, but also its positive ones. This can be achieved using evidence-based, unbiased, and holistic information, where truth matters.

The ubiquity of cannabis is a major health issue. Youth need to gain factual knowledge about cannabis so that they are able to make informed decisions about cannabis and its use in order to mitigate possible harm. We agree with the task force that 18 is an appropriate age for legal use. However, some EFSDP members agree with the 2002 Senate report that 16 is also appropriate.

As a society, we need to remove many misconceptions that are perpetuated by eight decades of prohibition. Educators must find common ground. As some people continue to push the prohibitionist agenda, educators are becoming more aware that teens are more at risk from alcohol, pharmaceuticals, and opioids. Neuroscientist Marc Lewis wrote a book called *Memoirs of an Addicted Brain*. He discusses in detail how cannabinoids are natural brain chemicals. I quote:

> The cannabinoid receptor system matures most rapidly, not during childhood, not during adulthood, but during adolescence. So it wouldn't be surprising if cannabinoid activity is meant to be functional during adolescence, more functional than any other period of the life span. As far as evolution is concerned, adolescents might well benefit from following their own grandiose thoughts, goals, and plans. By doing so, and by ignoring the weight of evidence - on sheer inertia - piled up against them, they would greatly amplify their tendency to explore, to try things, to imbue their plans with more confidence.... The evolutionary goals of adolescents are to become independent, to make new connections, and to find new territory, new social systems, and most of all, new mates. The distortions of adolescent thinking might be precisely posed to facilitate these goals.
>
> Adolescents ignore most of what parents think, most of conventional wisdom, and are spellbound by their own ideas. They follow chains of logic that nobody else finds logical, and voice excessive allegiance to their own predictions about how things will turn out. Even when they're not stoned, adolescents live in a world of ideation of their own making and follow trains of thought to extreme conclusions, despite overwhelming evidence that they're just plain wrong.

● (1120)

In 2001, I was offered a position as a first nation administrator in northern British Columbia. Not only was this experience life altering, but it was one that made me realize how ordinary Canadian educators and citizens have no idea what misfortunes, tragedies, and adversities many indigenous young people experience by the time they reach adolescence, how many deaths, what abuse they endure, and what despair they feel. I met Dr. Maté, a well-known drug addiction expert and author of *In the Realm of Hungry Ghosts* and *Hold On to Your Kids*.

He said, about the despair first nation youth feel, the self-loathing plagues them, the barriers to a life of freedom and meaning they have to face, that it is the educator who must always remember this: Don’t ask why the drug, ask why the pain.

At the core of unresolved traumas passed from one generation to the next, along with social conditions that induce further hopelessness, I witnessed untold, multi-generational traumas in several aboriginal communities. Native history resonates in aboriginal youth with their brilliant art, their dances, their music, and their wisdom. Maté said when educators see their first nation peers, they witness “their humanity, grandeur, unspeakable suffering and strength”.

Cannabis law enforcement has been shown to be racially biased. The “from school to prison pipeline” is real. Jail cells cannot be the new classroom. Our aboriginal youth are suffering. We must stop targeting marginalized people of colour, and we must learn to understand trauma and its multiple impacts on human mentality and behaviour. I agree with Dr. Maté that “the best-meaning people can unwittingly re-traumatize those who can least bear the pain and loss”.

EFSDP's goal is to promote an alternative to failed, punitive drug policies. As hard as we try, we will never convince 100% of youth to say no 100% of the time. If we can clear up the underlying problems, there will be less incentive for young people to use drugs as a way of coping with the stresses they face.

Thank you, and I welcome your questions.

The Chair: Thank you very much.

Mr. Paul Renaud (Communications Director, Educators for Sensible Drug Policy): Hello. My name is Paul Renaud. I'm very thankful for the opportunity to be here today.

While my wife Judith was principal of the band school in Bella Coola, B.C., I was hired by the Nuxalk Nation as their EDO or economic development officer. As EDO I had the chance to meet many locals and hear their stories. It soon became clear that there was not much job opportunity there, and many people were living on social assistance, even as alcohol and drug use seemed ramped up, particularly as pharmaceuticals were paid for by the government and children were also medicated under doctors' orders.

One day I decided to go to court, which was being held quarterly in the basement of the band administration building. I was astonished and dismayed by how much of the court's time was being taken up by cannabis offences and how many of the plaintiffs were young, in their teens and twenties. It seemed a cruel use of the judiciary. At the same time, it was clear to me that cannabis was being used by many in the community to help avoid alcohol, but because of the risks of having consumed cannabis, people were reluctant to talk about it.

Because cannabis shows promise in treating a wide variety of ailments, it will, like pharmaceuticals, be prescribed to children to be administered in schools, just like other drugs. This context provides the basis for some very important education about cannabis: it is primarily medicine.

As has already been noted by many, the line between recreational and medicinal use is not clear. Gabor Maté's definition of addiction is any behaviour that has negative consequences that one is compelled to persist in and relapse into and crave despite those negative consequences. With this in mind, the possibility of any person's—including a young person's—using cannabis to avoid alcohol or other more harmful drugs and having a positive outcome may not fit the definition of addiction and certainly should not be considered an offence. Youth cannot be criminalized for alcohol possession. What sense does it make to criminalize them for cannabis?

There seems to be mounting evidence, which some may call anecdotal, that cannabis is useful in avoiding other, more harmful substances. I've heard people say that this is not really quitting, just switching one drug for another. While that may be somewhat true, the principle of harm reduction is sound, and wherever abstinence may not be achievable, a reduced use of a more harmful substance may be a positive outcome.

The average age among first nations people is very young compared with the rest of Canada. Any laws or public health policies that affect young people will affect first nations youth disproportionately, just as incarceration rates also show.

The Government of Canada, led by Prime Minister Justin Trudeau, has indicated a willingness to engage with first nations in a deeper, more meaningful, and productive way. Because nations are so plagued by substance abuse issues and already have many people using cannabis, they may benefit—

● (1125)

The Chair: How much time do you have there, because we've allowed 10 minutes for your organization and we're over that now.

I know what you're talking about is very important, but in order for us to proceed and get everyone's fair share in, we have to only allow you 10 minutes. We're well over that now. If you could wind up—

Mr. Paul Renaud: I'll stop there, then.

The Chair: That's perfect. Thanks very much. We'll hear from you on questions, for sure.

Now we're going to go to Portage, to Mr. Peter A. Howlett, president, and Dr. Peter Vamos. I'm not sure how you're going to divide your 10 minutes, but you have 10 minutes between you.

Mr. Peter A. Howlett (President, Portage): Mr. Chairman and distinguished members of the committee, Portage, of which I'm the president, has been in existence for nearly 50 years, treating adolescents, adults, pregnant addicts, mothers with small children, indigenous communities, and mentally ill drug dependents, and has provided in-prison programming and programming in some 15 other countries. Portage is here today not to debate the merits of legalizing marijuana but rather to register our concerns about the collateral impact of Bill C-45 on youth in general, and substance-abusing youth in particular. We will offer some recommendations on how these risks might be mitigated.

This past April, Health Canada released a paper that reported that marijuana is an addictive substance with significant possible impacts on both mind and body of the users, and that continued frequent and heavy use is likely to cause physical dependency and addiction. Anthony reported that, using DSM-IV criteria, between 8% and 10% of adult users, and 16% of adolescent users, fit the cannabis dependency criteria. As a further risk factor, future lung cancer in heavy cannabis users of military conscription age in the United States is discussed by Callaghan, Allebeck, and Sidorchuk in their 2013 work. The American College of Pediatricians, in an article entitled “Marijuana Use: Detrimental to Youth”, of April 2017, reports a number of studies on potential causal relationships between heavy marijuana use and a number of non-infectious illnesses such as long-term impacts on the cardiopulmonary system.

Aside from these risks caused by heavy marijuana use, there are also a number of studies described by the American College of Pediatricians showing associations between chronic marijuana use and mental illness. The findings suggest that people who are dependent on marijuana frequently have comorbid mental disorders, including schizophrenia. Some of the studies cited found nearly a 50% increase of psychosis among cannabis users versus non-users. The authors are describing the consequence of heavy, persistent use, but Portage wishes to remind the committee that 16% of young users can be described as such. It is the protection of this significant, highly vulnerable minority that is the focus of Portage's presentation today.

While the proportion of dependent, heavy users to casual users might remain the same, the size of these groups is expected to grow dramatically as a consequence of legalization. In examining some of the evidence since 2007, there has been an increase in marijuana use among young people in the United States attributed to limited legalization and the diminishing perception of drug risks. As of 2014, the number of users aged 12 and up has increased from 14.5 million to 18.9 million. In the United States, 7.3% of all admissions to publicly funded drug treatment facilities were of persons aged 12 to 17. The prevalence of usage among young people is therefore noteworthy.

A study evaluating the impact of the legalization of marijuana in Colorado found, in the area of traffic offences, there was a 45% increase in impaired driving between 2013 and 2014, and a 32% increase in marijuana-related motor vehicle deaths. By 2013, marijuana use in Colorado was 55% above the national average among teens and young adults, and 86% higher for the age group 25 and over.

The American College of Pediatricians maintains that marijuana legalization will result in increased adolescent usage, addiction, and associated risks for them. Age-specific data on Colorado cannabis use compared data from two years before to two years after legalization for the age groups 12 to 17, 18 to 25, and over 26. The increases were 17% to 63% higher, while national averages for the same group remained the same or lower. Callaghan, in 2016, cited calculations of the approximate number of cannabis users in Ontario population groups below and above age 25 for 2013 and found that adolescents, young adults, are disproportionately represented among cannabis users.

Research suggests that existing alcohol and tobacco control measures are not likely to prove to be good models for controlling youth access to cannabis after legalization. Despite existing regulations banning distribution or sale to minors, alcohol continues to be widely used by Ontario students at all levels.

The evidence for driving under the influence for those 19 and under is very disconcerting. Up to 18% of those involved in fatal accidents between 2000 and 2007 tested positive for alcohol, drugs, or both. The numbers for those reporting driving under the influence of alcohol or cannabis is similarly high, and those reporting to be passengers in a car driven by someone under the influence are even higher.

● (1130)

As mentioned earlier, the findings of the Colorado data for cannabis-related driver fatalities after the broad commercialization of medical marijuana underlie the concern. In Colorado, experience in restricting access to medical marijuana failed. Of the 12- to 17-year-olds who enter drug treatment programs, 70% to 72% do so primarily for marijuana addiction. Among those, 74% reported using someone else's medical marijuana.

So here we are, on the threshold of legalization, discussing permissible age and denying access through regulation to minors. Something's not right with this picture.

First and foremost, there is the messaging. Marijuana is not a harmless substance. Adolescents are heavily involved with its consumption, and age restriction and control of legal distribution is not likely not to deter them or their suppliers from continuing their practices.

Hopfer, 2014, suggests that in the United States the Surgeon General's 1964 report declaring smoking as harmful may have been the most important substance abuse intervention. It resulted, with the aid of public health stakeholders, in triggering a shift in public perception of smoking followed by a steady decline in smoking. Portage fears that the current message surrounding recreational use, and Bill C-45 in general, will produce the reverse phenomena. Has telling adolescents “wait until you're old enough” ever dissuaded the majority of them from doing anything?

I must raise the question of who benefits. There is an assumption that legalization will create a windfall of revenue for the public purse like that from alcohol, which will support an increase of expensive public health education and programming. A finding by Rehm et al. in 2007 suggests the inverse may prove to be true. Their findings suggest that social and economic costs generated by alcohol consumption may possibly be greater than the revenue derived from the production and sale of alcohol. Is there any reason to believe that this will not also be the case for legal cannabis sold through government monopolies?

Portage fails to understand how policing costs would diminish. Under legalization, importation, production, and trafficking would continue to remain criminal offences and would still result in policing and court costs. The same principle applies in other areas. Shifting the debate to age of access and mode of distribution may have clouded the challenges facing our society and our young once the act is implemented. We need to have serious thinking devoted to protecting the at-risk young people, who will continue to become dependent, perhaps in greater numbers.

In terms of recommendations, because we are dealing with a high-risk situation with important consequences for a significant number of vulnerable young Canadians, we cannot proceed with a trial-and-error approach. We have to get it right the first time.

The federal government, as the drafter and promoter of Bill C-45, must ensure that all the provinces have sufficient resources both financially and infrastructure-wise to adequately respond to the collateral physical and psychological health problems the bill is likely to create. The government must legislate strict minimum standards that apply in all jurisdictions and not abdicate its responsibility under the cloak of provincial rights.

We recommend that references to recreational use be eliminated; that the messaging and dialogue be changed to alert parents, educators, and employers to the possible challenges that legalization may create; and that we anticipate and provide for the needs for increase of service for non-infectious diseases.

Distribution should be strictly regulated as to age and amount purchased and should be tracked through a centralized registry. The government should examine the European example of cannabis clubs requiring memberships, on-site consumption only, minimum age, etc., as a mode of ensuring that little of the legal marijuana makes it way to the streets.

The bill should rescind the right to purchase for convicted traffickers, people with substance abuse treatment histories, people with significant acute psychiatric diagnoses, or those found to be driving under the influence.

We should invest massively in prevention, education, and treatment resources to meet the augmented demands likely to arise as a consequence of the legalization of cannabis.

Thank you, Mr. Chairman.

● (1135)

The Chair: Thank you.

Now we'll start our first round of questioning, of seven minutes for questions and answers, with Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you all for coming.

Mr. Howlett, I wonder whether you could at some time in the near future provide the source of some of your information regarding Colorado. We have correspondence from the Attorneys General of both Colorado and Washington State regarding impaired driving and also the use among youth. They tend to indicate the opposite of what you have said in this. Certainly for driving the initial spike appeared to be due to improved detection methods that didn't exist before. Also, the effective use by youth after legalization has pretty much plateaued at what was the national average. This seems to be in contradiction of what you are saying.

Mr. Peter A. Howlett: Would you like a response now, Mr. Eyolfson?

Mr. Doug Eyolfson: Very quickly, yes. I have limited time, but, yes.

Dr. Peter Vamos (Executive Director, Portage): Mr. Eyolfson, the data comes from the impact study compiled by the Rocky Mountain High Intensity Drug Trafficking Area study and that is—

Mr. Doug Eyolfson: What was the organization that performed that study?

Dr. Peter Vamos: That is....in several papers written by Harold Kalant. I'll send you the exact—

Mr. Doug Eyolfson: Just send us the references. That would be great. Thank you.

Mr. Bernstein, I appreciated your comment about the young people. We agree. We do not want young people consuming cannabis. As you say, we know that it affects the developing brain and as well, Dr. Grant, I echo those sentiments. We need to restrict this because we know it's harmful.

I particularly appreciated the comment that if young people are smoking a lot, then the first question we have to ask is why. I practised medicine for 20 years and we do see changes in young people who smoke or consume cannabis. On more than one occasion, I've diagnosed schizophrenia where it was very clear that the onset of psychotic symptoms predated the use of cannabis. Young people were self-medicating with it because they didn't want to talk about their symptoms with anybody. They started hearing voices and felt better when they smoked cannabis.

That's not the whole story, but you're right. I think by a more open dialogue about these things.... We have to ask these people and not just young people, if anyone is consuming a lot of the substance, the first thing we have to ask is why. I think that's very important.

Dr. Grant, in your brief and in your statements here, you said you recommended aligning it with the legal age for alcohol. Knowing what you do about it and knowing what you know about adolescent behaviour and patterns, could you speculate about what would be the result if we put the minimum age at 21 or 25, as recommended by the Canadian Medical Association?

● (1140)

Dr. Christina Grant: The point I was trying to make was that we already know that Canada's youth are experimenting with cannabis at a rate of about 30%, depending on what age. By 15 years of age, 30% of Canadian youth will have already used or will have used cannabis in the last year. The reason the Canadian Paediatric Society has said that we must align the age of legalization for cannabis with other controlled substances, like alcohol, is that they're going to keep using. Setting the age at 21 isn't going to magically reverse those numbers. Then we get into a situation where we're looking at what the balance is of harms and benefits. If we put the age higher at 21 or 25, we are concerned that, should they choose to experiment, which we don't recommend, then we have all these youth and young adults up to 21 or 25 who don't have access to regulated products with known concentrations. That's our concern.

We don't recommend it. We know they're experimenting and it should be the same as alcohol and cigarettes.

Mr. Doug Eyolfson: Thank you for that.

You also wrote about public education campaigns and that this has to be part of it. Again, we agree that Bill C-45 has to include robust public education, particularly directed towards our young people.

We've seen public education campaigns in the past that were, to say it charitably, a little clumsy. I think we can all remember laughing at the ad with the fried egg in the pan, "This is your brain on drugs". We know that just did not resonate with anybody as an effective deterrent. What would be the most effective way of transmitting to young people that this is something they shouldn't be doing?

Dr. Christina Grant: That's getting a little bit outside my area of expertise, to be honest, but I guess I have a couple of important points that I mentioned in my brief. We need to partner with youth leaders and public health agencies, and we need to have clear messages in preparation, and not just sort of last minute, for what's going to happen should this go through next summer. We need to make sure that there's adequate investment in getting the word out. I agree with Peter Howlett and Ian Culbert that there needs to be more of a conversation.

There are a lot of myths around cannabis use for youth. When you ask youth, as we often do as pediatricians and adolescent medicine specialists in our offices, you will hear they're getting a lot of information from cannabis YouTube channels and different lobby groups, but there are no clear messages around what the risks are. One in six will develop a cannabis use disorder. There are actually structural and functional changes seen on MRI related to cannabis use. Those messages aren't out there.

Mr. Doug Eyolfson: Thank you.

The Chair: Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Mr. Chair.

Thank you to all of our witnesses for appearing today.

I'm going to start with some statistics that Mr. Culbert and Ms. Grant shared: 12% of Canadians and 30% of youth are consuming cannabis. We've heard a lot about what cannabis consumers want and need, but I think, in the interest of balance for this bill, we have to look at this another way, and that is that 88% of Canadians, i.e., the majority, are not consuming. How do we protect their rights to not be exposed to increased harm, such as second-hand smoke, drug-impaired drivers, and schizophrenic and psychotic youth? Similarly, 70% of young people are not consuming cannabis. How do we protect them so they don't start consuming?

We heard some suggestions in previous panels, so I want to talk about those two suggestions and then get input from each of you on whether you think those ideas would be good.

The first is in terms of public education. We heard from Washington State, where they have about seven million people. They're spending $7.5 million a year on public education and have seen that as a great deterrent. For us in Canada with 30 million people, I would suggest that the $9 million that the Liberal government has come forward with will not be adequate or timely in order to address that. I think we need more public education, and we need it sooner.

The second suggestion is that in order to give the right message to children about how much cannabis is good for them, the legislation should say that people under the age of 18 should possess zero, but that any amount that is possessed would then be a ticketable offence instead of the language that is in here.

I'm interested to hear from all of you on whether you think either of those two suggestions are good, as well as your comments. We'll start at the left and go to the right.

● (1145)

Dr. Peter Vamos: I think one of the things that concerns us is messaging. You can interpret recreational marijuana to suggest a lifestyle or that marijuana is comparable to a sport. We know from the data that it's potentially physically and psychologically harmful and lends itself to misuse. What we would like to see—and perhaps the bill can reflect that—is a change in messaging. It's not a question of legalizing or not legalizing. It's just a change in the presentation.

Mr. Peter A. Howlett: I feel that the harm that the abuse or the extreme use of cannabis can create is evident. We live with it all the time. We have 500 young people a year going through treatment. Most of them have cannabis as a precursor drug or their main drug of choice.

As Mr. Vamos just said, it's about addressing the question of messaging, trying to affect culture, making it not a cool thing to do, developing the story or narrative to point out that this is very damaging to you and very damaging over a term.

Ms. Marilyn Gladu: Let's just stick to my two questions. Do we think that we should have more education sooner? Do we think that we want to send a message of zero possession for those under 18?

Mr. Peter A. Howlett: Yes. The answer to both of those is yes.

Ms. Marilyn Gladu: Dr. Grant.

Dr. Christina Grant: For the first question, yes, we need it to be adequately funded, and I agree with your statement on that: messages need to come sooner. I don't agree with the ticketable offence under 18. That's going to penalize youth and is not helpful.

Ms. Marilyn Gladu: Mr. Culbert.

Mr. Ian Culbert: There are numerous players in addition to the federal government when it comes to education, so $9 million is a good start. Obviously, there are all the provinces and territories, and we have to differentiate between the public education component, which comes down to the nuts and bolts of what's going to be legal —where you can buy it, who can buy it, and who can possess it— and the health promotion component, which is the legitimate sphere of the federal government in health matters. We certainly encourage a robust investment there, and one that is focused on conversation.

In 2005 my association was funded by the federal government to do a project that was about getting parents talking to their children about cannabis use and driving. It was about having the conversation. It was non-judgmental and non-stigmatizing. It was just about breaking down some of those barriers.

There are a lot of misconceptions on both sides about cannabis use and the product itself that need to be broken down, making sure parents have access to those valuable resources that tell the whole story. Kids aren't stupid. You can have a conversation with them and that's what I meant about needing to normalize the conversation, not the use. We haven't even normalized the conversation about alcohol use, and that's the socially accepted substance.

There's a lot of work to be done, because we're seeing a big societal shift as far as what the norms around drug use are in this country.

We do support ticketing as opposed to those minors having a criminal offence.

Ms. Marilyn Gladu: Very good.

Mr. Renaud.

Mr. Paul Renaud: Yes, I agree with Mr. Culbert. I also feel that eight decades of prohibition have really skewed our information. There has not been much real science done around cannabis, and now that we're moving towards a regulated framework we'll actually be able to use science as a guide.

As we enter the legalization of cannabis, there will be a lot of studies. Obviously, things will be monitored very closely, and we can then at some point have more actual data on which to base changes in policy, to tweak the policy where it may need tweaking.

As for the age restriction, it seems appropriate to me to delegate a certain amount of that to the provinces, as we see differences in the legal age to consume alcohol in different provinces and different jurisdictions. If the age were made higher than the age to consume alcohol, for a lot of us that would not make a lot of sense. It would effectively promote more alcohol use, which, quite frankly, I don't think we want to do.

The incidence of fetal alcohol syndrome is a very profound—

● (1150)

Ms. Marilyn Gladu: In the interests of time, I'd like to get some input from Mr. Bernstein as well.

Mr. Scott Bernstein: Thank you.

In the area of public education, your first point is a great idea. We're definitely in favour of having evidence-based education at a young age about what drugs are, the various social scenarios where you might find yourself involved in drugs, the harms of drugs, and why people take drugs and report feelings of benefit or otherwise, in medical use or otherwise.

Having a discussion from a very early age based on evidence, rather than myth and scare tactics, is good. I grew up under "just say no" and the egg in the frying pan, and here I am testifying to the House committee on legalizing drugs. I don't think those messages work in the way they're intended to. Basing it on evidence and also, where possible, having young people themselves as the educators and talking about their own experience would make it more effective.

On your second point around the ticketable offence, again as Mr. Culbert said, ticketing is preferable to criminalization. In the best scenario, we would create a social framework where it's not necessarily a punitive approach against young people, but more working with them about use.

Having the floor of no tolerance, zero possession, isn't realistic. That would incentivize police to go after just minor things, hassling young people. If someone is smoking in public, it could be confiscated, and the peace officer could say, "Don't do this", but ultimately I don't think there should be any process at zero tolerance to be effective.

The Chair: The time is up.

Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

Dr. Grant, I want to probe the state of the research on this to separate what we believe and what we know. We've already heard from a number of witnesses the challenges of conducting research in a criminalized environment, wherein there are all sorts of difficulties with doing research. It's hard to have control studies, where we have a group of 15-year-olds smoking cannabis and a group who are not and chart their paths. You have ethical considerations, of course, and the fundamental issue of causation versus correlation.

A recent study from Harvard Medical School and the VA Boston Healthcare System found that:

> While cannabis may have an effect on the age of onset of schizophrenia it is unlikely to be the cause of illness....

It also reported:

> In general, we found a tendency for depression and bipolar disorder to be increased in the relatives of cannabis users in both the patient and control samples. This might suggest that cannabis users are more prone to affective disorders than their non-using samples or vice versa.

Although intuitively I share the concern that cannabis use in young people is not a good thing and can't be positive—I absolutely believe that—I think it's important that as a health committee we distinguish what we believe from what we know.

Is there, then, a causative element established in literature with respect to cannabis causing mental illness, or is it correlated?

● (1155)

Dr. Christina Grant: First of all, the CPS statement is based on the scientific literature, not on belief but rather on the facts that we have at the time we're reviewing the data. As I mentioned in my brief, the relationship between psychosis and cannabis is complicated.

My understanding of the state of the literature is that we can't say with 100% certainty that it's causative, in the sense that only cannabis use in a young person regularly over years would for sure result in their developing a psychotic illness; however, based on many studies we know that there are a number of different types of psychotic outcomes.

We know from rigorous research that one of the side effects of using cannabis can be an acute psychotic episode. Some youth experience that when they're high. There is another type of acute psychotic episode that can last days to weeks, and often those youth end up coming to emergency rooms, being seen because the psychotic symptoms have lasted beyond the high or the use. We know from research that those youth, if they're followed, have an increased likelihood of about 50% of having another psychotic episode in the future that is not related to cannabis.

I'm not a schizophrenia expert, but from reviewing the literature there is definitely a link between regular, ongoing cannabis use that starts young and continues, and the development of schizophrenia. As I mentioned in my brief, however, it's not that alone. Judging from the literature, for example, the risk of having a psychotic illness in an adult is about 1%. Add regular, ongoing cannabis and that doubles the risk to 2%, which sounds quite low if we think 2% versus 1%. However, if you have a family member who has suffered from schizophrenia or a psychotic illness and your risk as an individual is much higher, then doubling the risk with cannabis becomes significant.

Mr. Don Davies: Are people who are prone to schizophrenia more likely to seek out self-medication, as Dr. Eyolfson said, or would using cannabis lead to more psychotic episodes? That's the essence of my question. How do we know that the person wouldn't have had psychotic episodes in any event?

Dr. Christina Grant: It's a great question. Schizophrenia isn't my main area of expertise, but there are a number of studies. I'm happy to give you those references. They're referenced in the Canadian Paediatric Society's statement, indicating that it's not that the psychosis came first and then they're self-medicating, but rather the reverse. But it's complicated.

Mr. Don Davies: Okay, thanks.

I want to just push a little and pursue the issue of edibles. I'm not sure I have your testimony correct, so I want to clear this up. Are you suggesting that this legislation should not legalize edibles?

Dr. Christina Grant: My understanding is that in the current legislation we're talking about pot and growing of plants. Edibles are not mentioned.

Mr. Don Davies: Correct.

Dr. Christina Grant: My concern is that we need to make sure that this issue around young children having accidental ingestions with edibles is up there, that people know about this risk so that it's not lost.

Mr. Don Davies: Yes. Well, Colorado has done that and we've heard evidence about this. You're absolutely correct about that, about making sure that they're single servings, that they're in childproof containers, that there's no marketing to children, that the product itself is stamped so that you can tell what it's going to be. All these conditions have been implemented in Colorado. Would it be your testimony that if we do that, edibles should be legalized?

I'm going to run out of time, so I'm just going to get my context out here. The reason I ask is because of your testimony on aligning the age with alcohol and tobacco. You felt that it was preferable to get access to regulated products of known quantity and avoid high-risk behaviour. If you don't legalize edibles, you are leaving edibles to the complete black market where it's totally unregulated, and high-risk behaviour in young people who will continue to have access with no regulation whatsoever will continue. I want you to square that circle for me.

I'm putting to you that we should regulate edibles, because if we don't, the exact same problems will occur that you described occurring by not legalizing cannabis at a proper age.

● (1200)

Dr. Christina Grant: I'm not saying that edibles should be legalized. I am saying there are a lot of concerns about young people and toddlers ingesting edibles if they're around in the household. Even though those childproofing measures you mentioned might prevent harm, having them around is a concern. The edibles are a concern and that has not been discussed.

Mr. Don Davies: Thank you, Chair.

The Chair: Mr. McKinnon.

Mr. Ron McKinnon: Thank you, Chair.

I'd like to talk about education. One of the public policy objectives here, of course, is to reduce access or use, at least, among youth. Key to that, as we've heard from many people, is education.

What kind of education actually works for this? We've heard allusions to the fried egg on concrete example. I remember, way back, a movie called *Reefer Madness*, which was promoted in the sixties as a means of keeping kids off drugs, and frankly, it was universally scorned because it was so bizarre.

What works? I'd ask Mr. Culbert, perhaps, to start.

Mr. Ian Culbert: As I referred to earlier, it is about having conversations and normalizing the conversation about substance use and not limiting it just to cannabis. As a society, we are very uncomfortable. We don't like talking about sex, we're not great talking about alcohol, and we have a significant paradigm shift going here when it comes to currently illegal psychoactive substances. It's making sure that parents, teachers, social services, and health professionals all have tools to help them have that conversation.

Do I want to see a national campaign that is the Government of Canada telling you how to smoke pot? No. I don't think that is a legitimate way forward. A national campaign that directs all Canadians to vetted resources that are going to help them have that conversation in different contexts is the way forward.

It's simply having honest conversations and trying to leave personal biases or the myths that you've carried from your childhood out of the conversation. It's having an open mind when you're talking to kids or family members about this, and then being able to have an honest conversation about why you want to use these substances. If it appears that there's problematic use happening, it's being able to have that conversation as well.

Mr. Ron McKinnon: Ms. Renaud, would you like to respond?

Ms. Judith Renaud: What's important here is having the three levels of government involved. We need to ask for municipal opinions. They feel they've been left out of the discussion. We need to talk to the provincial ministries of education. Teachers have felt they have been muzzled, that they haven't been able to talk about this issue. They have feared for their jobs—it goes that far—and have left the discussion of cannabis to law enforcement officers, in particular, the DARE program.

Since l982 the DARE program has literally taken over the classroom on discussing the issue of cannabis, and it's usually with a zero tolerance and "just say no" message, which has left the children frustrated and unsafe because they stop listening. While the teachers are in the staff room, asking, "What do we do here? We haven't been given the responsibility to teach this", we have now asked for a moratorium on law officers in the classroom, so that we can return to educators the responsibility for delivering evidence-based drug education in a holistic manner.

The federal government needs to talk to the provincial ministries of education across Canada. We need to get the values of families discussed without fear or judgment. Until we do that, none of the governments are talking back and forth. Parents are feeling that they have to take matters into their own hands. If they do, educators must reflect those families. Right now we don't see that. If we can really get the dialogue going and have the discussion without the fear, the federal government can actually help move that forward.

● (1205)

Mr. Ron McKinnon: What I'm hearing is somewhat my own predilection in this matter, which is that we need to avoid the preachy and condescending, patronizing sort of message, right?

Ms. Judith Renaud: Absolutely.

Mr. Ron McKinnon: The comment was made by someone that we must not talk about recreational cannabis. They advised that we not talk about recreational cannabis in the act, just about cannabis.

Would you like to respond to the point on education as well, Mr. Renaud?

Mr. Paul Renaud: I agree with Judith that there has been a real dearth of good information available, especially to young people. If they feel they're being lied to, the tendency is to turn off and not listen. Now that we'll actually be able to have credible studies done in a legal environment, we'll all be able to find out exactly where things are going and what information is relevant. The main thing is to be truthful and honest, and not to have a predetermined agenda that needs to be supported, as has been the case in the past.

Mr. Ron McKinnon: Thank you.

Mr. Culbert, we've heard testimony that strict marketing and plain packaging could make it difficult for the new legal market to compete with the existing illicit market. Would you share your rationale for recommending plain packaging?

We've also heard testimony that branding can be important, still within the context of plain packaging. Could you respond?

Mr. Ian Culbert: Branding can be important to the bottom line of the private sector, plain and simple. It's why you make something look attractive, so that people know, "I want the product in the red package because that's the one my dad uses", whatever that product may be.

Nothing about plain packaging prohibits the provision of clear information about potency, outcomes, and potential side effects of use of the product. We need to not glamorize cannabis consumption the way we previously glamorized tobacco and continue to glamorize alcohol. This is not an industry that needs help selling its product, so it's a complete red herring that the poor industry isn't going to be viable if they don't have these rights given to them. They want to be able to market as strongly as any other industry wants to market itself, but there is no need for it. We have a proven marketplace in Canada already.

As far as competitiveness with the illegal market, which won't disappear overnight, the studies in Washington state and in Colorado have shown that when they have the option, people prefer to go to the legal option. Even if it's not exactly the same product they're used to, and even if it's slightly more expensive, they would rather not risk a criminal fine by purchasing an illegal product.

Once again, legalizing and regulating is helping the legitimate industry, and we will eventually see a reduction in the illegal market.

The Chair: That completes our seven-minute round. We'll go to five-minute questions now, starting with Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair. Again, this is another great panel. I wish I had more time to ask questions, but I have a very short period of time.

I want to start by picking up on a point that I think Mr. Howlett made, that with our youth there's a diminished understanding of risk. The CMA was here with very credible witnesses. Dr. Grant, thank you for updating us on the science, about the structural and functional effects, the problems with psychosis, with schizophrenia. I have a person close to me for whom it has been linked.

My concern is still, are we doing enough to help our young people? Talking to parents in my community, some of the comments were that this is a big experiment that Canada is conducting and that very few countries have gone this way. There are a lot of concerns. We can always get easier, but it's tough to get tougher.

You mentioned something that I thought was interesting. Not too many people have brought this up. You talked about higher THC levels and something of known potency. How would you see that being implemented? Should a certain amount of THC concentration be prohibited for those under the age of 25? We've heard that age mentioned a lot. How would you do that?

● (1210)

Dr. Christina Grant: One of the recommendations from the Canadian Paediatric Society is that one way to mitigate some of the risks, because we know that youth and young adults are going to continue to experiment, would be to allow only lower-potency cannabis to be available legally to those under the age of 25. That was our recommendation.

Mr. Colin Carrie: It would be different products available to different ages.

Dr. Christina Grant: Yes, a lower concentration of THC, because THC is the psychoactive ingredient.

Mr. Colin Carrie: The Liberals were very clear that they want to take it out of the hands of organized crime, but we've heard from witnesses from other jurisdictions that organized crime is not going to go away. In terms of decreasing the use by kids, again from the Colorado experiment, and we had Washington here yesterday, as Mr. Culbert said, it hasn't gone up but it certainly hasn't gone down any further.

I like this whole idea of education and implementing something. I'm disappointed that the Liberals have had two years and have done nothing yet, and this is rolling out in 290 days.

I want your opinion. We've had witnesses here who claim to be experts, and they're commenting, for example, that cannabis is not even as harmful as alcohol. I think the science, especially for our youth—and we should be concentrating on our youth—is very clear that it is worse.

With this bill, 12- to 17-year-olds are able to have, for personal use, up to five grams. You're on the record as saying that you don't like the ticketable offence. Twelve-year-olds, that is grade 6. You deal with kids; I don't, as a politician. What would you do with these kids? We've heard the government talk about harm reduction and that philosophy moving forward, but not a lot about the prevention and the treatment side of things.

A 12-year-old, who is the big kid in public school, who the younger kids are looking up to, can have up to five grams for personal use in this bill. If a teacher catches one of these kids, what do they do with them?

Dr. Christina Grant: Just to be clear, as I said in my opening statements, there is no safe age for cannabis use. Right?

Mr. Colin Carrie: Right.

Dr. Christina Grant: As a Canadian Paediatric Society, we don't recommend, obviously, any children or youth experimenting, because of all the risks I've outlined.

In terms of the age of legalization, again, we know that adolescents are already experimenting. The age, whether it's 21 or 25, is not going to be a deterrent from that standpoint.

Mr. Colin Carrie: I'm talking about 12-year-olds.

Dr. Christina Grant: What I'm suggesting is that obviously that would be a very grave concern. As a physician, getting back to what Ian spoke about, we'd be assessing that young person and trying to understand why. That would be a mark showing that there's something going wrong, most likely, in that young person's life.

Mr. Colin Carrie: What should be in this bill to allow you to do that? That's what I'm saying. What's the mechanism now? If somebody is allowed to have up to five grams, which in my understanding could be up to 15 joints, a 12-year-old, the potential for sharing it, selling it, of the criminal element utilizing younger people to get younger people hooked on it, is there. What tools should be in this bill to allow physicians, educators, and people who offer treatment to put them into that mode to catch it early?

In terms of prevention and treatment, what do we need in this bill that's not in there?

Dr. Christina Grant: It goes back to some of the comments of our first speaker this morning around mandating that young people get assistance, whether from a physician or from some kind of connection with counselling and involvement with the family to understand what's going on.

● (1215)

Mr. Colin Carrie: Does that need to be in the bill?

The Chair: The time's up. We move to Mr. Ayoub.

We may need translation here.

Mr. Ramez Ayoub: Yes, I'm going to ask the questions in French, so if you need any translation please make use of it. I will wait until everyone is ready, just not to waste my time.

The Chair: No, you're good.

[*Translation*]

Mr. Ramez Ayoub: Thank you to everyone for your testimonies, each more interesting than the last.

We sometimes experience historical moments, and I think this is one such moment. Last year, we passed legislation on medical assistance in dying. Today, we are spending a lot of time talking about legalizing cannabis. I'm listening to Mr. Renaud, Ms. Renaud, Ms. Grant and Mr. Culbert, and I'm hearing a sense of urgency. Am I wrong? Is there a sense of urgency in acting to save young people?

[*English*]

Ms. Judith Renaud: Yes, there is absolute urgency. We have a fentanyl crisis in British Columbia and now across Canada. We know that. We have a lot of turned-off people who have not really respected what they've been hearing from authorities. That's the case right from law enforcement to educators, to nurses, and to doctors.

At the last meeting I attended at an elementary school, the topic was cannabis and the brain. They called me up and asked me to sit in and listen. There were two doctors, three RCMP, and four community service people. All of them said there is an urgency for children to hear from all of them, but what they needed was to have everyone on the same page in order for the children to not be frustrated.

What I came out of the meeting with is that the police want to work with the doctors, the doctors want to work with the community services, and all of them want to work with parents. Everyone has felt isolated. If we stop the isolation and have the communication develop, that curriculum will be able to develop so that children will not be in harm's way.

Mr. Ramez Ayoub: Thank you, Madam Renaud.

Mr. Culbert.

Mr. Ian Culbert: Absolutely, the time for action is now. As mentioned before, parents, educators, and health professionals need to know what the landscape is going to be going forward. We don't know that.

Ontario is the first jurisdiction to announce a plan for how it's going to roll out, and—

Mr. Ramez Ayoub: I got the answer.

Madam Grant, is it the same answer?

Dr. Christina Grant: Yes, I agree.

Mr. Ramez Ayoub: Since you said yes to that question, what would be your thoughts on this? Yesterday, we had the Ontario police here, and they said they would not be ready. What would your answer be to them in the case that it's an emergency and it needs to be addressed?

On the one side, I have some people saying to wait, to not do anything, to wait until we're ready. On the other side, there's an emergency. My perspective is to save the children.

Mr. Ian Culbert: Absolutely. As I said in my remarks, we have high levels of use right now. We need to be doing something right now, and until we decriminalize the product—legalize and regulate it—educators can't have the conversation. Everyone is muzzled because it's still illegal. We need to move as quickly as possible.

Law enforcement absolutely has challenges, but to say that there aren't drug-impaired drivers today.... They are taking action today. Is there going to be an explosion of drug-impaired drivers on July 1, 2018? I don't believe so, but I don't want to take away from the real challenges law enforcement is experiencing as well.

[*Translation*]

Mr. Ramez Ayoub: I have a comment, as well.

Until now, I have never sent my children or even young adults to buy things from criminals. As Ms. Grant said earlier, currently, 30% of young people have direct or indirect ties to criminals, the Mafia. The opposition is absolutely right: we want to eradicate the illegal side and drive criminals out of the market. We want to save young people. I'm concerned that 30% of young people have a connection with criminals. We have to eradicate that. We mustn't wait because it is always on the rise.

What is your reaction to this system, Ms. Renaud?

● (1220)

[*English*]

Mr. Paul Renaud: As we've all perhaps heard said before, drug dealers don't ask for ID. Under the present system, which is no regulation and no control, all the decisions are being made by the criminal organizations. They decide the purity, they decide the price, and they'll sell to absolutely anybody.

We don't seem to have these problems with young people consuming alcohol so much, precisely because it is legal and because it is regulated. Our belief is that moving into a system of regulated cannabis will achieve the same results. It may take time, because the fact is that many young people are using cannabis, and perhaps inappropriately. Cannabis as medicine may turn out to be a very powerful tool to discourage use where it's not appropriate.

The Chair: The time is up.

Mr. Webber.

Mr. Len Webber: Thank you, Mr. Chair, and thank you to the panel.

Mr. Bernstein, I have a question for you. You support the federal minimum age of 18 years of age in this legislation. You suggest that any higher age will support the illicit market. You mention that strict enforcement policies do not work, that youth criminal penalties should be education and the soft approach, that there should be no criminal sanctions on youth whatsoever, under the age of 18.

I also heard from you, Dr. Grant, that you also do not agree with penalization of youth or the ticketing of infractions for possession.

Does not this then create a perfect environment for the black market, for the drug dealers to approach these children, who have no threat of legal consequences, and have them distribute their drugs for them? I just ask that question.

Mr. Scott Bernstein: I'll start by questioning your premise that fear of legal sanction reduces youth behaviour around seeking out and using cannabis. During our decades of prohibition when absolutely cannabis had been prohibited, there has always been legal sanction on the table, and we have, as some of the other witnesses mentioned, the highest rates of cannabis use among youth in many countries.

I think the point is this. If we rely on those old approaches and ratchet up the punishment for youth with the expectation that doing so is going to adjust behaviour, that's misguided and not borne out by the evidence.

I didn't say there shouldn't be any sort of intervention among youth who are found.... I agree that if my 12-year-old son, for example, came home and had some cannabis, that would be, as they say, a teachable moment. The point is that we probably need to create teachable moments before that happens, but the idea is that there's a conversation, and often that conversation should be with families who are equipped with evidence and equipped with information to share with their own children. It should be available to schoolteachers, guidance counsellors, and others.

For young people, that sort of intervention may very well be effective. Young people don't necessarily want to have confrontations with adults who are doing things. As the other witnesses have said, however, it's all about the approach. We know that criminalizing youth and telling them “don't do it” is a recipe for the opposite to happen, so it's time to rethink the way we're approaching this dialogue with young people.

Mr. Len Webber: Dr. Grant, do you have any comments on that?

Dr. Christina Grant: Let me just say that I completely agree.

Mr. Len Webber: Dr. Howlett, is Portage, your treatment centre, primarily for marijuana addicts? Is that correct?

● (1225)

Mr. Peter A. Howlett: No, it's for a wide range of substances.

Mr. Len Webber: You are obviously concerned about Bill C-45 in your comments. One of your recommendations was that the federal government should ensure that all provinces receive payments or sufficient funding to deal with the health issues that will arise from the legalization of marijuana.

Do you see an increase in demand for your service after this legislation is in place?

Mr. Peter A. Howlett: I think it's evident to everybody that the supply of marijuana is not going to decrease. Cannabis is not going to decrease. It's going to increase. The issue of approach that has been identified as an essential concern is what is preoccupying me as an individual and, I think, most of my colleagues as well.

There are ways to approach young people and ways clearly not to, and their inclination to listen and to be influenced by individuals is largely tied to their heroes and influencers of the moment. We have to be very thoughtful about how the messaging is communicated to them.

We're dealing with a situation. Supply is not in decline and won't be in decline. We also have a cultural environment to deal with where it has been cool, and marijuana has some outdated benchmarking against other drugs. It's as if it's less dangerous and less concerning, and therefore, if you indulge in the lesser evil you're within certain boundaries of safety. The fact that there are images of all the cool guys using it is the concern.

The Chair: Ms. Sidhu.

Ms. Sonia Sidhu: Thank you, Chair.

In 2015, the highest use of cannabis in Canada was among youth, at 21%. My question is to Mr. Culbert. You said the illicit cannabis market is like public health Russian roulette. Could you expand on the risks for public health and safety if we adopt a higher minimum age, as some people have suggested?

Mr. Ian Culbert: Certainly. As my colleagues have mentioned, 21% of 15- to 19-year-olds are using. If you set that age higher, at 21 or 25, you're forcing those young people to continue to go to the illegal market to obtain their product. It's not like they are going to stop. Complete prohibition hasn't stopped them. An age limitation is not going to stop them either.

Interestingly, partially we see such high rates of cannabis use in this country because our work around minimum drinking ages has been so successful. Also, there are limits on legal outlets for alcohol sales. In many parts of this country, especially in rural areas, it is much easier to get cannabis than it is to get alcohol. In fact, the cannabis comes right to your school.

Setting that age, despite the neurological evidence that may support it, is in effect going to continue the harms for those young people.

Ms. Sonia Sidhu: Thank you.

You said in your statement that we don't have the luxury of time. Canadians are already using cannabis. When it comes to enacting the legislation, we have heard from some witnesses that more time is needed. What would be the risk of delaying?

Mr. Ian Culbert: The risk of delay is added confusion amongst the population. We've signalled that we are moving in this direction. There's always that perception of a need for more time. The foundational work in Bill C-45 is on the right track. The provinces and territories have known since October 2015 that this was coming, and they have been working towards this. Will it be perfect on July 1, 2018? No, but the provinces will be on the right track.

The harm associated with the potential delay is that you're keeping all Canadians under a criminalized model that has serious negative consequences for all.

Ms. Sonia Sidhu: To the educators, do you think a shift of public education along with legalization would achieve the same results?

● (1230)

Mr. Paul Renaud: Yes, we do think that. Education around alcohol, for example, has been very effective, as has education on reducing the rates of tobacco use among youth. Those are the direct results of education campaigns aimed at youth groups, so I see no reason to think that the same paradigm would not work with cannabis consumption among youth.

Ms. Sonia Sidhu: Mr. Bernstein.

Mr. Scott Bernstein: Yes, I agree with that. Youth use is not going to decrease based on criminalization. Education is important as part of this legislation. It should be thought of as a key approach to addressing youth consumption, as I mentioned earlier.

Ms. Sonia Sidhu: The next question is to Ms. Grant. You said we need adequate investment in youth. You mentioned the cannabis YouTube channel and the need for a clear message. What kind of message, what kind of approach should we take for educational and health purposes? Health is a priority for our government, for all Canadians. Can you expand on that?

Dr. Christina Grant: Basically there needs to be a huge education campaign for young people and for families as part of it, similar to what Ian has already mentioned, to have conversations about the actual facts. What are the facts? What are the risks? It's communicating that clearly to Canadians, to families—to parents and young people—so that educators, physicians, etc., can be talking about it.

Harnessing the voices of youth and youth leaders would be really important to making those messages appealing, using the kind of language and words that will resonate with young people. They'll be able to see themselves, to understand. The peer-to-peer piece is important.

The Chair: Thank you. The time is up.

Mr. Davies.

Mr. Don Davies: Thank you.

Mr. Culbert, given your clear description of the harms caused by criminalization and the urgency to pass this bill accordingly, would you urge the Minister of Justice to direct prosecutors to cease charging Canadians for simple possession right now, pending passage of this bill?

Mr. Ian Culbert: Yes.

Mr. Don Davies: Thank you.

Ms. Renaud, Mr. Renaud, would you agree with that?

Ms. Judith Renaud: Yes, absolutely.

Mr. Paul Renaud: Yes, absolutely.

Mr. Don Davies: It would seem to be logical that if much of the harm that you've described to us here today has to do with the criminalized context in cannabis—organized crime involvement, the lack of product safety, the stigma and lifelong problems of criminal records that can attach to people—this is something we could and should be doing right now as well.

Dr. Grant, we haven't talked about smoking. I take it that from a pediatric point of view, smoking any substance of any type, tobacco or otherwise, would have significant and serious health impacts.

Would you say that it would be better from a health perspective to try to encourage the legal ingestion of cannabis by non-smoking methods, at least in terms of the respiratory system?

Dr. Christina Grant: If you're speaking solely of respiratory issues, of course not smoking is better, but there are unique risks with the edibles. We're back to the edibles again. For example, youth who are experimenting with edibles may be expecting to feel the effects of the cannabis sooner because of either what they've heard or what they've experienced with smoking it. There are reports in the literature of concerns that youth, when they are consuming edibles, will consume more and more because their body hasn't metabolized it yet and they haven't had the high yet from it, resulting in significant overdose and ingestion.

Mr. Don Davies: Has anybody ever died from that?

Dr. Christina Grant: Not to my knowledge.

Mr. Don Davies: Has anybody died from smoking?

I'm sorry, you're nodding. I take it that's a yes, that people have died from smoking.

● (1235)

Dr. Christina Grant: Well, your point.... I'm not sure exactly what you mean.

Mr. Ian Culbert: Do you mean smoking cannabis?

Mr. Don Davies: I mean smoking tobacco, smoking anything. I take it that there's a clear causative link between smoking any substance and death. Is that correct?

Dr. Christina Grant: Oh, yes. I wouldn't disagree with that.

Mr. Don Davies: Thank you.

I want to come back to the age issue. I'm not sure where I'm landing on the age issue. It seems to me that there are pros and cons. On the one hand we have to set some limit. We're not going to throw it open to say that any child can have access. There are arguments to link it to the age of legal access to alcohol, but then there are other factors as well.

I want to put to you, Mr. Culbert, this issue. Let's say we pick age 19. Seven out of 10 provinces are already at 19, and 19 has the added benefit of making sure that it's not really going to be in high schools, because overwhelmingly there aren't 19-year-olds in high school, by and large. If we set it at 18, in grade 12 half the class is going to be carrying legally up to 30 grams of marijuana and the rest of the school is not. Also, we have of course the information we have on brain development, so that's one more year of brain development.

Would it not make sense to set 19 nationally across the board, based on those factors?

Mr. Ian Culbert: CPHA would prefer that the legal drinking age across the country be 19, because we know that with the evidence regarding intoxicated driving and accidents, that one year makes a huge difference. When we once again look at the whole picture, to have alcohol being treated differently from cannabis, it doesn't make a lot of sense to have different ages in different provinces. The education component becomes that much more complicated. It is a false barrier and kids will see through that. They will question that. If they only have to be 18 to drink, why do they have to be 19 to consume cannabis? It's creating that logic of it.

At the same time, I am anticipating that with Ontario and Quebec being border provinces, there will be that disconnect as well. We'll have to start dealing with that the same way we've had to deal with it with alcohol. We would have preferred age 19 across the country, if it matched the legal drinking age across the country.

If I could go back to your previous question, yes, millions of people have died from tobacco smoking. There are no cases of anyone dying of smoking cannabis. Chronic use does have some respiratory issues associated with it, and there have been documented cases of death as a result of edibles. It was—

Mr. Don Davies: Can you tell us where that research comes from?

Mr. Ian Culbert: That was Colorado state, consumption of cannabis-infused brownies. Now that wasn't the death. The death was the result of the person jumping off a hotel balcony, so it's an associated death, but it wasn't metabolically related to the consumption.

Mr. Don Davies: The purpose of my question was on the metabolic.

Mr. Ian Culbert: Yes, that's just to clarify.

The Chair: All right, thank you very much. That concludes our session, our panel.

I want to thank all members on behalf of our committee, especially Mr. Bernstein. I know it's very difficult to be in your position, and we understand that. We appreciate your patience with us. It's hard not to be in the room and still be part of it, but you have done a great job. To all our members, all our panellists, you have all brought your different perspectives and helped us a great deal to understand what we're dealing with.

Thank you very much.

I'm suspending the meeting and we'll reconvene at 1:45.

● (1235)

(Pause)

● (1345)

The Chair: We'll resume. This is again meeting number 66 of the Standing Committee on Health. We have a panel before us now to discuss the age for legal possession and the impact on young Canadians.

We welcome our guests, and we thank you very much for taking the time to come. I'm going to introduce you, and then we'll have a 10-minute introduction for each, and then we'll go into questions.

Starting off, from the Canadian Centre on Substance Abuse and Addiction, we have Amy Porath, director of research and policy. We also have Drug Free Kids Canada, represented by Marc Paris, executive director, and William J. Barakett, member of the DFK Canada advisory council. From the Institut national de santé publique du Québec we have Maude Chapados, scientific advisor and François Gagnon, scientific advisor.

We'll start with Ms. Porath for your 10-minute opening remarks.

Ms. Amy Porath (Director, Research and Policy, Canadian Centre on Substance Use and Addiction): Good afternoon, Mr. Chair and members of the committee. My name is Dr. Amy Porath-Waller, and I'm the director of research and policy at the Canadian Centre on Substance Use and Addiction, or CCSA.

CCSA was created in 1988. We're Canada's only agency with a legislated national mandate to reduce the harms of alcohol and other drugs on Canadian society. We welcome the opportunity to speak to you today on the topic of age for legal possession of cannabis and its impact on youth.

CCSA's subject matter expertise on cannabis is founded on the research, policy advice, and knowledge mobilization activities that have been the priority area of focus for us since 2008. Accordingly, the issue of cannabis legalization is of great interest to our organization, and we believe we are well positioned to contribute meaningfully to the discussion on Bill C-45.

In respect of time constraints, my presentation today will be brief. CCSA submitted a brief on Bill C-45 in advance of our appearance today, and we would be pleased to cover the areas in the brief beyond the scope of youth and age of legal possession.

As many of you may already know, Canadian youth have among the highest rates of cannabis use in the world. Despite a decrease in use among youth in recent years, cannabis remains the most commonly used illegal drug among Canadian youth aged 15 to 24. Canadian youth aged 15 to 24 are also more than twice as likely to have used cannabis in the past year, as compared with adults aged 25 and older.

Youth are also at greater risk of experiencing harms associated with cannabis use than adults are, because adolescence is a time of rapid brain development. The risks associated with use increase the earlier youth begin to use and the greater the frequency and quantity they consume. Accordingly, delaying the onset of use and reducing the frequency, potency, and quantity of cannabis used can reduce this risk.

An important point that I want to make today is that when we speak of a comprehensive approach to reducing cannabis use among youth, we refer to regulatory tools, but equally important we also speak of a comprehensive, evidence-informed approach to prevention and public education. I will speak more on this latter point soon.

First, minimum legal age of access is an important component of a comprehensive approach to reducing youth cannabis use. Given the number of youth aged 18 to 24 who currently use cannabis illegally, the increased risk of health impacts must be considered alongside the risks associated with the continued use of cannabis obtained outside the regulated market.

Setting the legal limit at 18 years of age at the federal level means that young people will not face adult criminal charges for cannabis possession. Setting the age at 18 also provides the opportunity for the provinces and territories to set additional regulations that can discourage use without the harms of criminal justice involvement.

For example, the provinces may consider increasing the age of cannabis access from 18 to 19 to align with the minimum legal drinking age in most provinces. This provides a consistent message to youth of legal age that we trust them to use impairing and potentially harmful substances in a responsible way.

A second regulatory tool that is an important component of a comprehensive approach to reducing youth cannabis use is pricing. We know that youth are price-sensitive. Evidence from the alcohol literature indicates that standardized minimum pricing is an effective mechanism for reducing overall levels of alcohol consumption and that indexing—or rather, setting the price according to product potency, and in the case of cannabis by level of THC—can incentivize the use of lower-risk products. Certainly, ongoing analyses will be important to ensure that pricing maintains a balance between reducing consumption and encouraging diversion to the illegal market.

● (1350)

In addition to these regulatory considerations, there is also a need for a comprehensive, evidence-informed approach to prevention and public education in order to provide young Canadians with the knowledge and skills they need to make informed decisions about their personal use of cannabis. Accumulating evidence suggests that a multi-faceted approach, one that involves several components, including programming in schools, resources for parents and families, community interventions, as well as mass media, will help to maximize outcomes among our youth. A comprehensive approach to prevention and education also requires proactive and ongoing investment, as well as ongoing monitoring and evaluation to ensure that it has the desired impact.

CCSA has conducted focus groups with youth to understand their perceptions of cannabis and cannabis use. In these discussions, youth told us that they want information about risk that is linked to tangible outcomes, and they want harm reduction strategies so that they can reduce those risks if they decide to use cannabis. The evidence indicates, and we've heard directly from youth, that they want to hear both sides of the story on cannabis, both the benefits as well as the harms. To that end, education and prevention initiatives need to incorporate what we've heard from youth in order to be impactful.

We also know that youth continue to hold fast to certain misperceptions about cannabis, including the perception that everyone is using cannabis all of the time. We've also heard from our youth focus groups that while they recognize that drinking and driving is dangerous, they don't view cannabis in the same way.

We know from our focus groups as well as from the broader research literature that young people are influenced by the Internet, the media, and public discourse on cannabis. Clear, consistent, and factual information that addresses myths and misperceptions is therefore essential, to cut through the many sources and types of information and messages that youth are exposed to about cannabis on a daily basis. Such information will help to establish actual social norms that lower rather than promote the use of cannabis.

We also know from our research that youth want to receive information from sources they trust who can speak credibly about cannabis. Depending on age, this includes parents and educators, but perhaps most importantly it also includes peers. A comprehensive approach to prevention, therefore, means providing the needed training, resources, and consistent messaging for parents, educators, health care providers, coaches, youth allies, as well as peers. It also involves providing young people with the skills to critically evaluate the information they are receiving. This can include digital and media literacy.

It's also important for a comprehensive approach to include targeted messaging regarding high-risk cannabis use in order to assist young people in making informed decisions and reducing harms. This includes information about the effects of frequent and heavy cannabis use, use at an early age, use in combination with other substances—because we know youth often use other substances in combination—use by youth with mental health conditions, as well as use by young women who are pregnant.

In conclusion, regulations, prevention, and public education can work together to promote healthy decisions among youth by increasing awareness of risk and awareness of strategies for risk reduction. Effective prevention and public education requires clear, accurate, and consistent messaging that is targeted and relevant to the key audiences, and it needs to be delivered by trusted messengers.

I would like to thank the committee for the opportunity to speak today on this issue of vital importance to Canadians. I will be pleased to respond to your questions.

● (1355)

The Chair: Thank you, Doctor.

Now we'll go to Drug Free Kids Canada and Mr. Paris for 10 minutes.

Mr. Marc Paris (Executive Director, Drug Free Kids Canada): Thank you, Mr. Chair.

We welcome the opportunity to address this panel and to comment on the establishment of a minimal age for the possession of cannabis and its impact on young Canadians.

Drug Free Kids Canada is a non-profit organization devoted to educating parents about drugs, raising public awareness issues surrounding drug use, and facilitating open conversations between parent and teen in order to ensure that all young people will be able to live their lives free of substance abuse.

With me today is DFK advisory council member, Dr. William Barakett, from the Clinique Medicale in Knowlton. He is a family practitioner, clinician, and expert in addiction and chronic pain, with over 35 years of experience of dealing with families and youth facing substance use disorders.

We are here before you today to make the case that whatever the minimum age for cannabis possession will be, actively protecting the mental and physical health of youth—keeping our kids safe from harm—must be a main priority of the government. We acknowledge and respect the recommendations that have been made on the minimum age requirements by others on this panel and publicly, but we have chosen to minimize the time we spend talking about the effects of cannabis on the teen brain. We know the evidence is there.

Rather, we have chosen to use our time to address a fundamental question in society today. What are the underlying reasons young people turn to cannabis in the first place?

For DFK, the issue is not at what age cannabis is less harmful, but why kids are consuming it at all. Dr. Barakett is here to talk about his hands-on experience as a front-line worker. He'll also explain some of the reasons kids consume cannabis and the consequences of addiction affecting them and their families.

Dr. William J. Barakett (Member, DFK Canada Advisory Council, Drug Free Kids Canada): Thanks, Marc. As you indicated, I started in medical practice in 1972. Soon after that, I got involved in addictions because nobody else was doing it and I felt a great need.

Over the years, countless people have passed through my hands, and with great success. I've developed certain keys, certain techniques, and perhaps sharing these with you will help you to understand the dilemma we have with youthful use of cannabis. I have a certification in addiction medicine, and I hope that these practical comments will help to feed the creation of a public education program, which even has to precede the legalization.

Cannabis use in this presentation is predominantly about high-THC products. It does not include medical cannabis, which is predominantly cannabidiol or CBD. It's very important to make that distinction.

Teens often begin by using cannabis to relieve the anxiety of adolescence, naturally, and as a result of peer pressure, but beyond the recreational use, for some youngsters cannabis is a form of self-medication for an underlying disorder, either mental or emotional. The most common is attention deficit disorder, with or without hyperactivity. This provokes an anxiety and a feeling of inadequacy in youth. When they take cannabis, it calms this anxiety, but unfortunately it also diminishes their capacity for attention, compounding the problem.

ADHD and addiction are coexistent in at least 50% of cases. I can say that many of the youth I treat had an underlying ADHD problem that was not being treated. When I treat it, we get success.

Other coexistent psychiatric disorders include generalized anxiety, latent psychosis, post-traumatic stress, and bipolar disorder. All of these conditions exist in adolescence and are all too frequently missed by their treating physicians. They need to be diagnosed and treated, or otherwise the teenager will continue to self-medicate.

The parents of a habitual cannabis-using teenager and the physicians who treat them are well aware of the characteristic cognitive impairments affecting memory processing, reasoning and judgment, execution of tasks, insight, and time perception. These impairments become more pronounced with the duration and intensity of use and they require many months to resolve after stopping. A retardation of the emotional maturation process ensues, which is normally not completed, as you know, until the age of 25, in normal circumstances.

If addiction develops, as it will in a minimum of 17% to 25% of adolescent users, one also sees the features of addiction: a loss of control of the quantity of use, with the failure to recognize adverse consequences of use and craving leading to obsessional use. The withdrawal syndrome after cannabis cessation, which includes irritability, insomnia, and disorganization, lasts about two weeks. That plays a role in the difficulty of cessation.

Beyond that, the months required for the resolution of the cognitive impairment caused by the cannabis use contribute to a second phase of withdrawal as the person awakens to a reality that is entirely foreign and frightening, causing them to experience panic and anxiety, which often requires enormous support, including medication. The sort of behaviour we'll see is the 18-year-old who stops using, has not gone through his normal evolutionary growth from 13 to 18, and reverts to 13-year-old behaviour.

There are not many longitudinal studies to prove what is regularly observed and what I'm talking to you about. They are appearing, however. The National Institute on Drug Abuse in Washington, D.C. has produced considerable work—by Nora Volkow amongst others—and they've been cited elsewhere. A new study undertaken by NIDA in 2016 on the adolescent brain and cognitive development should bring more evidence to light.

A 2016 study in the U.K. looked at the pattern of cannabis use during adolescence and its link to harmful substance use later. In over 5,000 teens followed from the ages of 13 to 18, the study measured the amount of nicotine, alcohol, and illicit drug use. When they reached the age of 21, the study collated all of the data and found that the problematic use of nicotine, alcohol, and illicit drugs occurred 20% of the time in those using cannabis, and it was at an intensity at a rate related to the intensity of their cannabis use.

These are very telling studies that finally are being done. It's the sort of thing that we've perceived for years, but only now are they coming to light. Unfortunately, more money needs to be spent in order to aliment your public education program.

● (1400)

The rising problem of addiction to illicit substances and diverted prescription drugs in adolescents and adults directly correlates with the high level of regular cannabis use as well. Regardless of age, the vast majority of the people we treat for substance use disorder started with cannabis use in early life. Every single heroin addict, cocaine addict, and speed addict who I treat at 20, 30, 40, or 50 years of age started to use cannabis at the age of 12 or 13. In the case of teens caught up in the opioid crisis, for every teenager I see who is sniffing Hydromorph Contin, an enormous quantity of opiates, every single one of them started with cannabis. That's because of their loss of ability to discern danger.

As has been stated, adolescents will procure and use cannabis regardless of the legal restraints. With that in mind, the creation of an elaborate public education program is primordial.

Mr. Marc Paris: Thank you, Dr. Barakett.

Canadian youth have the second-highest rate of cannabis use worldwide, which is already very problematic, this even before recreational cannabis becomes legal. Cannabis is the number two substance used by teens after alcohol, with just over one in five teens, or 21%, using at least once. However, as teens grow older, consumption rises to over one third—actually 37%—in grade 12.

Whether the minimum age for recreational cannabis consumption is set at 18, 21, or 25, it's not going to matter much if we don't equip parents and kids with better approaches to dealing with drug use. Drug Free Kids Canada has already begun prevention education campaigns, but much more will be required.

We already have produced a brochure that has been distributed, with 100,000 copies, and a multi-million dollar, multimedia national campaign to support it has been running since mid-June. It will end at the end of September and will be repeated next fall until January 2019.

A recent study has allowed DFK to assess the value of prevention to society. The lifetime cost to society of one teenager suffering with addiction is $450,000. This amount factors in health, law enforcement, and loss of productivity, but not the human cost to individuals and families.

The benefit of DFK's prevention messaging, which encourages parents to engage in meaningful conversations with their kids about drugs, has been demonstrated to have protected 700 teens from substance abuse every year. If the cost to society of an addicted teen is $450,000, then DFK's prevention education messaging has saved Canadians close to $2 billion during our six years in operation.

As a society, we need to demonstrate to our youth that there are better ways to deal with personal or mental health issues than turning to cannabis or other substances. We believe that parents can be central to changing the relationship that kids have with drugs, and we are here to educate and support them. We want to help parents build stronger resiliency in their kids to deal with the realities teens face in the 21st century.

At this point, we know about the negative consequences of cannabis. Let's make sure we provide effective education and prevention awareness strategies well before legislation occurs, with ongoing messages that are consistent and clear, to ensure that our youth are protected.

We must remind you of the government's pledge to allocate a portion of the revenues to prevention and education. This is the only way to make sure that young people are equipped to make informed decisions on a substance known to be detrimental to their health and well-being but soon to become legal.

I would like to thank Dr. Barakett, the DFK advisory council, and this committee for allowing us to present our point of view.

● (1405)

The Chair: We'd like to thank you for presenting it.

Now we'll move to the Institute.

Madam Chapados, are you going to make the presentation, or will Mr. Gagnon?

Mr. François Gagnon (Scientific Advisor, Institut national de santé publique du Québec): I'm going to start and she's going to finish.

The Chair: Okay. That's perfect.

[*Translation*]

Mr. François Gagnon: Mr. Chair, thank you for inviting us to present the work of the Institut national de santé publique du Québec, the INSPQ, on the legalization of cannabis. At the institute, we are always interested in sharing our expertise with our colleagues across Canada, something we did last winter with a presentation to the FPT program on the legalization of cannabis. We also hosted webinars at pan-Canadian hearings and a conference on the legalization of cannabis at the Canadian Public Health Association in Halifax last summer. We will continue to present our work today, and we hope that you will benefit from it.

The INSPQ is a parapublic body created by the Government of Quebec. It is a scientific expertise and reference centre with a mission to support Quebec's minister of health and social services, regional public health authorities and institutions in carrying out their public health responsibilities. It is in this capacity that we have presented work for many years on alcohol and tobacco, and now on cannabis. All have a rather important point in common, and we will come back to that in our presentation.

The marketing of psychoactive substances is an important part of the equation to reduce harm and prevent their use. We have been interested in alcohol for a long time in terms of its commercialization, and essentially in the history of public health with respect to tobacco and the tobacco industry. This is a public health problem that we have been trying to contain for 70 years. We have decided that our comments today on Bill C-45 will deal with these commercial issues. For my part, I will strictly present our position on the minimum age for access to cannabis, which is part of the strategy to contain marketing, and Maude Chapados will address other issues later.

INSPQ's position on the age of access to cannabis reflects a recommendation we made to the Quebec authorities, which is to set it at 18 years of age, so that it is consistent with the legal age for alcohol and tobacco in Quebec. In the next few minutes, I will try to explain the reasons for our position.

First, according to the scientific literature, we know that raising the age of access to 21 years could significantly delay the age of initiation to cannabis. It is a disadvantage for public health to have a slightly lower age of access. On the other hand, there are many advantages to keeping this age of access lower. If we assume that legalization can have beneficial effects, it would be nice to also have it benefit people aged 18 to 21 if our intent was to take a position for access at 21 years.

If you haven't followed our work, I would point out that the institute recommended that the Quebec authorities set up a non-profit distribution system. Whether it is run by the public or private sector, we have stressed that it be non-profit. Whether it is run by the government or by non-profit organizations, we want the primary mission of the system not to be to make a profit, but to prevent and reduce harm. That is the direction we've taken. So there may be disadvantages in raising the age of access to cannabis.

Assuming that our distribution system fulfills its mission of preventing and reducing harm, 18 to 21 year olds should benefit in at least two ways. The first is the prevention of use and the reduction of harm. It would have to apply to the 18 to 21 age group if we are thinking of eliminating this category of the bill.

In terms of harm reduction, we have done a lot of work on substance quality assurance, for example. We want the quality of the substances to be controlled so that they are also safe for 18 to 21 year olds. By raising the legal age of access to cannabis, we believe that this would, at least in part, eliminate access to a quality-controlled substance for this age group, which does not seem to be so appropriate.

If you understand this correctly, the age of access to cannabis is an important issue, but it is only part of a set of concerns we have at the institute about psychoactive substances, and on their marketing in particular.

● (1410)

I have spoken to you about alcohol and tobacco, but the reason this situation is of such great concern is the same as in the case of cannabis. In Colorado, there was intense commercialization and the impact on consumption habits could be observed, overall and by age group. That concerns us directly today. Among youth aged 12 to 17, from 2009—when cannabis was first commercialized in Colorado—to 2014, declared usage in the past thirty days rose from 10% to 12.5%. Among young people aged 18 to 25, usage rose from 26% to 31%. In other words, in the two age groups that we are specifically interested in today, declared usage in Colorado rose by 25% and 20% respectively. Yesterday, I believe, you heard from stakeholders from Colorado and Washington. In those states, there has been an impact on emergency admissions and traffic accidents involving persons whose THC level was tested. The repercussions on the health system are immediately evident.

Before concluding, I would like to point out that it is not simply a matter of age. The system established in Colorado led to intense commercialization. Based on our analysis, it is this emphasis on the commercialization, marketing and advertising of cannabis that led to the results observed.

I will now give the floor to my colleague Ms. Maude Chapados, who will speak to other aspects of Bill C-45 which, in our opinion, warrant examination.

Ms. Maude Chapados (Scientific Advisor, Institut national de santé publique du Québec): Thank you.

Hello.

Beyond setting a minimum age, preventing cannabis use among young people depends in large part, as my colleague said, on establishing a strict legal framework for this product, which we consider to be no ordinary commodity, as certain public health stakeholders would say.

The creation of environments where the use of psychoactive substances is not stimulated or normalized is one of the best approaches to prevention. The measures taken by the provinces and territories with regard to authorized sale and consumption sites will be decisive in creating these environments. Certain measures in Bill C-45, however, and its subsequent regulations, will also be very important for the commercialization of cannabis, in particular among more vulnerable populations such as young people, be they under or over the age of majority.

The INSPQ would therefore like to take this opportunity today to repeat certain analyses that it presented in its brief submitted in August in order to ensure a better framework for marketing practices.

Research on commercial practices in the tobacco and alcohol industries shows to what extent sophisticated marketing strategies can affect consumption and the associated health problems. Research also shows that young people are particularly easy to influence. That is why the INSPQ is calling for an immediate ban on all forms of advertising and brand promotion, which raises four specific concerns related to youth and the bill under consideration.

First, packaging that is neutral and that provides information to allow for an informed decision on the nature of the product should be immediately required. Given that packaging is itself a tool for promoting the substance, the prohibition in clause 26 on packaging that could be appealing to young persons is neither clear nor sufficiently strong. The consultation report on plain packaging for tobacco products that was published in January 2017 should certainly be informative in this regard.

Second, promotional items should not be tolerated. Hats, socks, T-shirts and cups with hemp leaves or brands of medical cannabis on them are already popular, especially among young people, and help normalize cannabis. The display of a brand on “other things”, as provided in clause 17(6) of the bill, opens the door to branded derivative products. Once again, the prohibition intended to ensure that “other things” are not associated with or appealing to youth remains vague, and this brand promotion practice should be banned.

Third, clause 17(2) allows brand promotion in areas where minors are not permitted, which raises the same problem as packaging and derivative products. First, we know that minors often frequent such places. Young adults aged 18 to 25 are the group with the highest percentage of users. Moreover, we wonder whether the legal age should be raised. The fact that this group of young people can be exposed to advertising in bars, for instance, is inconsistent with a public health approach. This kind of promotion can not only encourage the use of cannabis, but also insidiously incite customers to consume cannabis and alcohol at the same time, which is a very high-risk behaviour, as you will agree, particularly as regards transportation safety.

Fourth, any effective strategy to regulate brand promotion and advertising should ideally include the Internet. Bill C-45 prohibits the publication and broadcast of advertising in the press and on radio and television, but is silent on measures to regulate this on the Internet. Yet it is mainly on digital platforms that youth and industry are already active, and this reality warrants particular attention in future regulations.

In short, there is reason to consider setting the minimum age above the age of majority. To the extent that the age of majority is a determinant of the age of initiation, this raises consistency issues as regards alcohol and tobacco, substances that are equally or more toxic than cannabis. Setting a minimum age above 18 for cannabis should therefore be part of a broader discussion of psychoactive substances and, indeed, of the age of majority.

In the meantime, the INSPQ maintains that certain provisions of Bill C-45 and its subsequent regulations can be amended or clarified in order to reduce the commercial promotion of cannabis to young people.

● (1415)

We hope that the considerations presented today will be helpful in this regard.

Thank you.

[*English*]

The Chair: Thanks very much.

We'll go to our first round of seven-minute questions, starting with Mr. Oliver.

Mr. John Oliver: Thank you very much for being here today and for your presentation.

Just as an opening comment, we're at the midway point of our week of studying the bill. At the end of the day, the committee will have to go through a line and clause-by-clause review of the bill.

There were three principal objectives, in my mind, for why the legislation was brought forward. One was to get these drugs out of the hands of our youth, or at least reduce their access to it. The second was to reduce the function and role of the black market and organized crime, and to at least reduce their access to this space and the revenues from it. The third was a public health agenda, which was to ensure that the production of cannabis for consumption was done by licensed facilities so that we understand the safety of the product and the toxicity or the dosage of the product as it's being prepared.

Most of the presentations we've heard seem to be in agreement with the legislation, but they are in disagreement about how the balancing of those three objectives takes place, particularly the first one and the second one, so I want to tease it out a bit more.

For instance, Dr. Porath, I didn't hear it clearly today, but I think that in the past you've had a recommendation that a standardized minimum pricing to reduce consumption would be a recommended strategy, a sort of national minimum pricing, right? If that's not the case, I apologize, but I understand that's something you guys have said. You get to the point, then, where organized crime knows exactly the lowest price their competitors will go to, so they can do a price thing.

We've heard from other witnesses that if the licensed market doesn't produce the variation in drugs, including in even some of the most distilled or high-potency products, youth will seek them out. Again, it leaves that window open for the black market to offer alternatives and to showcase with packaging and whatnot.

Could you speak a bit to that balance? I understand that from your perspective a particular health focus can lead us down one path, but then it opens up this other competitive window of black market access, which we're also trying to deal with. It's the duality of the act. Can you talk about your views and how you would see those better balanced?

● (1420)

Ms. Amy Porath: Yes, certainly.

During my remarks I was talking about how we could draw from our experience with alcohol in terms of standardizing the pricing of the potency of the product. In terms of cannabis, if we could tie in or index the pricing of the THC content, that could help incentivize lower-risk use, so the higher the THC or the potency of the product, the higher the pricing. That's sort of what I was recommending as part of my remarks. If we can draw that lesson learned from the alcohol field, that might be one way to encourage the use of lower-risk products.

Mr. John Oliver: You weren't recommending, then, a minimum pricing. It was something that was more price sensitive to the level of THC.

Ms. Amy Porath: Yes.

Mr. John Oliver: Okay.

Mr. Gagnon and Madam Chapados?

[*Translation*]

Mr. François Gagnon: In Quebec, we have a lot of experience in controlling alcohol and tobacco. With a monopoly on purchasing and public and private distribution points, Quebec is quite successful in controlling the illegal alcohol market, even though there are products that are illegally produced. That is the first part of the solution.

Perhaps cannabis—

[*English*]

Mr. John Oliver: I'm sorry, but we did hear from the police chiefs' association that the presence of organized crime in this space is pervasive. It's ubiquitous. It's not at all like the alcohol system. I think you would have to go back however number of years it was to when we legalized alcohol to understand the black market consequences.

I'm sorry for interrupting.

[*Translation*]

Mr. François Gagnon: This can be seen from a long-term perspective. We have gradually dismantled the illegal market in Quebec. You referred to prohibition, which did not occur in Quebec. As regards alcohol, we can say that we have not lost control over the black market in Quebec. There is one, but it is not large.

As to tobacco, the last estimates that I saw—

● (1425)

[*English*]

Mr. John Oliver: Sorry to interrupt, but on the alcohol side, wouldn't you agree that there are multiple brands, with multiple marketing? Limited ciders can go from 2% up to 90% proof. There is a wide range of product and a wide availability of product. It's not very narrow or restrictive—i.e., you can get this type of alcohol or that type of alcohol.

So the competition was effective by product variety. But you're recommending against that for cannabis.

[*Translation*]

Mr. François Gagnon: I will get back to product variety later on.

Our main thrust was to propose a not-for-profit model. This model revolves around a monopoly on purchasing with distribution points, whether public or private. We have not decided on public and private control of the distribution points. The key in our view is the not-for-profit model.

Since you mentioned it, the SAQ's monopoly on purchasing has not limited product variety

[*English*]

Mr. John Oliver: Yes, I understood the non-profit. I think maybe it was Madam Chapados who was talking about limited product variety and limited offerings.

Did you not raise that?

[*Translation*]

Ms. Maude Chapados: No, I was referring to creating an environment in which, ideally, the substance is not normalized. Our position is as follows. In order to facilitate the transition from an illegal market to a legal one, we must attempt to reflect the market. This market has not been documented; it is still not understood.

We therefore recommend a cautious approach. There is no question that a range of products and of THC content is needed. I was referring instead to derived products such as hats or branded merchandise. On the one hand, they create an environment that normalizes the substance.

On the other hand, as regards product diversity, there still has to be access to a product. Does that mean that multiple forms and types of products should be made available? Whether milkshakes, muffins, chocolate or candy, there is a very wide range, but these strategies are designed to cultivate new client groups and attract people who might not have consumed the substance otherwise.

[*English*]

Mr. John Oliver: Okay. Thank you.

Can I ask one more question?

The Chair: Your time is up.

Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

Thank you to all of our witnesses. Definitely I want to thank you all for your work to try to help reduce the number of youth who are taking cannabis.

One of the concerns we have heard is that the potency of marijuana today is increasing compared with where it was. I'd like to hear from each of you your view on being able to grow four plants in the home, where there's no real control of potency and where children live and can be exposed to it.

Dr. William J. Barakett: Listen, I live with addicts every day. They're in my office. These regulations will not stop people from growing their own. They will, they have, and they always will.

Yes, it is more potent. They do cross-breeding. They've increased the percentage of THC up to the 20% and 25% that get people very stoned. A lot of analogies are made with alcohol versus cannabis, but don't forget that you get rid of alcohol over the next 12 hours. Cannabis is a highly lipophilic substance. It's dissolvable in fat. It dissolves in the brain tissue. It's there, and you pee it out four to six weeks later. There is a cumulative effect, especially in the young and developing brain, which has all of the nefarious cognitive impairments that we talked about before.

Ms. Marilyn Gladu: So you're okay with having it homegrown.

Dr. William J. Barakett: I'm not okay with it, except that they'll do it anyway. That's why I'm saying that public education is the way that we'll avoid kids getting into it.

Ms. Marilyn Gladu: All right.

Mr. Paris.

Mr. Marc Paris: Perhaps I can make this analogy. I've spoken about alcohol being the number one substance being abused by teens today already. They're consuming it, and they're getting it somewhere. How have the tight regulations with alcohol worked for us? We're the number one consumers of cannabis in the world already. The question is, and has always been, about getting back to the source of why they are doing this, because no regulation will change that.

Ms. Marilyn Gladu: Okay. That's not my question.

Dr. Porath.

Ms. Amy Porath: I would echo the comments of my colleagues that it really underscores the importance of prevention messaging, public health messaging, for parents, young people, and youth allies, the people who interact with youth, about the effects of cannabis—for better education.

● (1430)

Ms. Marilyn Gladu: Mr. Gagnon.

[*Translation*]

Mr. François Gagnon: The answer has two parts. We said that home cultivation must be allowed and therefore regulated. The key is that it should be not for profit. Regarding home cultivation, the options we presented include user co-operatives, thus access points for not-for-profit sale. In the case of home cultivation, there are certain issues such as toxicity due to mould in homes and normalization of the substance around children. We have considered these issues. In the overall framework, we are favourable to user co-operatives cultivating agricultural land, for instance, to encourage the shift away from home cultivation to locations outside the home.

[*English*]

Ms. Marilyn Gladu: Ms. Chapados.

[*Translation*]

Ms. Maude Chapados: I would simply like to complete what my colleague said. That would have to be discussed with Public Safety Canada, but in terms of practical control, it should be noted that user co-operatives are often registered and have a list of members. That means we would know where things are happening, which would prevent chance discoveries.

[*English*]

Ms. Marilyn Gladu: Thank you very much.

This is for Dr. Porath and Mr. Paris.

Dr. Porath, I think you said you had a national mandate to reduce harm for alcohol and drugs. I think that is great. Have you been aware of any government programming to do the kind of prevention education with parents and the public since the Liberals announced in 2015 that they were going to legalize marijuana?

Ms. Amy Porath: We do a great deal of work at the CCSA in collaboration with many partners. Some of those partners involve the federal government, different provincial governments, and municipalities. I can talk about some of our products today. We've collaborated with a partner in Ontario, Parent Action on Drugs, to develop an infographic based on a systematic review we did looking at the effects of cannabis use. I talked about the focus group research we've done.

We actually created a friendly infographic for parents that talked about the myths that youth have and what the evidence actually says to counter those myths. We recently collaborated with Marc Paris and Drug Free Kids in the talk kit that he shared with the members today. As he mentioned, there's a lot of uptake, a lot of parents using this, and it's really key that we get the evidence out.

Ms. Marilyn Gladu: This is an excellent program.

Mr. Paris, did you receive any government funding to help with that?

Mr. Marc Paris: The only funding we got was for translation, printing, and distribution. The brochure itself, to be quite frank, was originally developed by our sister organization in the U.S. called Partnership for Drug-Free Kids. We were given the Canadian rights to it. We Canadianized it; we updated it; and we made sure it was all evidence-based, working with CCSA in particular going through all of the research. It was then vetted as well by Health Canada scientists. So this brochure has gone through many layers of review and is considered one of the best ones out there right now.

Ms. Marilyn Gladu: For sure.

My last question has to do with the definition of youth in Bill C-45. Youth are defined as people aged 12 to 17. Then there are a number of provisions, but children under the age of 12 are not included. Where we talk about a trafficking offence to people 12 to 17, they are covered as young people. But there's nothing in there for people 11 and younger.

One amendment I was considering was about defining youth as persons under the age of 18. I'm looking to anyone here for their comments.

Mr. Marc Paris: That's an interesting point, because we've been focusing primarily on teens. When we do our campaigns on drug-impaired driving, particularly high driving, we extend that to about age 23. Really the driving age is from 17 to 23. But we know for a fact that experiments with cannabis start at a very early age. The average age is 15, but we've heard, anecdotally, about those 11, 12, and 13. Probably Dr. Barakett can confirm that.

It's an interesting point. If we're going to have cannabis in the house, is there not a way that we should make sure we protect every kid?

● (1435)

The Chair: Your time is up, Ms. Gladu.

Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

Ms. Porath, it strikes me that if one of the aims of this bill is to reduce use by young Canadians, we'll need to know why they're using it. Many people have pointed out that use by Canadian youth aged 15 to 24 is either the second highest in the world or among the highest. Why is that?

Ms. Amy Porath: It's a very good question, and it's a question that I get asked a lot.

In our focus group research, we heard from the young people some of the reasons why they're using drugs, cannabis in particular. A lot of young people talked about dealing with stress and with mental health issues. Really, they were using cannabis as a way of self-medicating to deal with some of the pressures from school and pressures that they're experiencing in their day-to-day life.

I don't know if that gets at your question of why Canadian youth are some of the highest users. I don't know if I have an answer to that. I just know that it's a startling statistic and one that we want to address.

Mr. Don Davies: I don't mean to put you on the spot. Maybe we don't know the answer.

I'm going to ask you the same question, Dr. Barakett, because I would imagine that youth in France, Germany, Mexico, and Uruguay also are suffering from stress, so I don't know if that's really the answer.

Dr. Barakett, do you have any idea why use among Canadians seems to be so high?

Dr. William J. Barakett: I think cannabis has gotten a free ride. The older generation seems to have made it a banal issue by saying "oh well, it's just pot", but that generation that thinks back to it was smoking what was 4% and 6% pot, and that's not what the kids are getting their hands on today.

Also, the information has not been divulged to people in terms of the exact mechanisms of damage in the developing brain. That's where we need to really step up to bat. I remember giving a lecture on adolescent addiction to a group of doctors. They all sat there with their jaws dropped. One of them, who was in charge of an adolescent health clinic, said, "In Quebec we have normalized the use of cannabis by adolescents." That's normal behaviour, "normalized".... Sorry, but it's not.

We've done a poor job because of the lack of research. Look, research in medicine occurs because drug companies see something with a new medication to enrich their shareholders at the end of the line. Not enough money has been put into research to demonstrate what's going on.

Mr. Don Davies: Thank you.

I don't want to belabour this point, but is that different from western Europe?

Dr. William J. Barakett: When you look at Holland, where it's sold in corner stores, you see that the number of youth who use is far lower than it is here. Perhaps they've had a more public discourse.

You would probably know more, Amy, because you study those sorts of things.

I don't really know it. I just know that for some reason people haven't twigged to the fact that we have a very high dropout rate from school. We have a high rate of addiction. How come we have this opioid epidemic of diverted prescription opioids? Who's taking them? Teenagers. Which teenagers? The ones who started with pot. I mean, it all fits when you're in that milieu day in and day out.

Mr. Don Davies: We did a study on opioids. We found that in 2016 there were 19 million prescriptions written for opioids. That might have something to do with this. That's one prescription for opioids for every two Canadians in the country.

Dr. William J. Barakett: Yes.

Mr. Don Davies: I want to move to education. It strikes me as common sense—and I think a lot of witnesses are saying this—that we should be starting the education yesterday, if not today. In fact, the task force recommended that the federal government "[t]ake a leadership role to ensure that capacity is developed among all levels of government prior to the start of the regulatory regime". We don't have to wait until July 1, 2018, or thereafter.

You've heard that the federal government has announced $9 million for education. That's the amount of money that Colorado, with one-seventh our population, is spending on education this year. The State of Washington, which has one-fifth our population, is spending $7.5 million. I guess this is a pretty obvious question, but shouldn't we be ramping up the federal contribution on education now, in advance of the regulatory system coming into being?

Mr. Marc Paris: Just to specify, I think the $9.5 million was over five years, so it's not even $9.5 million a year. If you look at that, quite frankly, it's a drop in the ocean. For our campaigns that we do as a not-for-profit organization, with our 60-plus media partners who provide us with the time and space for free as public service announcements, we generate on our own $15 million a year in free public service time and space.

In the last six years that we've been in operation, $100 million of public service announcements have been aired on opioids, drug-impaired driving, and now cannabis. We have been on that forefront. We took the leadership with this thing because we followed the task force recommendations.

Mr. Don Davies: Yes. I appreciate that.

Mr. Marc Paris: We weren't waiting for anybody. We just go and do our stuff.

● (1440)

Mr. Don Davies: Thank you.

I'm not sure who said that the government should allocate money from tax revenue for treatment and prevention.

Was it you, Ms. Porath? Could you quantify that for us?

Mr. Marc Paris: Just for example, right now, we're trying to work with a group in Quebec, La Maison Jean Lapointe, that has developed a very fine in-school program at junior high and senior high levels with teachers. It was funded by Health Canada and it is ready to go. They've been doing it for three years. The cost of doing these in-school programs is about $10 a head. They've been doing it with 160,000 Quebec students. There has been an extremely high level of recognition for the program. We would love to roll this out in English Canada. There are 1.5 million teenagers in the rest of Canada. At 10 bucks a pop, that's $15 million.

Mr. Don Davies: Let me ask you a quick question, getting back to the issue of stress. It would almost seem to me that we should be addressing the social determinants of this problem too. It strikes me that it means talking not just about cannabis but about the underlying problems they are facing. We're facing a generation that is very, very stressed out. Should we not then be researching and investing in how we can address those fundamental issues, in addition to the tertiary issue of cannabis use?

Mr. Marc Paris: I totally agree. You mentioned that as well. It's all about building resiliency in our kids so they don't become anxious over too many things. We know social media and everything else is causing another level of anxiety that maybe the previous generations didn't face, but at the end of the day, you kind of have to question the helicopter parenting approach. Have we developed a bunch of anxious young kids who, as soon as they have a problem, turn to drugs?

That's why we have to change that view to there being better ways to deal with these personal issues than by going to drugs, whether their parents are going through a divorce, or they're suffering from neglect or abuse, or they have self-identity issues. All of these things come into play, and the first solution can't be to take drugs. We have to change that dialogue.

The Chair: Thank you very much. That's very good.

Now we will move to Dr. Eyolfson.

Mr. Doug Eyolfson: Thank you, Mr. Chair.

Thank you all for coming.

I agree that this is a very, very good resource. I notice that it was also thanks to Health Canada. Apparently it also assisted in the support, collaboration, and distribution of that. I'm glad to see a lot of sectors helping to create this. Congratulations. This is very good work.

Mr. Marc Paris: Thank you.

Mr. Doug Eyolfson: Dr. Barakett, something you said really resonated, and we talked about this earlier today with some witnesses. You have some underlying problems with why they are consuming substances. In my medical career, we talked about people who actually had psychiatric illnesses that predated their cannabis use, drug use, and self-medication. It's analogous to when we were told by our mothers to not sit too close to the TV because we'd need glasses. Why didn't we ask why they were sitting so close to the TV in the first place? It's one of the things we need to look at. You're right that if they're abusing any substance, we need to be looking into why this has been happening. The drug abuse is only going to make it worse, but you have to remember to deal with two problems now: what got them there in the first place as well as the issue. Thank you for helping to underline that.

In another committee we talked to some colleagues in the States about this. Whenever we'd mention anything about research in cannabis, everyone would look uncomfortable and change the subject because, federally, of course, it's still illegal and heavily stigmatized. We need more research, as you said. We need a lot more research. Do you feel that the legalization is going to remove some of this stigma and stimulate more research into the subject, both from an addiction standpoint and with regard to its use medically?

● (1445)

Dr. William J. Barakett: I should hope so. The research is also going to be in the direction of medical cannabis, because we're flying by the seat of our pants. We know it works. I'm involved in the Quebec cannabis registry. I have 220 patients to whom I prescribe cannabis oil, predominantly CBD, for chronic painful conditions. To my amazement, these people have dropped their opioids like stones. They've stopped taking them. They're far better relieved. We have a number of different illnesses that benefit from it, but we don't have the neurobiological research to demonstrate to us what exactly we're doing, so it's a trial-and-error thing.

On the research, I mentioned a couple of things, including the United Kingdom study in which they followed 5,000 kids aged 13 to 18. The National Institute on Drug Abuse has launched a study on the development of the brain in adolescence. There's also all the other work that Nora Volkow of NIDA has done.

All of this stuff has to be brought to the fore and told to people. We used to have, in the 1980s and 1990s, commercials about smoking that were so enormously successful. The most notable was the cigarette that hung limp, because of smoking causing impotence. People remember it, and the smoking rates are down phenomenally. We need to bombard the public with this kind of thing.

Mr. Doug Eyolfson: Okay, thank you.

Madam Chapados, you talked about how you believe that there should be plain packaging for all cannabis products. You also recommended that it not be advertised in places like bars because you don't want that combination of cannabis and alcohol in the same place. That part of it I agree with completely.

We heard some testimony in regard to branding, that the people who take intoxicants have something in common with those who consume alcohol, that there is a sense of, as it were, brand loyalty. We do know different brands of alcohol will have different labels. Some witnesses thought that if you had plain packaging, which would have these items look pretty much like the black market, it would be hard to differentiate, or you wouldn't have the same loyalty, and users might have more brand loyalty, as it were, to the marked product. How would you respond to that?

[*Translation*]

Ms. Maude Chapados: Plain packaging is a major topic of discussion between the industry and the public health community. Ways of designing packaging to differentiate these products from illegal products are being explored. We can already see the first statistics for tobacco, for Australia and France in particular. We can see a link. There is a range of measures. There are advertising campaigns, but specific measures can affect perceptions in particular. The choice of colour can affect the perceived taste of the cigarette. This fact has also been made known publicly. I am referring to motivations to quit smoking. If a cigarette package is white, pink or brown green, the perception is that the cigarettes do not taste as good. The effect is unconscious. In short, it is a complete, comprehensive approach that combines various measures.

There is also the issue of young people. In Quebec, the "*Enquête québécoise sur le tabac, l'alcool, la drogue et le jeu chez les élèves du secondaire*", a survey of tobacco, drugs, and gambling among high school students, revealed that the rates of declared use have fallen dramatically since 2000. In 2000, the rate was 41%, but just 23% in 2013. This is a significant difference. The reason for this drop in declared use of cannabis is not clear.

Have these young people become dependent on other substances? That could be. On the other hand, we must recall that Quebec undertook a major campaign in the late 1990s to denormalize smoking and also implemented tobacco legislation. So we cannot establish a causal relationship. The use of tobacco in bars in Quebec is another issue. It is prohibited by law to promote cigarette brands in bars. The question is then why this would be allowed in the case of cannabis.

● (1450)

[*English*]

Mr. Doug Eyolfson: That's a very good point.

On a completely unrelated note, I'm glad to hear you referencing Australia. We're getting some propaganda from the tobacco industry saying that the plain packaging experience in Australia hasn't worked. But, again, I'm glad to hear someone corroborating that this does work. On that unrelated note, thank you very much.

I believe that's my time.

The Chair: It is your time. Thank you very much.

That completes our seven-minute round. We are going to our five-minute round starting with Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

Again, thank you to the witnesses. So little time, so many questions.

I just want to start, though, by commending Drug Free Kids Canada for the booklet. The government has had two years now, it's their own mandate, and it's a little disappointing. I think Colorado called the government out for a lack of funding being allocated to these public education campaigns. We're all aware of how important that is and the importance of getting it out ahead of time, so kudos to you guys for taking that leadership role.

We've also heard of a lack of resources for data collection and the importance of data collection. I want to start with Dr. Barakett.

Do you think that there needs to be an annual report released to the public on marijuana consumption in Canada following legalization? Do you think this type of transparency would help raise awareness? If you look at the government narrative, they're saying one of the reasons they're doing this is to decrease marijuana use by our youth. We've heard from our witnesses that it isn't the case they're seeing in Colorado. We'd like to find out what's working and what's not working. What about these annual reports, do you think they are important?

Dr. William J. Barakett: I think they are essential. Really, you're having to put your money where your mouth is. It would be very useful, if we're doing it to help society, for people to understand what cannabis does, the benefits of it on the medical side, which are not yet completely researched, although we certainly have some direction that it is a useful substance, and that high THC substances can have a nefarious effect, especially in developing youth. If we see that there's a rise in use in the under-18s, then we're in trouble. It means that our public education program has not worked.

Mr. Colin Carrie: Do you think being transparent instead of just keeping this data and not even releasing it will help raise awareness?

Dr. William J. Barakett: I would think so. Transparency to me is public health. We have to be as transparent as we would be if we were talking about the rates of diabetes. It's essential.

Mr. Colin Carrie: Mr. Paris.

Mr. Marc Paris: I think if we're using public money to do research for the good of the public, then the public should know.

Mr. Colin Carrie: I agree.

We talked to witnesses before you on this whole challenge. As I said, I think we're all in agreement. We would like to see youth use decrease in Canada. It's way too high, but there don't appear to be any tools in the toolbox, when we look at this legislation. There have been all kinds of opinions. My colleague brought up that for kids between 12 and 17, this bill allows for up to five grams. It is disturbing for some of my constituents to think that 12-year-olds who are in public school, this is grade 6, will be able to have this in their possession for personal use.

She mentioned that maybe it should be a ticketable offence. Nobody wants to criminalize kids. We don't want to have them carry that over. We had a lawyer from B.C. He said most police officers don't even charge kids. They just confiscate it, but it does give them the opportunity to address it and maybe bring it up to parents and teachers.

There's nothing in this bill. They say that they want it to decrease youth use, but there's really nothing prescriptive in here. There are no ideas.

Do you have some ideas? You deal with these kids every single day. For a gateway drug, at that age, what tools can we give our educators and our public health officials so that if there is a problem, we can get kids into some type of program or some type of educational system that will help them?

Dr. William J. Barakett: That's a very good question. For most of the youth who are referred to me, it is because they were apprehended at school for possession.

Mr. Colin Carrie: Do you see that as a good or a bad thing?

Dr. William J. Barakett: It's excellent. The kids are called out. The parents are called. Then what they say is you have to see your doctor.

Thank you very much for mentioning it, because my pet peeve is that our medical profession has turned a blind eye to addiction for far too long. The tremendous epidemic of opioids we have is not just because we over-prescribed. People weren't over-prescribing on purpose. It was because we had to treat chronic pain. We had nothing good to do it with, so we tried the opioids.

The big problem is that when people become addicted, or kids have alterations in their behaviour pattern because of early onset use of cannabis, the average doctor doesn't know what he's doing. He's never been taught. Medical schools in 2017 still don't teach addiction.

I've been receiving residents, R2s in family medicine, and third-year medical students for the past 35 years. In my practice, they come and spend a month. I am the only exposure to the treatment of addiction they will get in all their medical training.

● (1455)

Mr. Colin Carrie: You said having them called out is actually good.

Dr. William J. Barakett: Absolutely. That's because if a kid is 12 years old, and he's using, I'm sorry, but it's not a benign thing. There are going to be consequences, especially a kid that has it at school. He's either selling or he's habituated.

Mr. Colin Carrie: What would you recommend be put into this bill for that?

Dr. William J. Barakett: I don't know. I'm not a legislator, but if schools apprehend, I think there should be, not a legal sanction, but a call to the parents, and they would be obliged to consult medically. The big problem is, who are they going to take them to?

Mr. Colin Carrie: Are there any permanent consequences for the kids who are called out now?

The Chair: Time is up.

Dr. William J. Barakett: No. There's no permanent— They are discharged from school for, say, two weeks, during which time they cool their heels and get the chance to go talk to their physicians.

The Chair: Time's up. Thanks very much.

We'll move now to Mr. McKinnon.

Mr. Ron McKinnon: Thank you, Chair.

It's pretty clear that the key to success here will be public education for youth. You say you have had a multi-million dollar campaign running since June. What has been the nature of that campaign? What are its goals? Are you able to measure its results, and is it working?

Mr. Marc Paris: The goal of the campaign was exactly to get this brochure into the hands of as many parents as possible. The call to action in our message was to download the brochure or get it for free. Parents can go the homepage of our website. They can either download it or get it for free.

As I said, to date we've distributed 100,000. They were either downloaded or sent out and distributed. We sent out 36,000 samples to schools and medical clinics during the course of the summer. We're now seeing orders coming in. School principals are ordering 300, 450 copies of this for all their parents. I suspect that the 100,000 will grow very quickly. That's a good thing, but it needs to be supported by mass media.

We have experience doing these campaigns. This is our 12th national multimedia campaign. The secret to it is to keep doing it. Our campaigns are continuous, 12 months of the year. We have 60-plus media partners—television, radio, print, every form of out-of-home media you can imagine. It's ongoing. We replace one campaign with another. But education messages can't be just a six-week spurt and then off you go. The problem is that we get the messages for free, but if the government has to do it—Health Canada, for example, has done education messaging—they have to pay for it, and it's extremely expensive. National multimedia campaigns could cost tens of millions of dollars a year, easily.

Mr. Ron McKinnon: So your campaign, this campaign, was about this document.

Mr. Marc Paris: Correct.

Mr. Ron McKinnon: Further campaigns would probably expand into other things, would they?

Mr. Marc Paris: We would continue. Our plan is to recycle that campaign in September of next year, and to run it right up until mid-January of 2019. Our next campaign, starting in October, will go back to the misuse of prescription drugs and the need for parents to secure their meds and bring back all leftovers to the pharmacy. Last year alone, with the help of Shoppers Drug Mart, we recuperated 243 tonnes of unused and expired medicine. This year we're expanding that with probably 4,000 retail drop-off points. Most of the major national chains are coming on board with the campaign this year.

That campaign will run until mid-January. Then we go back to a campaign on drug-impaired driving, called “The call that comes after”, which just won an international award for best creative.

Mr. Ron McKinnon: Apart from promoting access to this, which is a good thing, what other kinds of ads or promotions to dissuade youth from marijuana would you envision would be effective?

● (1500)

Mr. Marc Paris: Some campaigns need to be aimed directly at the kids. These campaigns that we do are directed at the parents. You need different types of approaches with kids. You won't use the same media mix as you would with the parents. They don't consume the same media. I would see national campaigns, both in-school and multimedia, but different types of media mix aimed at youth, and continuing to....

You see, there's a direct equation between a sense of risk and a trial. The higher the sense of risk, the lower the trial. It's not about scaring kids, but if they sense that it's a risky proposition, they'll think twice about going down that path of risky behaviour.

Mr. Ron McKinnon: So you don't see ads of the nature of “this is your brain on marijuana” kind of thing.

Mr. Marc Paris: It could be, but I think it would be a different approach. I think we now know about this. The science has been proven. Kids are starting to get it. They're starting to understand that there is some risk to their personal health and the development of their brain.

It's the same thing with drug-impaired driving. We have to change the dialogue here. Kids understand, after 20 years of Mothers Against Drunk Driving doing campaigns, about alcohol, but at this point kids don't see having a joint and driving as being risky as having alcohol and driving. We have to continue that as well.

Mr. Ron McKinnon: Do I have more time, Mr. Chair?

The Chair: You have time for just a couple of real short questions.

Mr. Ron McKinnon: That will be tough.

Madam Chapados, you spoke about branding. We heard testimony that while promoting in terms of branding could be problematic, and I would agree, the identification of product in terms of branding would be useful so that people would recognize the product that they're familiar with, know what they're getting, and know what they're dealing with. Would you like to comment on that?

[*Translation*]

Ms. Maude Chapados: Yes, that touches on what your colleague and I were talking about earlier. Product recognition requires that the name and brand be indicated, and so forth, whereas stimulation seeks to make a product attractive. There is a difference between the two. That is not addressed in Bill C-45. Stimulating demand and creating new client groups must be avoided. That is why, from a public health perspective, neutral packaging is one of the options preferred in the literature, for both tobacco and cannabis.

[*English*]

The Chair: Okay, thanks very much.

Now we're moving on to Mr. Webber.

Mr. Len Webber: Thank you, Mr. Chair.

Dr. Barakett, do you believe that marijuana is a gateway drug?

Dr. William J. Barakett: Oh yes, without any doubt. I cited that United Kingdom study. It puts into evidence what we've known for years, but finally somebody quantified it.

Mr. Len Webber: And the reason for it, is it because the marijuana product is not doing what it used to do for these users?

Dr. William J. Barakett: I don't know if it's necessarily because it's more potent. It's simply because it hinders the person's cognitive development, which causes them to undertake risky behaviours because they lack judgment. Reasoning and judgment are the two principal cognitive impairments. That's why they go from using that to.... And if they have an underlying disorder, if they are ADD, as a sizable proportion of teenage cannabis abusers are, and they're not treated, then they need to calm themselves. Once you treat the ADD with the appropriate long-acting stimulant medication that helps them to learn, concentrate, and feel good about themselves, they stop using.

Mr. Len Webber: Right.

You have opioid patients who you are now prescribing marijuana to because of the CBD in it.

Dr. William J. Barakett: Yes.

Mr. Len Webber: For their chronic conditions, it's successful, apparently. That's what you're saying.

Patients who have post-traumatic stress disorder, they're also, I hear, moving into marijuana medication. Is it for the CBD or is it for the THC?

Dr. William J. Barakett: They're having to use THC because it has the more calming effect. The trouble is that the THC is strong, and what happens when you use CBD—which is anti-epileptic, by the way—is that it's also anti-neuropathic pain, but you need a combination of the two. What we're doing in our practice is mixing a proportion of one part THC to two, three, or four parts CBD, the amount that is required to neutralize the stoning effect of the THC, and it goes for pain conditions, it goes for chronic inflammatory conditions such as rheumatoid arthritis and inflammatory bowel disease. We're seeing good results.

The trouble is that it's sort of a bric-a-brac study where the patient is obliged to buy his own from one of the companies that produces cannabis under the aegis of Health Canada.

● (1505)

Mr. Len Webber: That's interesting.

Again, I'm just a little bit confused here with respect to the difference between CBD and THC. The THC is more of a hallucinogenic type of drug.

Dr. William J. Barakett: Yes, it's psychoactive. Cannabidiol is non-psychoactive.

Mr. Len Webber: So these patients with post-traumatic stress disorder, are they looking to hide their trauma through a hallucinogenic drug, rather than...?

Dr. William J. Barakett: The most troubling feature of PTSD is insomnia, the dreams, the nightmares, recurrent nightmares, and the reliving of that trauma, whatever it was back in their past, so you use medications that will help to deepen their sleep. If they try taking benzos or anything else, they just don't work. Anti-depressants just make them feel poorly, so we've happened onto a few things. One of them is nabilone, which is a synthetic cannabinoid. It looks nothing at all like CBD or THC, but it helps to improve the depth of sleep and to suppress—

Mr. Len Webber: What does it have in it? THC, CBD, or a bit of both?

Dr. William J. Barakett: It is neither. Nabilone is neither. It's just a synthetic cannabinoid that came out on the market to help in pain management years ago. It doesn't work, but it does work for inducing sleep in PTSD. For the people we have who want to get on it because of PTSD sleep disturbance, we're using an equal of combination CBD and THC. They're fifty-fifty, so they're not stoned, but they relax enough to have a more profound sleep.

Mr. Len Webber: That's interesting. Thank you for that.

Mr. Chair, I'm finished with my questions.

The Chair: You're out of questions. Okay. Good.

We'll move along to Madame Fortier. Welcome.

[*Translation*]

Mrs. Mona Fortier (Ottawa—Vanier, Lib.): Hello.

Thank you for your presentation. We are pleased to see that you have worked very hard on your campaign directed to parents.

I represent a very diverse riding, which includes many aboriginal youth and francophone youth from cultural communities.

Based on your experience, do you think it would be possible to reach these specific client groups through public education campaigns, given that they are directed to parents?

Mr. Marc Paris: Every time we prepare a campaign, we conduct tests using a sample of at least 300 parents. We make sure to include a range of respondents to obtain the best possible results and to achieve our objective with this target group. In the case of certain communities at risk, however, specific campaigns might be needed.

Since our organization currently depends on the generosity of the media, which give us air time, it is difficult for us to target specific markets. The media give us air time or space in newspapers, but we do not know when we will get it since it is often space that is not sold. As a result, we do not have complete control as to targeting diverse communities.

Mrs. Mona Fortier: Based on your expertise, do you think these aspects should be considered in the future?

Mr. Marc Paris: Children are children and parents are parents. The problems affect nearly everyone in the same way. There is some universality. Whether in the United States or Canada, I think parents have the same problems, in most cases. Children go to school together, and so forth.

Mrs. Mona Fortier: Ms. Chapados, in your presentation, you talked about the importance of using digital platforms and the Internet, I believe, as regards marketing and promotion.

Can you elaborate on the kind of measures you would suggest?

Ms. Maude Chapados: I am not a social marketing expert, but applications are available now, and campaigns....

Mrs. Mona Fortier: As an expert, have you conducted studies?

Have you confirmed how this could apply to what you have studied?

Ms. Maude Chapados: No. On the other hand, we know that young people are on the Internet. Furthermore, just walking around Montreal you see signs for the web applications of companies and dispensaries that are currently illegal. This is tolerated or at least the approach is lax. This is clearly an issue. The industry is already on the Internet.

● (1510)

Mrs. Mona Fortier: Very good. Thank you very much.

[*English*]

The Chair: Thanks very much.

Now we'll go to our final round, with Mr. Davies.

Mr. Don Davies: Thank you, Mr. Chair.

We have warnings on tobacco products. We have warnings on alcohol products. I presume there's going to be a warning on cannabis products.

Maybe I'll start with you, Ms. Porath. What should be on that warning?

Ms. Amy Porath: I think we need to have evidence-based information on that warning. I don't think we want to take a scare-tactic approach, but I think we really need to state what the facts are.

We've identified that there's still a lot we don't know about cannabis, but there has been some research, and we can come to some firm conclusions in a few areas. We know that it increases the risk of psychosis. We know that it impairs the ability to safely drive a motor vehicle. We know that there's a risk for addiction. Based on the science that we know conclusively, I think that's what should inform the warning labels.

Mr. Don Davies: Dr. Barakett or Mr. Paris, would you add anything to that?

Mr. Marc Paris: I think, as long as it's evidence-based, because kids are smart.... They can go and find out, and if they smell that it's BS, then they're not going to—

Mr. Don Davies: It could actually be counterproductive.

Mr. Marc Paris: Yes, exactly. It has to be totally evidence based. I totally agree.

Certainly, marketing should be out of the question. Right now, we are seeing medical cannabis companies sponsoring concerts of rappers and giving it a bit of a lifestyle thing. To me, this is a huge no-no, because as we learned with alcohol.... It's too late now. We can't undo that. We can't unscramble that egg, but we had to unscramble it in tobacco, because way back when, you had ads from doctors saying that smoking is good.

Mr. Don Davies: Why can't we roll that back? Why couldn't we? If we've done it with tobacco, why not? What's the hockey stadium in Montreal called? Is it the Molson Centre?

Mr. Marc Paris: Correct...it's the Bell Centre now.

Mr. Don Davies: The Bell Centre, but it was the Molson Centre, right? Is it that kind of thing? Why couldn't we bring those kinds of —

Mr. Marc Paris: I think trying to unscramble that egg at this point, mostly—

Mr. Don Davies: But again, we've done that for tobacco. We've currently unscrambled that, so why couldn't we?

Mr. Marc Paris: The harms from alcohol, as I think we'd all agree, are huge to society, just like we know that the health impact of tobacco was hugely difficult. We know there are some dangers and risks with cannabis, so let's not fall into the trap of alcohol.

Mr. Don Davies: There's a reason I'm pressing on this. I'll venture a thesis. I'm the father of three children who've grown up. Young people are particularly sensitive to hypocrisy. The hypocrisy of seeing us with a differential treatment of alcohol, which I will argue is the real gateway drug and also is responsible for at least as much, if not more, harm.... Again, that's not to minimize cannabis—

Mr. Marc Paris: No.

Mr. Don Davies: —it's to place it in its proper treatment.

If we're perceived to not have the same kind of approach to alcohol that we have to cannabis, is there not a risk that that youth are going to look at their parents kicking back with six Scotch on a Friday night and, as someone else said, popping a Valium? Does it not damage credibility when we talk about the harms of cannabis or if we have a different legislative framework in terms of advertising and tolerance? Do we not risk perpetuating that sense of hypocrisy among young people, which will dampen our ability to get our message out?

Dr. William J. Barakett: You know, 10% of the population has an inherent inability to drink alcohol in a controlled fashion. These are the people we call alcoholics. There is a genetic predisposition to the loss of control, the cognitive impairments that they suffer from. It's the same kind of cognitive impairment, but there are two different drugs: one with an enormously protracted duration of action, cannabis; and alcohol, with which the next day you're sober, unless you're a daily drinker, in which case you're going to have cognitive impairment.

It's important. You can't nuance these things on the cover of a product where you're going to talk about the problems. I think it's just as important for everybody to understand that what we can say so far is that this is a damaging drug in the developing brain and that it is a risky substance to use in motor vehicle driving. Those are about the only two things we can say right now.

The other thing I would love to be able to say is that if you're an adult recreational cannabis habitual user who is using it a lot—guess what—you have an underlying psychiatric disorder that you are masking. I treat those people. They come in at the age of 30 and 32. They've been smoking for years, and they can't get off it. I discovered that they have underlying ADHD, and for 20% of those with the ADHD, they are coexistently bipolar.

● (1515)

Mr. Don Davies: Could I ask a quick question? I'm going to run out of time.

It has to do with treatment. One thing in this country, I believe, is that there's an appalling lack of publicly paid for universal access to treatment facilities.

Dr. William J. Barakett: Absolutely.

Mr. Don Davies: People come to see you with this. Are you finding beds for these people, in every case where it's appropriate for them, that are paid for by our public health system, or do we need to ramp up our expenditure in that regard?

Dr. William J. Barakett: It needs to be ramped up, but, you see, unfortunately, these one-month treatment centres don't really accomplish a goal. The cognitive impairment is such that during that first month, the poor person doesn't learn anything. That's why there's such a high relapse rate immediately upon departure—

Mr. Don Davies: I think the standard now is not one month; it's three months to nine months.

Dr. William J. Barakett: It has to be three months or six months.

If the person is “fortunate enough” to be on welfare, he'll get into one of the multitude of treatment centres that will take his welfare card in Quebec. If it's somebody who's not on welfare, he's going to have to sublet his apartment and gather the money to go in and pay $2,000 a month, which most people can't afford, especially if they have a drug problem. There's a huge problem of access.

The Chair: We're done, Mr. Davies.

We're done, but we have some time. I'm seeking consensus. Is there interest in carrying on? We're actually done our questions, but we're learning here, so is there a consensus to have four more questions at five minutes, if we can fit that in?

All right. We're in.

Dr. Eyolfson.

Mr. Doug Eyolfson: Dr. Barakett, I want to challenge you on one of the things you said in the last round of questioning. You referred to marijuana being a gateway drug. There are definitive textbooks on the subject. We're talking about textbooks that are used in residency and actually for post-graduate fellowships for toxicology—*Ellenhorn's Medical Toxicology* and *Goldfrank's Toxicologic Emergencies*. They're very clear that the concept of marijuana as a gateway drug has never been definitively established. This has also been said repeatedly in multiple scientific journals on addiction in the meantime.

Given that information, what is the basis of the statement you made about marijuana being a gateway drug?

Dr. William J. Barakett: The basis is 30-plus years of observing. The basis is also the coming to the fore of studies such as the United Kingdom study I just quoted—published only this year, having terminated in 2016, in which they followed kids from age 15 to 18 and saw a definite correlation in abuse of the three substances, nicotine, alcohol, and illicit drugs.

Mr. Doug Eyolfson: I agree there's correlation. That is why that effect was always described.

Dr. William J. Barakett: The coexistence of a psychiatric disorder, most predominantly ADHD, is where the nuance is. When the ADHD goes unnoticed, then the kid self-medicates.

Mr. Doug Eyolfson: I will agree with you completely—

Dr. William J. Barakett: When you look at adult addicts, there is easily 50% coexistence of addiction and ADHD.

Mr. Doug Eyolfson: On that, you and I are in complete agreement. There's a large proportion of those addicted to all sorts of drugs that go hand in hand with mental illness. People will self-medicate for mental illness.

This is a different issue—the issue that if you try marijuana, it's the gateway drug to harder things. There are many studies that show correlation; however, there's a difference between correlation and cause and effect. This has been studied for decades. Every time they saw a correlation, there were so many confounding factors and comorbidities that it was never definitively established that marijuana was a gateway drug. To the best of my best knowledge of the literature, that particular point still hasn't been firmly established.

Dr. William J. Barakett: Whether it's a gateway drug or not, it is deleterious to the cognitive development of the brain.

Mr. Doug Eyolfson: And on that we agree.

Dr. William J. Barakett: On that we agree, and that's all you need to say, because the whole thing about.... What we see is a very high correlation. When I say that every addict who I treat started to use cannabis at the age of 12 to 13, I don't know the mechanism by which it happened, but it's a fact.

Mr. Doug Eyolfson: Oh, yes, I'm saying that, but again, it goes to credibility and to something that Mr. Davies said, that if we're teaching our kids things, we want to make sure it's the right evidence. We want to say the things that are credible that they aren't going to look up somewhere and disprove. The fact that it's deleterious to the developing brain is true, so we can say that definitively. They'll listen to that; it's credible.

But I don't want the message to get mixed with other things where there is so much information out there that says this particular thing.... If one of the things we say is, “Don't do this because it's a gateway drug” and there is lots of evidence—

● (1520)

Mr. Marc Paris: I agree.

Mr. Doug Eyolfson: —that's not the case, or it hasn't been established, then we could do more harm than good by promoting this narrative. That's what I'm saying.

Dr. William J. Barakett: Of course. You can't scare people. It's like telling an alcoholic, “You're going to die of cirrhosis”. He's not going to die of cirrhosis. The guy is going to have an automobile accident, he's going to make a thousand people miserable, and he'll never have a happy life. That's the message you have to deal with.

Mr. Doug Eyolfson: Exactly.

Thank you.

The Chair: Thank you.

Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Mr. Chair.

If I don't run out of time with my own questions, I'll share with Dr. Carrie.

Dr. Barakett, you seem to know quite a bit about marijuana and its effects on people, so I have a lot of little questions that I was saving.

One of them is that Health Canada says that men who want a family shouldn't use cannabis. Why do they say that?

Dr. William J. Barakett: I'm sorry, Health Canada says what?

Ms. Marilyn Gladu: They say that men who want to start a family shouldn't use cannabis. Why do they say that?

Dr. William J. Barakett: No. I think there was an old study that showed that there was a fall in sperm count and impotence, but I don't believe those things are true.

Ms. Marilyn Gladu: Okay.

The hemp producers have asked for an exemption from this cannabis legislation. Do you have any concern about that? They're saying that it's low THC content and so, you know, it's—

Dr. William J. Barakett: There are going to be the same rules. Kids shouldn't be using it. If they smoke enough of it, they're going to accumulate it in their brain and suffer similar effects. I don't think, if I had a young child at home, I'd enjoy having him walking around smoking hemp.

Ms. Marilyn Gladu: All right.

The last question I have is about the possession amount. Thirty grams was set as the limit you could have when you are over 18.

Dr. William J. Barakett: This is dried cannabis, right?

Ms. Marilyn Gladu: Yes, it's dried cannabis. Do you have any concern about that amount? Depending on how you roll a joint.... It could be 60 grams....

Dr. William J. Barakett: As I said before, I rub shoulders with addicts all day long, every day. If they want something, they're going to get it. You can limit the amount, but how do you apply that sort of thing? It really is education and making people understand.

There is a whole notion that cannabis has had a free ride through the years because people have just said, “Oh well, it's only pot”. Well, I'm sorry, but there is far more to it than that. In youth it causes harm. In adults who are abusing, they're masking an underlying disorder.

Ms. Marilyn Gladu: Okay, very good. Thank you.

I'll turn it over to Dr. Carrie.

Mr. Colin Carrie: How much time do I have?

The Chair: I think you have far too much, three minutes.

Mr. Colin Carrie: Okay, that's great to know because my colleague across the way did bring up a really important thing about credibility. I think, when you're talking about youth use of marijuana, we need to be honest, and we need to show the science behind it. That's one of the challenges I have with the government's approach to this bill because they're saying that they have to legalize because they want to decrease youth use. The evidence we're seeing in the committee here is that in Colorado and Washington that is not the case.

What we realize is that the government is going down this route, and we'd like to make this bill the best we possibly can, the best bill for Canadians to look after the health and safety of Canadians.

With your understanding of the bill, what do you think the federal government needs to address youth use of marijuana? Do you think this bill is the answer to solving the high usage amount among our youth, or do you think there has been a lack of certain things that need to be put into this bill?

I know I talked a little bit about the lack of education, the data collection, and the tools in the toolbox to get kids into some type of treatment. We really would like your advice, and I'd just like to go through the panel from Dr. Barakett across. If you could you help us make this a better bill, it would really be helpful.

Dr. William J. Barakett: I just see the bill as an opportunity to finally get out the information about cannabis and to dispel the myths that exist that it's a harmless substance, especially at the moment when we have already legalized medical use and people automatically draw the conclusion that all cannabis is the same and it's good for your health. We need to educate people. People just don't understand.

When I see an old lady of 80 years with rheumatoid arthritis and I put her on cannabis oil with a bit of THC, she's horrified until I explain, and then she is surprised when she comes back and she's no longer using painkillers.

Mr. Marc Paris: We know prohibition hasn't worked, so I think we need to do something else. I think getting to the root cause is one of the solutions, but also it's to break down those myths. When kids say to their parents, “Well, it's just a natural plant, Mom”, well that's when the parent has to say, “Well, so is poison ivy”. Not every natural plant is good for you. We just have to make that evidence based, so that they understand it's not a harmless drug and there are consequences, so that the kids have to make those informed decisions. We're going to make it 18. They're old enough to vote, to smoke, to drink, to drive a car, and borrow money for house. Even though their judgment's not totally fully developed, that's why we have to build up the information with them, so that they feel they're going to make a smart choice.

● (1525)

Ms. Amy Porath: CCSA was fortunate to visit Colorado and Washington state a couple of years ago to really hear from our colleagues to the south what were some of their experiences and lessons learned, and I know you heard from some of those witnesses yesterday. Just to reiterate, what we heard when we visited Washington and Colorado, and in some of the dialogue we had here today, is to have really strong upfront investment in prevention and public education and to really make sure we have targeted messages for different groups. We're going to need public education for youth, but we're also going to need it for their parents. We're going to need, beyond a mass media approach, that multi-faceted approach that I spoke to during my remarks: evidence-based programs in schools, community interventions, supports for parents. Anyone who's working with youth really needs to understand what the effects of cannabis are and how to have that discussion with young people, because it's not easy. I really commend Drug Free Kids Canada for its tool to help parents unpack that and really know how to start that conversation.

The other thing I would emphasize is really having resources for the implementation of the legislation. That's something we heard from a lot of the stakeholders when we went down to Washington and Colorado, making sure there's enough training for law enforcement, making sure there are resources put aside for prevention, but also for treatment, and we talked a bit about that as well, making sure we have that investment.

The other piece is research. As a researcher who's been studying cannabis for 16 years, I know there's a great deal we know, but there's so much we don't know. My organization led a two-day meeting last fall, where we pulled together 50 of the North American experts on cannabis to really start to map out some of the priority areas where we need further research. We're working collaboratively with CIHR and our partners at Health Canada and Public Safety to really start to move forward with that agenda. I'm actually going to a meeting next week in Montreal with CIHR.

Those are the points I would emphasize: we need investment for research, ongoing monitoring and evaluation, and prevention and public education.

Thank you.

[*Translation*]

Mr. François Gagnon: I do not want to repeat everything that my colleague said, and the INSPQ does not have the mandate to recommend anything other than what is already in its brief on Bill C-45. To elaborate somewhat, I would recommend including in the bill provisions to ensure there is absolutely no for-profit distribution system in Canada, but that would go well beyond the INSPQ's scope.

Nonetheless, that is essentially what we told Quebec officials when we recommended that they do everything in their power to prevent a for-profit model that would determine future regulatory options. The history of tobacco and alcohol is a history of commercialization. So the more that is done to limit commercialization, if not prevent it completely, the better it might be for public health.

Ms. Maude Chapados: Let me conclude by adding the following. You mentioned the data from Colorado. It is interesting that the increase was observed prior to legalization in 2014. Those figures are actually from 2009. The issue of non-medical cannabis arose in 2014. The whole commercialization of cannabis predates that, back to 2009, and increases can be seen.

Moreover, other reports indicate that it is not the change in legal status that leads to increased use, but rather the way it is regulated, whether that is decriminalization as is the case in Europe, or actual legalization of the consumption of non-medical cannabis. We must remember this and not demonize cannabis. This is important for the sake of consistency with the approach to alcohol and tobacco in particular.

The fact remains that cannabis is not an apple; it is not an ordinary commodity. That is why regulation is needed.

● (1530)

[*English*]

The Chair: Thanks very much. I want to compliment you, Dr. Carrie. You're learning from Mr. Davies.

Mr. Davies, you have five minutes.

Mr. Don Davies: Thank you.

It's funny. It seems that our approach is legalize, regulate, discourage. That seems to be the general approach to this, which I think is appropriate, given everything we're hearing.

I want to come at it from the other point of view. There's a phrase that if you're out of step with the army, maybe it's not the army. I'm just wondering if we could spend a moment on some of the reasons millions of Canadians use cannabis responsibly. Much like some Canadians on a Friday night go home and have a beer or two or enjoy a couple of glasses of wine, there are clearly millions of Canadians who use marijuana because it's pleasurable, or maybe it helps them deal with some pain. These are the words of Dr. Neil Boyd, who was here the other day. I think that's a reality of why people use it. There are millions of people who do not experience the negative impacts we're describing. They don't experience psychosis. They don't lose their jobs. They're not getting into car accidents.

We haven't spent any time on that aspect of the education component of government policy as we go to legalize this product. Do we run the risk of losing credibility if we don't acknowledge some of that? I don't really have a cogent question. I'll just throw that out for your consideration and comment.

[*Translation*]

Mr. François Gagnon: Different approaches are taken to different psychoactive substances. For alcohol, it is generally accepted that it is pleasurable to consume and the alcohol regulation framework seeks to reflect that.

For tobacco, it is not at all accepted that its use can be pleasurable or beneficial. Users can nonetheless say that they enjoy it in some way because otherwise they would not consume it. So the approach truly differs from one substance to another.

The pleasure and benefits that users enjoy from consuming a substance must be better reflected in policy development. That said, you are perfectly right in pointing out that there are different consumption patterns.

We have not mentioned today that, according to the best figures available to us, it is just a small percentage of users who consume a large part of the production. This is true for alcohol and tobacco. For cannabis, we do not have sufficient data in Quebec to clearly indicate this, but we suspect this to be the case.

In Colorado, for instance, about 20% of users account for 80% of all the cannabis consumed. Both the regulatory approach and prevention and treatment policies must therefore make these distinctions and tackle these issues head on.

[*English*]

Mr. Don Davies: You've said that quite well. I guess that's what I'm asking. None of them are perfect analogies. Cannabis isn't the same as alcohol. It's not the same as tobacco. I agree that tobacco gives a sense of pleasure, but I don't think there's a smoker who will tell you that it's good for them in any way. But I think cannabis users who use it occasionally and responsibly would probably differentiate that product. How do we differentiate, from a public policy point of view, responsible cannabis use?

Mr. Marc Paris: One caveat we have to make with cannabis is with regard to drug-impaired driving. In that particular case, as far as I'm concerned, impaired is impaired. We have to make it clear to everybody that whether you're smoking pot or drinking alcohol, or worse, the mix of the two, you shouldn't be driving a vehicle, end of story.

Beyond that, absolutely, we can't say that everybody who smokes a joint is going to be stoned out of their heads. The danger is if we don't have a controlled way in terms of the contents. When we get into highly concentrated marijuana, like shatter, which is essentially a concentrate that has up to 30% and even more of THC, this is getting into serious levels of psychoactive content. I have to believe that it starts to get into a danger zone. It's like having 80 proof alcohol.

● (1535)

Dr. William J. Barakett: People become non-functional when the levels of THC are so elevated.

I like the way you put it: legalize, regulate, and discourage, but if we're going to legalize, that means you have to regulate, but who are we discouraging? Is it youth? Also, we are educating adults about the use. As I said, a lot of people are self-medicating, whether it's for a painful condition or a psychological condition.

The other thing is, with the legalization is going to come the availability of oral compounds that they can take. Why should people be smoking this stuff and taking in all the products of combustion?

There's a big field ahead, and I think the government is dead right in proceeding with legalization because of the fact that it gives us an opportunity to educate.

The Chair: Mr. Oliver.

Mr. John Oliver: Thank you very much. When we heard from Colorado, we actually saw a letter they had drafted that had gone to the attorney general, the honourable Mr. Sessions. It said that in the most recent national survey on drug use and health that between 2013-14 and 2015-16, the period in which adult-use marijuana businesses really opened their doors, youth marijuana use had declined by about 12%. They attributed that quite remarkable outcome—because we haven't achieved that—to three different activities. One was enhanced funding for law enforcement to really tackle the black market and make sure there were proper restrictions put in place and charges being laid, which the government has currently done. Appropriate education and awareness was another one. In fact, they had appropriated $22 million, I think, from their marijuana tax revenues for education, which goes right to the heart of what I think your message is, Mr. Barakett and Mr. Paris. That's really what you're here to talk about. The third was strict regulatory provisions to prevent youth use, including age verification requirements, point-of-sale requirements, and prohibitions on advertising, packaging, and products. When I asked them if in those three tiers of activities there was a magic bullet, they said they were all really important to getting that youth utilization rate dropping.

I know you're here primarily to talk about the importance of education and the health promotion message. The other two you're simpatico with as well. Do you have any concerns about these other two?

Mr. Marc Paris: I totally agree. I think regulation has to be important. How is it going to be sold? Where is it going to be sold? What are the contents? What about edibles? Where is it going to be consumed, publicly or in the house? Are we going to allow parents to smoke pot in their cars when their kids are sitting in the back? These are very serious questions. If parents have four cannabis plants in the back yard, what if the kid goes in the back yard and starts chomping on leaves? There are lots of scary scenarios.

Mr. John Oliver: I think the act and the government's actions find a really good balance in those priorities, and I think you're really emphasizing that education message.

Mr. Marc Paris: The parents have to take the responsibility.

Mr. John Oliver: I have one other question. It's on your non-profit model, which is an interesting model. It's the first time I've heard that one being put forward so strongly. In Colorado, they raised a concern about preventing vertical integration in the industry, in particular, separating grower-producers from distribution-marketing, from retail. In a non-profit model, would you have concerns about vertical integration? Do you think they should be separated, that there should be three categories of non-profits, or do you think a monopoly vertically integrated non-profit would work?

[*Translation*]

Mr. François Gagnon: The model we proposed to officials in Quebec included a state monopoly, which prevents vertical integration of the market. Whether it is a completely public system, a private system, or a distribution system was less important to us than the type of model. In any case, the model we have proposed prevents vertical integration of the market.

● (1540)

[*English*]

Mr. John Oliver: I guess that makes sense. In a non-profit environment you're not worried about a monopoly to that extent then.

Those are my questions. Thank you.

The Chair: I want to thank the panel on behalf of our committee. We've certainly learned a lot, and we've enjoyed your presentations, your comments and information.

There's a lot of consistency within the hearings and the presentations we're getting. There's been a lot about research, information, public awareness, and training.

Again, I want to thank you on behalf of the committee for taking the time to do this and for sharing your experience.

We're going to suspend and return at four o'clock.

● (1540)

(Pause)

● (1600)

The Chair: I'll call our meeting number 66 back to order.

Now we have a panel here to discuss prevention, treatment, and low-risk use of cannabis. We welcome our visitors by video conference and those who are present.

I'll go through an introduction.

As an individual we have Gabor Maté, retired physician, by video conference from British Columbia.

Then we have, from the Centre for Addiction and Mental Health, Benedikt Fischer, senior scientist, Institute for Mental Health Policy Research. Hopefully we also have Bernard Le Foll, medical head, addiction medicine service, by video conference from Toronto.

Do we have him?

I don't think we have him. We have an empty chair.

From the City of Toronto we have Eileen de Villa, medical officer of health, Toronto Public Health.

Thanks very much for coming.

As an individual we have Sharon Levy, director, adolescent substance abuse program, Boston Children's Hospital, by video conference from New York.

Welcome. Thanks for taking the time to help us with this.

From the Ontario Public Health Association we have Michelle Suarly, chair of the cannabis task group, and Elena Hasheminejad, a member of the cannabis task group.

Welcome, and thanks very much.

We're going to open with 10-minute opening statements. I understand that some of you are splitting your time, but we'd like to try to keep it to 10 minutes.

I'm going to offer Dr. Maté, retired physician, to open up with a 10-minute opening statement.

If you would like to, give us an idea where you stand.

Dr. Gabor Maté (Retired Physician, As an Individual): Thank you for including me in this conversation. It's a pleasure to be here.

I worked for 12 years in the Downtown Eastside of Vancouver, which I think is notorious throughout North America as the continent's most concentrated area of drug use; and right now I travel extensively internationally to speak on addiction and related issues.

In terms of cannabis, first of all, I welcome the legislation that's going to bring some rationality to the policy around this substance. Drug laws in general—and I'll refer to that later—are quite irrational, in the sense that they have no connection to logic and very little connection to science whatsoever.

When it comes to marijuana, it's a substance that's been around for a long time. I think the first archaeological evidence of its use by human beings goes back 4,000 years, and it was first mentioned in a medical compendium published in China in 2,700 BC, so that's how long its use goes back.

In modern times, it was well known to the British in India, where physicians studied it and found it to be helpful in tempering nausea, relaxing muscles, and treating pain. As a matter of fact, Queen Victoria herself was prescribed marijuana for menstrual cramps, so the medical use of the substance and what you might call its recreational use go back a long time.

In terms of its addictive potential, it's just a misbelief that the plant is either in itself addictive or that it's a gateway plant for other addictions. If there's a gateway substance to addiction, it's tobacco, because most people who end up addicted to anything have used tobacco first. But it's not a question of gateways. The fact about any substance, whether it's marijuana, heroin, alcohol, food, or stimulants like cocaine, is that most people who try it even repeatedly never get addicted, but a minority will.

The question always becomes whether the substance is addictive. The answer is yes or no. In itself, nothing is addictive, and yet potentially everything is addictive. Whether something becomes addictive or not depends very much on the individual susceptibility. Now those susceptibilities may be to some extent genetically determined, but for the most part I don't think that's where the answer lies. I think fundamentally that substances that people use serve a function in their lives.

If you take the case of ADHD, for example, it's well known that kids with attention deficit hyperactivity disorder are more likely to use marijuana. Why? Because it calms the hyperactive brain. Very often addictions are self-medications; they begin as self-medications.

Marijuana also soothes anxiety. Now does that mean therefore it's benign? Not necessarily, because some people will start to self-medicate and they start using it to the point that now it creates a problem in their lives. Now it's an addiction. So the question of a substance being addictive is not to do with the substance itself, but whether or not a person uses it to the degree that creates a negative impact on their lives. Like any other substance, marijuana can do that, so it's neither true that it's addictive, nor is it true that it's not addictive. Again, it's a very individual matter, and the question is how we approach that.

First of all, we have to approach it rationally. This may be shocking or surprising to non-medical personnel, but legal substances like tobacco and alcohol are medically far more harmful than almost any of the illegal substances. For example, if you take 1,000 people who are heavy smokers or heavy drinkers and compare them to 1,000 people who use heroin in a non-overdose amount every day, and you look at those people 10, 15, or 20 years later, you will see that there's going to be much more disease and death in the alcohol and tobacco users than amongst the heroin users. This is especially true for marijuana.

● (1605)

Long-term studies show that over time marijuana users just don't suffer significant consequences, with one significant exception, and I hope the committee takes this into account, which is that there's a very persuasive study out of Britain that showed that if adolescents use marijuana extensively during the period of brain development, that can actually have deleterious effects on their long-term psychosocial and cognitive functioning. In other words, while it's true that marijuana is not as harmful as the already-legal substances of tobacco and alcohol, it's also true that if it's used extensively during the stage of brain development in adolescents, it can have negative long-term effects.

The question is how to address these problems. The trouble with adolescents and marijuana is that even when the substance has been completely illegal, as it has been up until now, it has not stopped adolescents from using it. In fact, it's the easiest thing to get for almost anybody aged 12 onward.

I don't know what, in the legislation, can possibly address that issue. I don't know what legal measures can stop the use by adolescents. In other words, when we're looking at prevention, we really have to look at why people use a substance, what's in the culture that's driving their use, and how we can address those issues.

Unfortunately, when it comes to drug prevention strategies, the idea of telling kids that stuff is bad for them just doesn't work. The reason it doesn't work is that the kids who will listen to adults are not at risk; the kids who are really at risk are not listening to adults. The real issue is how do we create conditions in our homes and our schools so that children will actually listen to what adults tell them. Without that connection, that trust on the part of the adolescent, they will simply listen to their peer group far more closely than to adults.

There is such a thing as marijuana addiction, and I'll define addiction as any behaviour, substance related or not, that a person craves doing, finds temporary pleasure in, or enjoys, and finds relief temporarily from, but which causes negative consequences in the long term and the person can't give it up. That is what an addiction is.

When it comes to treating any addiction, simply trying to address the addiction itself is inadequate, because there's always a reason why people use a substance or engage in a certain behaviour. When you ask somebody why they use marijuana, they'll say it makes them more relaxed. When you ask somebody why they use heroin, they'll say because they won't feel emotional pain.

In other words, the real problem is not the use of the marijuana or the heroin, the real problem is the emotional pain that person feels. The real problem is the overwhelmed state of their brain. In other words, the addictions are always a secondary attempt to solve a problem. Addiction treatments in this country, I have to say, for the most part don't address the real issues. Addiction treatments, for the most part, address the behaviour of addiction but not the underlying causes of it—not the underlying purposes that the individual finds in their behaviour. Those treatments will be insufficient.

When it comes to prevention, I think we have to look at what conditions in this society promote substance use in large numbers. If we look at the statistics for children, the number of kids who are anxious and depressed, alienated, troubled, or diagnosed with this, that, or the other thing is going up and up all the time. Every year the statistics are more and more dire. That's the real issue.

The drug use is a secondary phenomenon. It's those primary issues in our society that are driving the mental discomfort of our youth that we have to address. Those are broad social questions.

When it comes to treatment, again it's a question of how do we address the trauma, stress, and emotional distress of individuals who then use substances to soothe those factors. Again, we have to look into causes rather than just behaviours. I don't know where I stand in my 10 minutes. I'd like to bring it to a close.

● (1610)

I'm going to say that I'm encouraged by Parliament's willingness to take a rational perspective towards something about which our attitude has been completely unscientific and irrational. I just hope that the same open-mindedness and willingness to be realistic will soon be extended to drug policy in general, because all the irrationality that has characterized marijuana policy in this country for decades still characterizes opioid policy, for example. The current epidemic of opioid overdoses could be addressed effectively, but only if we take science and experience into account and only if we actually look at the evidence.

Some years ago I was asked to speak to a Senate committee on an omnibus crime bill and I said to the honourable senators that as a physician I'm expected to practise evidence-based medicine, and that's a good thing. When it comes to drug laws, I wish Parliament would practise evidence-based politics, because the evidence internationally is that the current approaches to drug use normally do not work. They make the problem worse.

Thank you for your attention. I'm very encouraged to see this moving forward and I hope there will be more to follow.

● (1615)

The Chair: Thank you. On behalf of the committee we very much appreciate your taking the time to do this.

Now we're going to go to the Centre for Addiction and Mental Health. We have Dr. Fischer, and I understand you're going to split your 10 minutes with Dr. Le Foll. Is that correct?

Dr. Benedikt Fischer (Senior Scientist, Institute for Mental Health Policy Research, Centre for Addiction and Mental Health): Yes, and I'm very glad that he's actually here now.

The Chair: Oh, there he is. The chair is full.

Dr. Benedikt Fischer: Thank you, honourable members. It's great to be here and to share some thoughts with you.

My name is Benedikt Fischer. I'm a senior scientist at the Institute for Mental Health Policy Research at CAMH, and chair in addiction psychiatry of the Department of Psychiatry at the University of Toronto.

I will share my opening remarks with my colleague, Dr. Le Foll. I will speak to you primarily from the public health perspective, and he will speak primarily from the clinical perspective on treatment.

I have worked on cannabis epidemiology, interventions, and policy for almost 20 years. Let us generally say that we very much welcome the federal government's initiative towards legalization of cannabis use and supply with strict regulations, because we believe —and we have stated this clearly in our 2014 CAMH policy framework—that this is the best way to improve public health and the safety outcomes related to cannabis use. We have said that before it was politically popular on the federal level.

On cannabis use, I'll make a few substantive comments. Cannabis use is not benign in terms of health risks. Cannabis use is associated with a number of different acute and chronic health risks. I will not repeat those; they're very well documented in the scientific literature.

This is a panel on prevention and treatment interventions. I'll elaborate a bit on the prevention side. In the intervention field, we typically distinguish between primary and secondary prevention, primary prevention being general prevention, and secondary or targeted prevention being aimed at users to reduce concrete use-related risks for adverse outcomes.

Let me emphasize that primary prevention for cannabis, especially under legalization, is an important facet of policy and interventions. Let me emphasize that abstinence from cannabis use is still the safest and most reliable way to avoid and reduce the risks of use.

However, we have a large number of Canadians—about 15% of the adult population, but up to 40% to 45% of youth and young adults—who've made the decision, for whatever reasons, to be users. So we have to combine our efforts on the prevention side both to keep the true abstinence rate as low as reasonably possible and to do everything we can to reduce the risks and harms among those large populations of people who've made the decision to actually use. That really, in essence, is the main practical challenge under legalization.

Given that the majority of use is concentrated in the 15-to-29 age group—in other words, youth and young adults—we have to ensure that this sizable population of young Canadians makes it through that cannabis use period into mid- and late adulthood with as little and the most limited health and social harms as possible for legalization to succeed as a public health intervention. That's essentially the quintessential challenge under legalization policy for the benefit of public health.

To elaborate a bit on the secondary or targeted prevention side with some examples, secondary prevention is of course a very broad realm or range of efforts that relate to a lot of different details of how legalization is designed and implemented. In other words, these are things such as what do we sell, where do we sell, who do we sell to, and how do we control distribution, but they're also things like avoiding the promotion and advertising of cannabis, and also pricing policy. All those kinds of aspects of the organization of legalization as it is enacted, as we know very well from data from alcohol and tobacco policy, are extremely powerful levers in terms of the risks and harms that we want to avoid. A lot of these details—or the devil that is in those details—are very relevant to the kinds of outcomes that legalization policy will produce and entail.

● (1620)

I'll just give a couple of examples. What will be extremely relevant for those kinds of risks and harms is what products are sold. We should avoid selling high-risk and high-potency products. At the same time, things such as edibles should be allowed, because they bear the potential to reduce, for example, smoking-related harms.

We should categorically not allow any kind of commercialization through advertising or promotion that leads to higher use and higher harms. As we know from alcohol and tobacco, we should keep distribution in public monopoly hands.

Pricing and taxation is enormously important, but not in a static way. It needs to be flexible so that we can adjust to organize demand and supply.

I'm personally concerned about restricting cannabis use—and potentially production through home growing—to private homes. It's not in the good interest of public health.

Finally, there's also the potential to reduce risks and harms among cannabis users through behavioural choices they make. That's exactly the conceptual basis of the lower-risk cannabis use guidelines that we launched in June from an international committee of scientists, published in the *American Journal of Public Health* and endorsed by the federal Minister of Health and five leading national health organizations. This is one ready tool for targeted prevention among users, as part of a comprehensive prevention strategy that we're happy to help with.

I'll hand it over to my colleague, Dr. Le Foll, to speak on issues of cannabis disorder and treatment.

Dr. Bernard Le Foll (Medical Head, Addiction Medicine Service, Acute Care Program, Centre for Addiction and Mental Health): Thank you, Benedikt.

Honourable members, thanks for the opportunity to talk about the treatment of cannabis use disorder. By way of introduction, I am a clinician scientist working at the Centre for Addiction and Mental Health. I practise addiction medicine. I have done research on the impact of cannabis, doing studies on cannabis administration in human subjects as well as clinical trials studying a treatment approach for cannabis use disorder.

I would like to start by describing a variety of clinical presentations we can see. We can have subjects presenting with cannabis intoxication. The symptom may be euphoria, but it can be also tachycardia, impaired judgment, and psychiatric complications associated with intoxication. I'm talking here primarily of physiological symptoms and psychosis symptoms.

There is no overdose associated with cannabis, so it's much less risky than opioids, which can lead to death.

There are also a clear symptoms that can occur when a subject discontinues exposure to cannabis after regular prolonged use. There is a typical cannabis withdrawal syndrome. It presents with anxiety, dysphoria, sleep disturbance, irritability, anorexia. Cannabis withdrawal can be distressing, but it's not life threatening. Even so, we know that withdrawal symptoms make cannabis cessation more challenging and that these symptoms are associated with a higher risk of relapse.

The main challenge is the loss of control over the use of cannabis. This can develop in a fraction of users and can result in an addiction problem. Currently in the field, we are defining this as cannabis use disorder. Cannabis use disorder is characterized by a pattern of cannabis use that causes clinically significant distress or social impairment resulting in negative consequences such as the inability to stop using.

Previously the field was using the terminology of “abuse” and “dependence”, with dependence being the most serious form of addiction. The research based on epidemiological surveys clearly indicates that 7% to 9% of those who use cannabis during their lifetime will develop a dependence at some point in their lives. There is a fraction of people who will lose control of their use and will develop cannabis use disorder. It is estimated that the fraction is 30% to 40%.

It is important to realize that those numbers are lifetime numbers, which means that you have subjects who will experience problematic cannabis use only for a restricted period of time in their lives and who will get over this kind of problematic use without necessarily requiring specialized treatment. This is currently seen as a growing problem, however, because we see more and more people coming to addiction treatment who require treatment for cannabis use disorder or who have addictions associated with cannabis.

I would like to make it clear that at this point the number of subjects coming for addiction treatment with cannabis use disorder as the main reason is very small compared with the number of subjects who seek treatment for alcohol or opioid addiction.

Treatment of cannabis use disorder can be performed in an outpatient setting, but sometimes patients can be treated as in-patients or in a residential setting, but usually that is more for the subjects who have concurrent psychiatric or polysubstance use. It is recommended that the treatment provider evaluate precisely the treatment goals of the patient and understand that these goals may vary greatly. Some subjects may want to be completely abstinent; others may want to reduce their level of use or avoid risky use.

● (1625)

The Chair: Dr. Le Foll, I'm sorry, but your time is up. Could you bring it to a close?

Dr. Bernard Le Foll: Sure.

At this point in time, we have interventions that are effective. They are psychosocial interventions, mostly cognitive behavioural therapy and motivational enhancement therapy. The analysis of the literature indicates that those are the most effective treatment approaches. It should be noted that the treatment sector in addiction is not necessarily using those approaches that have shown the best efficacy. There is currently research being done on pharmaceutical treatment for cannabis use disorder. This is not yet a mainstream treatment approach. It's still under the domain of research, so we do not currently have pharmacological interventions available. We think that it's very important that more trials be done in this area to generate the evidence that we need to better practise in the future.

The Chair: Thanks very much.

Now we'll go to the City of Toronto.

Ms. de Villa.

Dr. Eileen de Villa (Medical Officer of Health, Toronto Public Health, City of Toronto): Thank you.

Good afternoon, everybody.

The Chair: I'm sorry, Dr. de Villa.

Dr. Eileen de Villa: That's okay. I'm fairly flexible with the title, although I did work hard to get it.

Good afternoon, and thank you, Mr. Chair and members of the committee, for the opportunity to speak with you today.

As you heard, I am Dr. Eileen de Villa, and I am the medical officer of health for the City of Toronto, where I serve the 2.8 million residents of our very fine city.

I should point out that my comments here today represent not just my views, but also the views of Toronto Public Health and the Toronto Board of Health and are restricted to the proposed legislation for non-medical cannabis.

Just to kick off, I'd like to say that we do support the goal of Bill C-45 to provide Canadians with legal access to cannabis and, in doing so, ending the practice of criminalizing people who consume cannabis for non-medical purposes.

As you've heard from presenters thus far, the science on cannabis is indeed still emerging. We do know that it's not a benign substance. We know that it's a psychoactive substance with known harms of use. It's therefore imperative, in my opinion and in that of my organization, that the development of a regulatory framework be guided by public health principles to balance legal access to cannabis with reducing harms of use.

As you've heard already from some of the other witnesses before you today, there is health evidence that shows that smoking cannabis is linked to a number of health conditions, respiratory disorders, including bronchitis and cancer. It's also known to impair memory, attention span, and other cognitive functioning. It impairs psychomotor abilities, including motor coordination and divided attention. These are relevant public health concerns because of their connection to impaired driving in particular.

You've also heard that heavy cannabis use during adolescence has been linked to more serious and long-lasting outcomes such as greater likelihood of developing dependence and impairments in memory and verbal learning. In addition, the risk of dependence increases when use is initiated in adolescence, as rightfully pointed out by Dr. Maté.

As you may know, motor vehicle accidents are the main contributor to Canada's burden of disease and injury when it comes to cannabis. A recent study revealed that many Canadian youth consider cannabis to be less impairing than alcohol; however, as mentioned earlier, the psychoactive effects of cannabis can negatively affect the cognitive and psychomotor skills needed for driving.

In addition to strengthening penalties for impaired driving by amending the Criminal Code as put forward in Bill C-45, preventing canabis-impaired driving will require targeted public education. It's my understanding that the Government of Canada is preparing a public campaign to raise awareness about drug-impaired driving. Toronto Public Health would recommend that the government use evidence-informed messaging targeting youth and young adults in particular and launch this campaign without delay.

Further, I would recommend that the government support municipalities, provinces, and territories with local initiatives to discourage people from driving after consuming cannabis.

In its final recommendations to the government, the task force on cannabis legalization and regulation expressed concerns about the reliability of predicting impairment based on levels of THC, the main psychoactive compound in cannabis detected in samples of bodily fluids. These concerns have also been raised by other organizations, including those in the United States. I would recommend that the government make further investments in research and refinements to technology to better link THC levels with impairment and crash risk for developing evidence-informed standards.

The stated key objective of Bill C-45 to prevent young people from accessing cannabis is central to adopting a public health approach to the legalization of cannabis. We must apply lessons learned from tobacco and alcohol in developing the appropriate policy framework at all orders of government to prevent young people from using cannabis.

● (1630)

As mentioned by my colleague, evidence about tobacco advertising shows that it has an impact on youth smoking and that comprehensive advertising bans are most effective in reducing tobacco use and initiation. Personally, I welcome the requirements in Bill C-45 that maintain existing promotion and marketing rules in place for tobacco, including restrictions on point of sale promotion. We would also like to see these restrictions strengthened to include advertising in such venues as movies, video games, and other media, including online marketing and advertising, which are accessible to youth. Further, additional research on the impact of marketing and promotion is essential for making evidence-informed amendments to regulations and to develop prevention strategies. Federal funding should be targeted to this area.

Furthermore, we know that labelling and packaging are being used for promoting tobacco and tobacco brands. While I appreciate that Bill C-45 prohibits packaging and labelling of cannabis in a way that could be appealing to young people, a key omission in the act is a requirement for the plain packaging of retail cannabis products.

In a recent report, the Smoke-Free Ontario Scientific Advisory Committee identified plain packaging as a highly impactful tool for reducing tobacco use. The requirement for plain and standardized packaging for tobacco is currently being proposed in federal Bill S-5, and we recommend you do likewise for cannabis.

Fundamental to a public health approach for legalizing access to cannabis is regulating retail access. I am pleased with the Province of Ontario's recently announced intent to establish a provincially controlled agency for the retail sale and distribution of non-medical cannabis, separate from that for alcohol. A government-controlled retail and distribution system that is guided by public health objectives and social responsibility will ensure better control of health protective measures for cannabis use. I also urge your government to direct other provinces and territories to establish a retail and distribution system that is guided by public health principles and social responsibility.

I commend the government for not legalizing access to cannabis-based edible products until comprehensive regulations for its production, distribution, and sale have been developed. The experience in the United States cautions us of the challenges posed by edible cannabis products, including accidental consumption by children, overconsumption due to the delay in feeling the psychoactive effects, and in ensuring standardization of the potency of cannabis in edible products.

I would now like to draw your attention to some of the limitations of the existing cannabis research. While there is growing evidence about the health impacts of cannabis, some of the research findings are inconsistent or even contradictory, and causal relationships have not always been established. There is still much that we don't know. Most of the research to date has focused on frequent, chronic use, and the results must be interpreted in that context. More evidence is needed about occasional and moderate use, as this comprises the majority of cannabis use. I therefore urge you to earmark funding for research related to the full range of health impacts of cannabis use, in particular for occasional and moderate consumption.

Evidence-informed public education will be imperative for implementing an effective health-promoting regulatory framework for cannabis. There is an opportunity to promote a culture of moderation and harm reduction for cannabis that may extend to other substance use, especially among young people. The Government of Canada has stated its plan to pass Bill C-45 by July 1, 2018. However, in the meantime, Canadians continue to be arrested for possession of cannabis. Criminalization of cannabis use and possession impacts social determinants of health such as access to employment and housing. Given that cannabis possession will soon be made lawful in Canada, I urge you to immediately decriminalize the possession of non-medical cannabis for personal use.

In closing, I would like to reaffirm that Toronto Public Health supports the stated intent of Bill C-45 and recommends strengthening the health promoting requirements in the bill. I appreciate the complexity of building a regulatory framework for non-medical cannabis. Given that we're still learning about the impacts of cannabis use, the legal framework for cannabis must allow for strengthening health promoting policies while curtailing the influence of profit-driven policies. I look forward to ongoing consultations with the Government of Canada on the evolving policy landscape for this important public health issue.

Thank you for your attention.

● (1635)

The Chair: Thank you very much.

Now we're going to go by video conference to Sharon Levy, director of the adolescent substance abuse program, who is speaking to us from New York. Thank you.

Dr. Sharon Levy (Director, Adolescent Substance Abuse Program, Boston Children's Hospital, As an Individual): Thank you very much for the opportunity to comment on Bill C-45, an act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other acts. As a developmental behavioural pediatrician and a researcher in the field of adolescent substance use, I'm concerned about the potential impact of these changes, specifically on the health of children and adolescents.

I've served as the chair of the American Academy of Pediatrics' national committee on substance use and prevention, and I've been the director of the adolescent substance abuse program at Boston Children's Hospital since its inception in 2000. Over the past 17 years, I've evaluated and treated hundreds of teens with substance use disorders, and while many of my comments have already been said in one form or another, I'd like to speak from personal experience.

Cannabis is an addictive drug that's particularly harmful to developing adolescent brains. Teens that consume cannabis have poorer life outcomes on a number of measures. They have more mental health disorders, including depression, anxiety, and psychosis. As a group, they complete less school and are more likely to be unemployed or underemployed than are their peers. These harms are distinctly different from the harms of use of other substances, such as tobacco, alcohol, and opioids, but they're no less serious or consequential.

As the director of an adolescent substance use disorders program serving youth aged 12 to 25, I work regularly with children and young adults who use cannabis. In fact, more than 90% of patients we see in our program have a cannabis use disorder. While almost all of them started their drug use histories with cannabis, few stick to one drug alone. Almost all of our patients in treatment for heroin addiction first used cannabis, and most use it very heavily.

We've treated a number of teen cannabis users who've developed schizophrenia right in front of our eyes, and who will never be able to care for themselves or live independently. We don't know what would have happened to them if they hadn't used cannabis, but the science and the statistics made us wonder if they might have had a different life had it not been for a completely preventable risk factor.

More commonly, we see again and again adolescents whose cannabis use more subtly impedes them. Two patients with similar histories paint a very clear picture of cannabis addiction. Both were good students in high school and were accepted to elite universities, where they began using cannabis heavily and ended up failing out. Both blame their changing academic status on heavy cannabis use. All four of their parents have been devastated. One of the fathers confided about adjusting his own hopes and expectations for his son. A few short years ago, he had envisioned his son becoming a successful professional. Now, he simply hopes he'll be able to function well enough to support himself.

The list goes on and on, with many adolescents that I care for falling short of their own educational goals, being underemployed, and struggling with mental health disorders while their families watch and wonder about their future.

Bill C-45 would prohibit the sale or marketing of cannabis to adolescents and young adults under the age of 18, and legalization is often proposed as a mechanism to reduce youth access by taxing and regulating cannabis, raising the price, eliminating the black market, and making shop owners gatekeepers. This approach has failed with other substances in the past. Marketing restrictions have historically been of limited utility when tested against the potential for substantial profits. While it's illegal for tobacco companies to market cigarettes to children, the familiar story of Joe Camel is a good example of how pernicious advertising can be.

In the U.S., the experience in Colorado, which was one of the first two states to legalize cannabis, is instructive. The number of teen users in Colorado increased by 20% in the two years immediately following legalization, while falling by 4% in the rest of the country. As a developmental pediatrician and also the parent of two teenaged children, I do not find these findings at all surprising. The retail sale of cannabis serves to normalize use. Teens are very responsive to cultural trends. When cannabis use is condoned, teens are more likely to use it. To argue otherwise is simply unreasonable from a developmental perspective.

In the U.S., evolving cannabis policies have resulted in changes to cannabis itself. The concentration of THC, the main active ingredient in cannabis, has increased dramatically over the past three decades, exposing users to higher levels of this drug than ever before. That's one of the reasons the science has been so tricky to pin down, because the product is actually changing. New edible products, including cookies, candies, and sodas have appeared on the market and are sold under the umbrella of marijuana.

● (1640)

Now, this market expansion is to be expected, because creating new and improved products is a tried-and-true technique for boosting sales, constantly inviting new users to try, and old users to add, new products to their repertoire.

Dabbing, a newly popular way of using cannabis, results in extremely high blood levels of THC. Higher THC exposure produces more euphoria and also causes more medical problems. In our clinical practice, kids are coming in with new problems that we rarely saw 10 years ago. Cannabis hyperemesis syndrome, which causes recurrent vomiting, was once rare but is now quite common in our practice. Psychiatric symptoms and complaints have also increased. Many of our patients have heard voices, experienced delusions, or become anxious and paranoid with cannabis use. In a study that our group is currently conducting in our primary care centre, more than 25% of cannabis users report that they've hallucinated while using cannabis, and more than 30% report having been paranoid.

As a pediatrician, I find these numbers terrifying. While there's been limited study of these questions in the past, our clinical experience suggests that these rates are increasing, just as would be expected with ever-increasing drug exposure.

Drawing from my experience as both a researcher and a clinician, I'd like to offer the following suggestions. First off, I recommend delivering clear messages to youth that avoiding cannabis use is best for their health. The American Academy of Pediatrics and the Canadian Paediatric Society both oppose marijuana legalization, and encourage parents, health care providers, teachers, and other adults to give clear and unambiguous guidance to children.

Campaigns that educate the public in an attempt to prevent use or delay initiation could be beneficial. For example, the Truth Initiative campaign that targeted tobacco use was remarkably successful in shifting the public perception of tobacco from glamorous to repulsive. Rates of tobacco use plummeted over the past 20 years with the stigmatization of smoking. Cannabis is well known as a psychoactive substance that's particularly detrimental to developing adolescent brains. Although misconceptions that cannabis is “healthy because it's natural” or “safe because it's legal” have cultural traction, they're false. They require ongoing strong messaging of evidence to the contrary.

Age restrictions are effective at reducing youth substance use. In the U.S., the enactment of the National Minimum Drinking Age Act, which effectively raised the drinking age to 21 in all 50 states, resulted in a 16% reduction in motor vehicle accidents. This was as a direct result of lower alcohol consumption. Canada, which has a lower drinking age, also has the highest rate of problem alcohol use in the Americas. These facts support higher minimum age limits as a good public health strategy.

Innovations to cannabis-based products are public health risks, particularly for adolescents. It may be that addictive substances need completely new policy approaches. Novel regulatory schemes that control or eliminate profits, control prices, and conduct surveillance at both the individual and population level should be considered. This type of approach would be expensive and would require unprecedented collaboration between branches of government and other sectors of society. History and current evidence suggest that simply legalizing cannabis and giving free rein to the industry that it will engender would be to entrust private industry with safeguarding the health of the public, a role that industry is not well designed to handle.

Finally, we need more clinicians trained to treat adolescents with cannabis addiction. This will require financial support. With the legalization of marijuana in Canada, there will be a pressing need for health care providers specialized in youth addictions and treatment of adolescent substance use disorders. I am pleased to report that the first physician to acquire specialized training in pediatric addiction medicine in all of North America is a Canadian. They are currently training at Boston Children's Hospital. Much more support and many more funded training spots and training programs are needed.

Thank you for listening and for the opportunity to address this panel.

● (1645)

The Chair: Thank you, Dr. Levy. We're fortunate to have access to your expertise. We'll be asking you questions shortly.

We'll now hear from the Ontario Public Health Association. Michelle Suarly is chair of the cannabis task group and Elena Hasheminejad is a member of the cannabis task group.

Are you going to split the time?

Ms. Michelle Suarly (Chair, Cannabis Task Group, Ontario Public Health Association): Yes.

The Chair: All right. I'll give you a signal when you're five minutes in.

Ms. Michelle Suarly: We're going to alternate.

Good afternoon, Mr. Chair, and committee members. Thank you for the opportunity to appear before your committee.

My name is Michelle Suarly, and I am representing the Ontario Public Health Association in my capacity as chair of the task group for cannabis. I am pleased to be joined by my colleague, Elena Hasheminejad, who is a member of the task group.

The Ontario Public Health Association, or OPHA, is a non-profit, non-partisan association that brings together those from the public and community health, academic, voluntary, and private sectors who are committed to improving people's health. Many of our members, whether they are public heath nurses like us or from other fields, are working on the front lines to promote and improve public health in their communities.

OPHA has been championing prevention, health promotion, and protection since its creation over 68 years ago. Our mission is to provide leadership on issues affecting the public's health and strengthening the impact of people who are active in public and community health throughout Ontario.

Our task group encourages the federal government to adopt a public health approach to cannabis regulation to allow for more control over the risk factors associated with cannabis-related harms. Based on evidence that the risks of cannabis are higher with early age of initiation and/or high frequency of use, a public health approach would aim to delay the age of initiation of cannabis use, reduce the frequency of use, reduce higher-risk use, reduce problematic use and dependence, expand access to treatment and prevention programs, and ensure early and sustained public education and awareness.

We advocate that the federal government apply the health equity lens and recognize the role played by the social determinants of health, understand those who are most likely to be affected by the legalization of recreational cannabis, and support corresponding strategies to mitigate impacts.

Elena will now highlight OPHA's recommendations.

● (1650)

Ms. Elena Hasheminejad (Member, Cannabis Task Group, Ontario Public Health Association): Thank you, Michelle.

I'd like to start off by indicating our support for the federal task force on cannabis legalization and regulation's objective to protect young Canadians by keeping marijuana out of the hands of children and youth.

As I'm sure has been shared with you today and throughout this week, Canadian youth have one of the highest reported rates of use among developed countries, which we know is concerning, because research has found that the brain continues to develop until the early twenties.

To protect young Canadians, it's important that we consider some of these prevention measures. Health Canada recognizes that tobacco packages have been powerful promotional vehicles for the tobacco industry and has stated that it is committed to introducing plain packaging, which a lot of my fellow colleagues have also highlighted today.

We recommend that the same regulations be put in place for cannabis products as well. We recommend clear and restrictive requirements for the mitigation of the sale and promotion of products to youth, consideration of unintended exposure, and retail licensing requirements. We recommend that all cannabis and cannabis containing product labels include clearly displayed THC and cannabinol content, evidence-informed health warnings, harm reduction messages, and information on accessing support services.

Although plain and childproof packaging may reduce the risk of unintended exposure through regulation, it would not effectively reduce the risks for edibles. Children may mistake edible products as regular food when these products are not enclosed in their packaging. With that in mind, we recommend that regulations regarding edibles consider the impact of products manufactured that resemble candies, cookies, gummies, and other products typically marketed to children.

Last, given that a significant proportion of cannabis users are young adults, we encourage the federal government to facilitate discussions with all levels of government to ensure that the minimum age is consistent. A consistent minimum age would eliminate cross-border variation, which would limit the effectiveness of minimal legal age regulations in protecting young people.

Ms. Michelle Suarly: We also want to ensure that Canadians are well informed through sustained, appropriate public health campaigns, and for youth in particular, to ensure that the risks are understood.

As mentioned earlier, the Canadian Centre on Substance Use and Addiction report "Canadian Youth Perceptions on Cannabis" stated, "Overall, youth considered cannabis to be less harmful than alcohol and other substances."Youth also felt confused about cannabis laws.

We are concerned that there is not enough public awareness about the harmful effects of cannabis. Further research is needed to continue to understand the impact, be it on brain development, pregnant and breastfeeding women, or other areas. We urge the federal government to engage youth in the creation of health promotion materials and strategies targeted to them.

To ensure that the public is fully aware of the harms associated with cannabis use, we recommend that the government develop and implement an evidence-informed public education campaign ahead of the federal legislation being passed. Both general awareness to promote lower-risk cannabis use guidelines and targeted initiatives to raise awareness of the risks among specific groups, such as adolescents, those who are are pregnant, and people with a personal or family history of mental illness, are needed.

It is also crucial that the federal government commit to using a high percentage of revenue gains from the sale of cannabis products as a source of funding for prevention, treatment, harm reduction, and enforcement. Significant funding toward a population approach to mental wellness, stress management, and healthy coping strategies must also be considered.

Ms. Elena Hasheminejad: In terms of keeping our roads safe, it's important to note that we know that impaired driving is a leading criminal cause of death and injury on our roadways, and cannabinoids are among the most common psychoactive substances found in deceased and injured drivers in Canada.

We agree with the federal government that there is a need to strengthen our impaired driving laws to better understand drug-impaired driving. In addition, we also support the recommendation of the Canadian Association of Chiefs of Police for advanced funding for enhanced officer training and drug recognition technology investments to ensure that there is a clear and reliable system for identifying, testing, and imposing consequences for drug-impaired driving prior to legalization.

In terms of workplace wellness, cannabis use or impairment in the workplace, especially in safety-sensitive positions, can pose a danger to everyone, including the person who's impaired. While substance use in the workplace is not a new issue, employer groups and workplaces would benefit from clear guidance from both the federal and provincial governments regarding measures such as policies and procedures that they can follow through with to address cannabis use in the workplace. In addition, access to programs and services to support employees with dependence or problematic substance use needs to be greatly increased.

● (1655)

Ms. Michelle Suarly: Lastly, we support research and ongoing data collection, including gathering baseline data to monitor the impact of the new framework.

Our task group emphasizes the need for investing in research and centralized national surveillance systems so that problems could be detected at an early stage, successes are tracked and emphasized, and course corrections can be made. This should be implemented now so that we have baseline data.

We also emphasize the need for a comprehensive policy monitoring and evaluation framework. Moving forward, we recommend further research to investigate maternal cannabis use during pregnancy, impact on birth and childhood outcomes, the impact of cannabis exposure through breastfeeding, the impact of cannabis use on mental health, interactions between cannabis use and pharmaceuticals, testing methods to determine cannabis levels and/or impairment levels, and the health effects of heavy, regular, or occasional cannabis use, just to name a few.

Our recommendation is to enhance current national surveillance systems such as the Canadian community mental health survey and the Canadian tobacco, alcohol, and drugs survey to include additional questions on public opinion on cannabis policy and regulation, awareness of the health effects of cannabis use, and the effects of cannabis use during pregnant or while breastfeeding. This data can help inform the development and changes to health policy, public health programs, and communication campaigns geared towards cannabis use.

Ms. Elena Hasheminejad: We would like to conclude by thanking you for the opportunity to convey the ideas and recommendations of our members. Further recommendations related to the legalization of the recreational use of cannabis can be found in our position paper, which we've left with you today, titled "The Public Health Implications of the Legalization of Recreational Cannabis".

Our position paper expands on the recommendations that we've made today, along with other areas of focus such as taxation, age, sales, and access, and we would be happy to speak to these as well.

OPHA believes that Bill C-45 and the recent response from Ontario are steps in the right direction. We believe that, through effective public health-focused policy interventions, a comprehensive, collaborative, and compassionate approach to drug policy can be put in place that the government's commitment to legalize, regulate, and restrict access to cannabis.

We welcome the opportunity to collaborate with the federal government and others to achieve this shared goal and will continue to offer our local, provincial, and national networks our evidence-based information, knowledge, and expertise.

We thank you for your time and consideration today.

The Chair: Thank you very much.

Now we'll go to a round of seven-minute questions. We'll start with Ms. Sidhu.

Ms. Sonia Sidhu: Thank you, Chair.

Thank you, all, for your presentations.

A key goal of the legislation is to restrict access of young Canadians to cannabis. In order to shut down the illicit market and keep profits away from criminals, the government has set the federal legal age at 18, but with provinces able to change that.

Mr. Fischer, could you tell us the reasons you believe 18 is the right minimum age for the federal law?

Dr. Benedikt Fischer: Eighteen, or 19 as decided in Ontario, is a good political compromise, I'd say. It's a good political compromise because it makes the age limits consistent with alcohol and tobacco regulations. It wouldn't make sense otherwise. It wouldn't make sense to let people drink at age 19 and consume an overall less hazardous substance at a higher age.

At the same time—and I've used this term before—I think there's a certain sense of, if you allow me, political naïveté in the sense that we think we will legalize and regulate and set an age limit, and all of a sudden all the young people below the age of 19 who used cannabis under prohibition, when the age limit was 500 years or 0, will all of a sudden stop using cannabis. We have to be very realistic and aware of that.

The best we can hope for under the age limit of 19 for people under the age of 19 is that we will have trickle-down beneficial effects on that age group that will make their use of cannabis less risky and less harmful through regulated products, safer distribution, etc., combined with more effective, more realistic, and evidence-based prevention. Please, do not fool yourselves that legalization with the strictest and best possible regulation will eliminate cannabis use by the people under age 19. We would all fool ourselves if we thought that. It will not happen. That is the Achilles heel of the current policy and law proposed. Politically it wouldn't be more defensible to lower the age limit. I understand and appreciate that, but we have to put everything in motion to reduce the risks and harms of what will certainly be ongoing cannabis use at the highest levels, relative to other populations, in the age groups below 19.

● (1700)

Ms. Sonia Sidhu: Thank you.

I noticed that you also support the model of the LCBO in Ontario as the distribution system. Why do you feel that is better than private storefront sales?

Dr. Benedikt Fischer: I supported all along a publicly controlled, public monopoly distribution system. Whether LCBO stores alone will be the best system, I think is in question. I question that personally.

I advocated for a hybrid model between public, LCBO-based sales and community storefront outlets primarily for the following reason. The success of legalization will, to a large extent, hinge on the what extent to which we can effectively bring current consumers from illegal markets and sources to legal sources, in practice—not on paper or in theory. In other words, if we design a distribution system now that is perfect on paper but is too strictly regulated, too sterile, too aloof from the realities and wishes and preferences, as subjective as these may be, of current users, then they will not go there, but keep buying illegal, hazardous, risky products from illegal markets and sources. Legalization will fail. It will have succeeded maybe in abstract theory, but it will have failed in practice. This is a crucial hinge variable of the success of this, whether we can bring users, all of them or as many as possible, from illegal markets and sources to the legal markets. Therefore, that part of the equation needs to succeed.

At this point, we don't know perfectly how to do that best and well. We have good theoretical ideas. I think some of the ideas are a bit misguided as currently designed, probably being overly restrictive and too sterile, but it remains to be seen. We need to try to see what happens, and if necessary, adjust. That may have to be a little, that may have to be a lot, but we have to bring people into legal distribution systems. If that doesn't happen, if we don't succeed, legalization, to a large extent, as a public health venture, will fail.

Ms. Sonia Sidhu: Thank you.

My next question is for Dr. de Villa.

Thank you for serving 2.8 million Toronto residents. I noticed that you support the idea that cannabis products should be sold in plain packaging. Could you tell us why you favour this model?

Dr. Eileen de Villa: As I indicated in my remarks, the idea is to borrow from that we know from other products already out there. There's quite a bit of research with respect to how packaging impacts the uptake in use, by youth in particular. We do know, and I do believe there is good reason to believe, and I think my colleagues to my right also speak about this within their position, that plain packaging not only allows an opportunity for appropriate information to be conveyed, but also minimizes the attractiveness to youth.

As we've heard from all of us across the table here, there are particular concerns around the initiation of cannabis use among youth, particularly heavy use by youth, and its long-term consequences. That's where the evidence is actually most solid, despite the fact that we know that our comprehensive understanding of the health impacts of cannabis is still something that's very much in development.

The notion is to try to minimize or reduce its attractiveness to youth so as to minimize the negative health and social impacts associated with early initiation and heavy use by youth.

● (1705)

The Chair: The time's up.

Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Mr. Chair, and thanks to the witnesses. Again, we've had great witnesses here, but so little time to ask them questions. I have so many. Maybe I can start with Dr. Levy.

First of all, thank you very much for participating in this really important committee. As a developmental pediatrician and somebody who's on the ground, I really appreciate your input. I want to ask you a question.

We've had different opinions, but one thing is clear: the younger you start smoking marijuana the higher the chances of becoming addicted. I was wondering what you think of the fact that the legislation will allow 12-year-olds to 17-year-olds to possess up to five grams. My understanding is that could be 10 to 15 joints. Is the federal government sending the wrong message with that?

Dr. Sharon Levy: You know, that's an excellent question. I've heard a lot from other committee members about the need to decriminalize marijuana possession, marijuana use, and I think that's very important. What we don't want to do, because we know it's a failure, is to arrest users, arrest those who are in possession of cannabis and send them off to jail or give them criminal records. That doesn't help anybody and it's a waste of effort, it's a waste of time and money, and it also creates bad consequences down the road.

On the other hand, there are ways in which the judicial system can be used as leverage to get people into treatment. For underage users, I think there is a tremendous opportunity not to arrest them or give them a criminal record or throw them in jail, but somehow to use their possession of marijuana to have them evaluated, to have them meet one-on-one with a physician, social worker or other health professional who can really figure out where on the spectrum the youth falls and determine the appropriate next steps, which could be anything from advice and guidance all the way to more formal treatment for cannabis use disorder.

Mr. Colin Carrie: At the previous panel, I asked a similar question of one of the other doctors. What has become obvious is that this legislation really doesn't provide those tools. I don't think anybody wants to see a young person criminalized and have that record follow them, but one of the witnesses did say that there should be a way to allow the issue to be addressed, and we still haven't come up with any answers here. We're hoping, as all of us sit around this table, to make it a better bill. If the government is going down this route, we want to make it the best we can.

There is also a controversy over how dangerous cannabis is to young minds. Again, the former panel said it is more dangerous because of the cumulative effects for young people. We heard Dr. Fischer say this is a less dangerous substance.

I was wondering about your opinion. Is cannabis less dangerous than alcohol for youth, or is it more dangerous? You brought up different things about new disorders, things along those lines. What is your opinion?

Dr. Sharon Levy: Each substance has its own profile of consequences and harms. In some way, the question is really comparing apples to oranges.

Cannabis use very clearly cause problems with mental health disorders and problems in functioning. By the way, those are harder to pick up because, typically, monitoring systems are picking up things such as heart disease and lung cancer, the classic problems with smoking. They are not so good at picking up depression or underemployment, so we can miss some of those. That's an important point.

To ask which of those is more harmful is really not such a logical question. I think both of those outcomes are bad. We'd like to avoid all of them. To me, trying to compare the substances doesn't make a whole lot of sense.

Mr. Colin Carrie: I agree. I think both of them are very significant and very serious. Because youth in Canada have this idea that it's just pot and nothing to really worry about, we really have to get ahead of the education. The current government has had two years to get out ahead of this and it's a real lost opportunity.

That's what I want to talk to the OPHA about. You mentioned the importance of things such as data collection. Again, we're trying to make this a better bill. We've had witnesses say that data collection should be ongoing now, and I don't think this bill even addresses it. I don't even see anything moving forward in terms of data collection and helping out the provinces and municipalities on how to do that.

You talked about education. Again, what a lost opportunity it has been. The government has had two years to do that. We had a private organization talk about what they're doing and the government has put forward, I think, $9.5 million over five years for Canada. Colorado put forward $10 million per year for a population of five million people; and the State of Washington, $7 million for seven million people. I wonder if you could really comment on the lack of direction in this bill for data collection and education, and you also meant treatment.

● (1710)

Ms. Elena Hasheminejad: I can speak to the education piece and highlighting its importance, as you said. Coming from when I worked the front-line, I have had the opportunity to go out to schools, albeit for many years we had difficulties even going into schools.

The fact that we are moving towards legalization has brought attention to this and allowed us to begin talking about this substance. For those of us who work on the front line, it's not that we haven't attempted to, but there has always been a barrier because it has been an illegal substance. We know that Canadians are among the highest users, and we know from even our fellow colleagues from CCSA that when they are interviewing youth, or even when I see youth up front, the perception is that it's natural, that it's not harmful. That's where the big gap is.

Mr. Colin Carrie: That's the problem.

Ms. Elena Hasheminejad: Yes, education needs to start. One of the biggest keys to prevention is bringing that education forward, and not just for youth, but for parents, educators, or those who are working alongside youth. They are a population that's important.

However, I think something that also needs to be brought up is that a lot of youth are questioning why we're moving towards legalization. At times it builds up the perception that it's even safer. Even having education on the reasons we are moving towards this can at least help them understand that we're not legalizing this because, as some of them quote in some of these interviews, “it's natural” or “it's a plant”, but for the reasons we have outlined. I think those are very key components in education that need to be started.

I know when we look at different public health units, we are all trying to work together to do the education. I saw the drug-free kit, which we had heard about—

Mr. Colin Carrie: If I could interrupt you—

The Chair: The time is up.

Mr. Colin Carrie: —with 290 days before it's implemented, have you received any support from the government?

The Chair: Mr. Carrie, the time is up.

Mr. Colin Carrie: Oh, darn.

The Chair: Mr. Davies.

Mr. Don Davies: Thanks to all the witnesses for being here.

Dr. Maté, perhaps I might direct some questions to you first. The Liberal government has asserted that the proper public policy in respect to cannabis is to legalize it to meet a specified set of purposes. The New Democrats agree with the government on this in terms of its being a proper public policy approach.

I want to read you the purposes of why they want to legalize cannabis:

> The purpose of this Act is to protect public health and public safety and, in particular, to
>
> (a) protect the health of young persons by restricting their access to cannabis;
>
> (b) protect young persons and others from inducements to use cannabis;
>
> (c) provide for the licit production of cannabis to reduce illicit activities in relation to cannabis;
>
> (d) deter illicit activities in relation to cannabis through appropriate sanctions and enforcement measures;
>
> (e) reduce the burden on the criminal justice system in relation to cannabis;
>
> (f) provide access to a quality-controlled supply of cannabis; and
>
> (g) enhance public awareness of the health risks associated with cannabis use.

However, Prime Minister Trudeau has gone on record as explicitly ruling out taking a similar approach to other substances. I'm picking up your comments at the end of your opening statement. In your view, is that a rational position to take?

Dr. Gabor Maté: Well, I think there are two worlds: there's the world of reality and there's the world of politics. Somehow the two have to be conjoined. In the realm of politics, I totally understand why the government has taken the very rational step—and for the laudable purposes that you just outlined—of bringing rationality into the marijuana situation. I also understand that for political reasons it would just not be popular and acceptable to a lot of people, due to ignorance and a lot of propaganda over the decades, to bring that same rationale into drug policy in general. From the political point of view, I totally understand it. From the medical point of view, from the human suffering point of view, from the humane point of view, from the point of view of what would best serve prevention, treatment, and healthy judicial system approaches, of course I can't agree with the present reluctance to extend this same broad-mindedness and rationality to the other drugs that are currently illegal.

So, yes, politically it's understandable. From the point of view of what would be best and what would be right and serve the population, no, I can't agree with the present approach.

● (1715)

Mr. Don Davies: Well, I'm just wondering, because we've heard lots of evidence about cannabis and its health impacts, the undesirability of using it, it's impact on young people, yet we, as a Parliament, are trying to provide a rational system that recognizes that, while people are using it, we may as well regulate it and ensure that organized crime is not involved it it and that there are safe amounts of it. Of course, I come from Vancouver, where the opioid crisis is raging. We're on track this year to have more deaths than last year, which was in itself a record, from fentanyl and other opioids, and it strikes me that a similar approach.... If this is the right approach to cannabis, I'm struggling to find out what the differentiation would be with the other drugs.

Dr. Gabor Maté: Well, yes, I agree with you. In the United States, a presidential commission recently reported that every three weeks they suffer the equivalent of a 9/11 because of opiate overdoses, and yet the overall policies are not changing. There's a real contradiction between what's happening in the real world and what's happening in the realm of politics.

I will be in Ottawa, I think, in November. An event is scheduled, I believe, with the participation of the former health minister, now indigenous affairs minister, Jane Philpott. I trust that if the event goes forward, we will be talking about this material. I totally share your impatience and frustration with the lack of congruence. The fact is that with all substances that we've talked about today—marijuana included—the licit substances like tobacco and alcohol can have deleterious negative effects. It's not a question of anybody saying that these things are good; it's a question of asking what's the most rational policy towards them. Just as we've learned with alcohol what prohibition costs, to great cost; just as we should have learned by now about the impact of prohibition on opiates and other drugs; and as the impact and the irrationality of prohibitive approaches on marijuana are just being finally realized, I hope at some point we get to the stage of rationality when it comes to drug policy in general. I wish for that no less fervently than you do.

Mr. Don Davies: In a May 2017 interview you conducted with Jaisal Noor, you said, “the fundamental assumption that informs the legal approach to drugs, is that drug use—and particularly addiction —is a choice that people make”.

Dr. Gabor Maté: Yes.

Mr. Don Davies: The current U.S. attorney general, Jeff Sessions, recently made a statement about how we had to go back to the 1980s and to Nancy Reagan's “just say no” approach. He thinks that's the way to prevent drug use: if people are just told how bad drugs are, they'll stop using them. The public conversation on drugs simply does not take into account the realities of why people use and get addicted in the first place. In your view, Dr. Maté, what are the realities of why people use drugs and get addicted in the first place, and how would that inform public policy?

Dr. Gabor Maté: This also pertains to the present discussion on marijuana and prevention. If Mr. Sessions is right, that those policies of telling people that drugs are bad and not to use them at any age work, why does the United States have five or 10 times as much heroin use as it did 10 years ago? In other words, the current situation more than amply demonstrates the failure of that kind of approach.

The reason people use drugs—and I indicated that to some degree with marijuana.... If you ask young people what they get from it, they'll tell you what they get from it. They'll get a sense of social connection. They'll get a calming of their minds. For certain conditions like ADHD, it actually has a soothing effect that they crave. Heroin is a painkiller. It soothes emotional and physical pain. Stimulants make people feel more alive, more present, more vivacious, and more vital.

The real question is, why is it that people have emotional pain? Why are so many young people anxious? Why are so many young people depressed? Why are these numbers going up and up and up? Why are more and more kids diagnosed with ADHD, which itself is a risk factor for addictions of all kinds, particularly a marijuana addiction?

Those answers are not to be found in individual people; they are to be found in social factors. When I'm talking about prevention, our prevention approaches really have to address those social factors: what's happening in the schools, what's happening in the homes, and what's happening in the culture.

I know that this legislation can't address those questions in any comprehensive or even deep way, but I certainly concur with all my colleagues who said that this should be a public, monopoly-based system. I also concur with everything they said about how the money being made from it should not go into funding highways or anything else. It should go into funding programs that help prevent the social conditions and the social pressures that drive young people into drug use. In other words, if we're going to have a monopoly here, let's use the income from that to actually address the real issues as to why kids are using drugs.

Finally I'll say—and I've written about this in one of my books—that the problem with exhorting kids not to do stuff is, one more time, that the kids who are listening to adults are at much less risk, and the kids who are at high risk are not listening to adults because of what's happened in their lives.

Our prevention approaches need to go beyond telling kids not to use stuff. They also have to go to bringing these kids into a healthy relationship with adults so that they will listen to us. That's a big issue.

● (1720)

The Chair: Time's up.

Mr. Oliver.

Mr. John Oliver: Thank you very much, and thank you for the testimony you've given today.

We've had a number of fairly wide-ranging conversations about different things, but for us as a committee, at the end of day, our mandate is to sit down and actually review the act in a clause-by-clause way to see if it meets the stated objectives or there need to be amendments.

In that regard, one area that we haven't really delved deeply into as a committee yet is this issue of packaging, branding, and promotion. I thought I would spend a bit of time on that with you. I think both the Public Health Agency of Canada and OPHA have proposed the plain packaging. I've certainly seen that for cigarettes, and it's worked very well in certain jurisdictions. I'm just not sure how you legislate it.

I am going to just quickly read what's here in the act around promotion and around branding. See if you think it's sufficient or if you have any advice for us as a committee to add more to it.

Under promotion—I'm going to shorten it a little bit, just to make it easier:

> 17(1)...it is prohibited to promote cannabis...
>
> (a) by communicating information about its price or distribution;
>
> (b) by doing so in a manner that there are reasonable grounds to believe could be appealing to young persons;
>
> (c) by means of a testimonial or endorsement, however displayed or communicated;
>
> (d) by means of the depiction of a person, character or animal, whether real or fictional; or
>
> (e) by presenting it or any of its brand elements in a manner that...evokes a positive or negative emotion about...a way of life such as...glamour, recreation, excitement, vitality, risk, or daring.

Those are all the ways you can't promote.

Under branding, it says a person may promote cannabis by displaying a brand element, like Players versus—I don't even know what the brands of cigarettes are—either on the product or on a thing that is not the product, not cannabis,

> 17(6)...other than
>
> (a) a thing that is associated with young persons;
>
> (b) a thing that there are reasonable grounds to believe could be appealing to young persons; or
>
> (c) a thing that is associated with a way of life such as one that includes glamour, recreation, excitement, vitality, risk, or daring.

Those are pretty clear limitations. It's sort of a name and maybe a colour, and in cigarettes there's not even colour used in plain packaging. Are those provisions sufficient, to your mind, around promotion and around branding, to strictly prohibit anything that would make this product appealing to young people? Are there any reactions to that?

Dr. Eileen de Villa: It it sounds like that list has most of the elements covered. I'd have to reflect on it a little more, but the notion is to follow the evidence that has been used and been shown to be impactful with respect to plain packaging as it applies to tobacco. I think we have some experience with that, which can be used to inform the committee in its deliberations on this particular issue.

● (1725)

Mr. John Oliver: Thank you.

Ms. Elena Hasheminejad: I'm going to echo that, but I have just one thing to point out.

Again, we would have to look at this a little more in depth, but I know that even when we've looked at some of the lessons learned from Colorado and Washington, they stated that individuals express that when there is the legal option to getting cannabis, they prefer that rather than going illegal.

I know there has been a discussion of finding a balance with branding and marketing and thinking that if we don't have that, then where is the competition? Or individuals go for that branding piece, like they do with cigarettes. But as we have learned from the lessons with tobacco, as my colleagues have pointed out, on the benefits of plain packaging and what we have seen, and knowing that in other jurisdictions that have legalized cannabis individuals are still taking that route to promote that, plain packaging is something that I think —

Mr. John Oliver: In your experience of plain packaging, do those prohibitions...? You can't just say “plain packaging”. I don't think that's a legislative term. You have to be more descriptive. Do these cover off the plain packaging in your mind, or do you think there are specific elements that should be added to those prohibitions?

Ms. Elena Hasheminejad: To what you read out from the bill? Again, I would probably have to look into that a little more. I know that—

Mr. John Oliver: If you wouldn't mind, if anything comes to mind later, I would love to see anything you would have on this.

Ms. Elena Hasheminejad: Yes, of course.

Ms. Michelle Suarly: We'd be happy to share it.

Mr. John Oliver: Nobody wants this to be promoted to children in any way or to make it look attractive.

Do any of the other witnesses have any comments on promotion or branding?

Dr. Benedikt Fischer: I'll just add here that of course part of the issue or the challenge is that the genie is out of the bottle a bit, because the bill allows private commercial producers, and quite a few of those issues are tied to that. You cannot really have commercial producers without any branding or advertising or whatever, because they need to have a name and they'll use a certain font, etc., right? Part of the genie is out of the bottle a bit, and now the environments, the products, and the advertisements have to be restricted as rigorously as possible.

A key issue that I think you need to address, or that the bill needs to address, is about things like cultural promotion. I read the papers, and there are already cannabis music festivals, culture festivals, movie festivals, and all sorts of other things that we don't necessarily directly associate with typical advertisement and promotion. It needs to be looked at much more broadly and widely.

For tobacco and alcohol, there are the issues of indirect branding and advertising 2.0—virtual world, websites, computers, etc.—which are very difficult to legislate and restrict in the best of circumstances and need to be thought about here. This is a tricky challenge.

Also, of course, we've proposed to distribute this, at least in Ontario, through the LCBO, a public monopoly that we think is very safe and restricted, but at the same time, look at how alcohol is advertised and promoted in those public monopolies. The glossy "buy as much as you can" brochures are everywhere. There are a lot of tricky details still—

Mr. John Oliver: Just to be clear, I read a very limited section here dealing with promotion and branding. There is a whole other section on a prohibition against sponsorship, and a prohibition against some of those kinds of public events you referenced. I was just focusing on promotion packaging bit on this question.

The Chair: Your time is up.

Mr. John Oliver: Thank you very much.

The Chair: That completes our seven-minute rounds.

Now we're going to five-minute rounds, starting with Mr. Webber.

Mr. Len Webber: Thank you, Mr. Chair. I'll direct this first question to Dr. Levy, who is down in New York.

Because you are a developmental pediatrician and have experience with Boston Children's Hospital and such, I'm curious about the effects of marijuana on pregnant mothers. It was brought up in Michelle Suarly's presentation and hasn't been talked about much around the table here. Are there any studies out there? I know there are not a lot of studies with respect to marijuana and that we need more research, but maybe you can talk a bit about your experience with pregnant women and their use of marijuana and the negative effects that occur from that.

● (1730)

Dr. Sharon Levy: I can't say too much because there haven't been adequate studies yet. I personally care for adolescents, occasionally pregnant adolescents, but I don't typically care for newborns. I just want to make that clear. I can tell you that the concern is that marijuana is very fat soluble, so it crosses membranes very well, and going to cross the placenta, and very concerningly it's going to be in very high concentrations in breast milk. So a breast-feeding mother who is using cannabis is going to deliver a much higher dose to her infant than she is ingesting herself. The studies on the impact of what that does, I think they're all—pardon the pun—in their infancy, and I think it's going to take a period of time for us to really understand that.

Mr. Len Webber: I was going to direct that question to Dr. de Villa as well.

Do you have any thoughts on that particular issue with respect to expectant mothers and the use of marijuana? Do you have any knowledge of studies out there?

Dr. Eileen de Villa: To be frank, it's been quite some time since I practised that type of medicine, so I don't know that I have a particular comment to add on that topic. I would suggest to you, however, that even amongst non-pregnant individuals, as I mentioned earlier, there is fairly limited research on this subject largely because it has been illegal in most jurisdictions for quite some time. That's hindered our ability, and, again, speaks to the need for further research.

Mr. Len Webber: Absolutely. There's still much that we don't know, and research is essential.

Dr. Eileen de Villa: And there's much that we do know, right?

Mr. Len Webber: That's true, too.

Dr. Eileen de Villa: We do have information, but I agree that there are areas that require further undertaking and study.

Mr. Len Webber: Exactly.

I'll address this one to Dr. Maté.

You mentioned that you worked down in Vancouver's Downtown Eastside. Is that where your practice was? Of course, we all know East Hastings quite well. I had the opportunity to tour the InSite facility there with a colleague, Dr. Carrie, a few months ago. It is really disturbing to see the number of people there, and throughout the country and the world, who have these addictions.

We had a presenter here just before this present session indicating that as a doctor he felt that marijuana was a gateway drug to harsher drugs.

I just want to know what your thoughts are on that, Dr. Maté. Do you believe that marijuana is a gateway drug?

Dr. Gabor Maté: I just want to make a comment on your previous question about pregnancy. I think it's an important question. I think that from the medical point of view—and possibly the legislation can consider this—there should be a warning for pregnant women that since we don't know what the effects are since the research does not exist, in general the best policy is to avoid stuff that we don't know the effects of.

Mr. Len Webber: It's a big experiment.

Dr. Gabor Maté: That's just the rational thinking, I think, in the absence of good evidence.

As to gateway drugs, the fact that somebody uses marijuana first and then goes on to use something else afterwards, or uses tobacco first and then goes on to use something else afterwards, does not mean that there's a gateway drug phenomenon going on. In fact, we don't even know that there's such a thing as a gateway drug phenomenon. Gateway means that unless you open that gate, the person doesn't go through it and doesn't develop a problem. There's just no evidence for that. It may be the case that a lot of people, before they get into the heavier drugs, will use lighter drugs, if you like, such as alcohol, tobacco or marijuana, but there's not necessarily a causative relationship. What is much more the case is that the people who are driven by their internal discomfort to use any substance at all, are more likely to use other substances in a heavy way or are more likely to use other substances in the same way later on, but this does not mean that the one led to the other. I don't think there's any evidence for basing policy on a gateway drug theory.

● (1735)

The Chair: Okay, thank you.

Dr. Gabor Maté: I appreciate the evidence from Dr. Levy, from New York that a lot of the adolescents she deals with who have a substance use disorder in general may have used marijuana first, but that doesn't mean there's a causative relationship, nor does it mean that legalization....

And I know, Dr. Levy, you're not suggesting that legalization is a good idea at all. So from the point of view of legislation, I think the gateway drug theory is just not a helpful way to look at it.

The Chair: Thanks very much.

Dr. Eyolfson.

Mr. Doug Eyolfson: Thank you very much, Mr. Chair.

Dr. Maté, I really appreciated your comments about having to think about what the best science is, but also having to think politically. I'm a physician, but now, as you've probably guessed, I also have to think politically in my current job. It was kind of amusing to think about that and the way it is part of our deliberations at this level.

One of the things you mentioned earlier—and we've had a lot of discussion about this—is that there are many people with a pre-existing mental illness who then go on to develop a substance use disorder, whether that be with cannabis, tobacco, alcohol, or anything else. Do you believe that if we had better investment in and commitment to primary mental health care and were more effective at treating people at the primary care level, that would be helpful in the primary prevention of a lot of drug use disorders?

Dr. Gabor Maté: Absolutely. In almost every case of substance use, you can identify something that's present. Often, it's ADHD—and I talk about ADHD because I've been diagnosed with it myself and I know a little bit about it. It could also be depression, anxiety, post-traumatic stress disorder, social phobias, or bipolar disorder, which is typically self-medicated with alcohol. In a lot of cases of substance use there is a pre-existing mental health problem.

Not only that, but, as some of my colleagues have pointed out, the drugs themselves can either cause or exacerbate mental health problems. There is a strong correlation between cause and effect, from which would follow the pertinence of your comment that better mental health treatment, particularly amongst adolescents and children, would tend to reduce drug use. That's my belief, and it makes sense for all kinds of reasons.

Again, the broader question that I've raised a couple of times, which is not to be answered in this context, is what is it about our culture and our way of life that's driving more and more people...? There are studies in Canada and the States every year that show that more and more kids are suffering from symptoms of mental health disorders of all kinds. There is something going on here, and that's a broader social question.

Specifically, when it comes to mental health treatment, the answer is yes. If in the schools we had better recognition of mental health problems, if we recognized that many of the behavioural problems that we're seeing are actually manifestations of inner turmoil, if the schools, for example, could act as screening venues for identifying kids at risk—and we could do this much more broadly on a community basis as well—I think the more we did this, the less substance use we would have to confront.

Mr. Doug Eyolfson: Thank you very much.

Dr. de Villa, we talked about impaired driving due to cannabis. I agree. Certainly, not just in my experience talking with my patients but going back to when I was in high school in the 1970s—yes, I'm that old—there was a belief that there was nothing wrong with driving on it. There were people I knew who would smoke it, and they swore that their video game scores improved after smoking up, so driving must be okay. People have always believed that nonsense.

We know that there have been a lot of ads on drunk driving, and by a lot of metrics they have been pretty effective in getting the message across. In particular, MADD, Mothers Against Drunk Driving, have had some very powerful and effective ads. Are we overdue in getting the same message about driving while impaired on cannabis into these ads and perhaps putting that in the same context? Might that have a bit more credibility now that we're dealing with a legal product, the way we are with alcohol?

Dr. Eileen de Villa: I would like to think so. As I mentioned in my remarks, injury and motor vehicle accidents related to that are the main contributor to the burden of illness associated with cannabis right now in this country.

Might those education campaigns help? Yes, I think that's part of it. A whole series of elements are required in an education campaign, impaired driving being one of them. You've heard from other witnesses here that in fact there are other topics of conversation, like trying to ensure that our young people do understand that the earlier they start and the more they use, the more likely they are to suffer longer-term consequences.

By the same token, I think we heard from my colleague here to the left that there is a lot of use among youth. As is the case with virtually every drug, we have to ask how we adopt a preventive approach and, where it is being used, how we adopt a harm reduction approach minimizing the harms associated with the use of that substance, whatever it is, at both the individual level and ultimately the social level.

● (1740)

The Chair: The time is up.

Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair, and thank you to all of our witnesses today.

My colleague, Mr. Davies, read to you some of the purposes of the legislation, the more important ones being the protection of the health of young persons by restricting their access to cannabis, and providing access to a quality-controlled supply of cannabis. We've been looking and listening to testimony to try to find best practices to keep cannabis out of the hands of our young people.

The State of Washington said that their data shows now, with what they've implemented, that young people are having a harder time getting a hold of cannabis. What they did was merge their medical and recreational marijuana supply systems, so that it's controlled, age-restricted, and tracked. They've only allowed home growing for medical purposes.

My question is for Dr. Fischer. Do you think that this current legislation, which allows home growing, is going to provide a quality-controlled product that will stay out of the hands of younger people?

Dr. Benedikt Fischer: Since you're asking me that question so directly, I'll tell you that in my opinion the home-growing provision is one of the worst pieces of the current legislative draft, for several reasons. I think it's a very bad idea for public health, because we should not rely on private homes for the production of psychoactive substances.

Second, there are adverse potential health consequences to other people in the home—everyone in the home, as a matter of fact. This includes a lot of non-users, but also vulnerable people like children, parents, or spouses.

Third, it's probably the safest way to ensure possible diversion of cannabis from what is otherwise supposedly a regulated and restricted market.

Fourth, the home is probably—unfortunately, the former Toronto police chief is not here anymore—the most difficult environment for authorities to control and regulate, at least in our society.

Ms. Marilyn Gladu: Absolutely.

Dr. Benedikt Fischer: Overall, home growing is probably the worst or the most inappropriate place for cannabis to be produced. We should leave that to licensed production, distribution, and retail outlets.

Ms. Marilyn Gladu: I fully agree.

Dr. de Villa, knowing that home grow operations are 24 times more likely to have a fire, and knowing that the Ontario Provincial Police have already testified that they are going to have great difficulty trying to enforce this, would you agree that the home-grow option is probably the least preferred way of making sure that we keep cannabis out of the hands of our children?

Dr. Eileen de Villa: I don't know that it's the least preferred way with regard to that specific goal, but I agree with my colleague, Benedikt Fischer, that this is not an ideal or optimal provision within the context of the legislation. It's rife with difficulties, for sure, on a series of levels. Whether it does anything with respect to access by youth, clearly, we prefer a publicly regulated, well controlled, and well monitored method of distribution. That is the right way to manage it.

Ms. Marilyn Gladu: Very good, thank you.

Dr. Levy, I was very interested when you talked about tobacco and its stigmatization, because it brought to mind the fact that tobacco was already legal, and an age of consumption was established. It did nothing to prevent people from smoking at alarming rates. It was really that public awareness campaign to change public opinion that was most effective.

I'm interested in what your thoughts are on doing a similar thing for cannabis. Obviously, we've been talking about legalizing it for two years, and we haven't had that public awareness campaign. Could you expand on that?

● (1745)

Dr. Sharon Levy: I think that a critical component of the public health strategy has to be our campaign to get out the real message about marijuana. As we heard earlier in the testimony, there is a lot of cultural traction around the message that marijuana is safe, harmless, natural, and legal.

I'll tell you, in my experience, the state where I practise, which is Massachusetts, has recently passed legalization as well. Kids come in now and say, “Well, I know it's not that bad, because it's legal.” There's a lot of work that needs to be done there. “Safe” and “legal“ don't mean the same thing.

I think that because of where we are with marijuana, we can use tobacco as an analogy. It's legal. It's not safe. It's not healthful. It doesn't cause any overdoses, but that doesn't mean that it's safe for consumption. I think making those comparisons is really critical. It is important to have children, their parents, and the other adults who interact with them understand this and to give very clear messages.

Ms. Marilyn Gladu: Thank you very much. I think my time is up.

The Chair: Your time is up.

Mr. McKinnon.

Mr. Ron McKinnon: Thank you, Chair.

Dr. Maté, my riding is Coquitlam—Port Coquitlam in the Lower Mainland. As a Lower Mainland resident, I'm well aware of your long advocacy and as a force for good in this area, so I'd like to welcome you in particular for joining us today. I particularly appreciate your insight and clarity of testimony.

I note that our government has invested $5 billion in budget 2017 to provide mental health support, including for 500,000 people under 25. This goes to prevention, I would suggest to you. In your model that you propose for addiction, many of the underlying causes are psychological and psychiatric problems. I would ask if you think that significant funding for mental wellness programs and funding for early diagnosis of mental illness conditions would be worth doing, and whether it's an effective prevention mechanism.

● (1750)

The Chair: Dr. Maté, can you hear me? We can't hear you; we've lost the sound.

My understanding is that we're not going to be able to get the sound back. I would like to say thank you very much for your participation. It's been very enlightening, sharing your knowledge and experience. I'm sorry we can't finish up.

Mr. McKinnon, you still have some time.

Mr. Ron McKinnon: I'm going to defer to any of my colleagues who may have a question. I was ready with some great questions.

I'll pass.

The Chair: For the last question I`ll recognize Mr. Davies. As usual, you always bring up the end.

Mr. Don Davies: Thank you.

Dr. de Villa, you issued a report on approaches to protect health and minimize harms of use. You noted how the criminalization of cannabis and possession impacts the social determinants of health. You pointed out that people arrested and convicted of pot possession can face long-term consequences, including their access to employment and housing, their economic status, and social stigmatization. You pointed out that this disproportionately affects young Canadians and racialized and marginalized communities. You also pointed out that, based on current rates—this was back in June—59,000 people will be arrested and 22,000 will be convicted for simple possession of cannabis before this legislation comes in, and you called for an immediate decriminalization to now start addressing those concerns. Is that still your position?

Dr. Eileen de Villa: Yes, it is. As I mentioned, we're talking about long-term consequences associated with personal possession.

Dr. Maté, before his unfortunate sound issues, was talking about many of the social problems and the social factors that drive lots of these things. I think, in fact, creating new social harms does not make sense.

Mr. Don Davies: Now Bill C-45—I've used this term before—legalizes to some degree, but it's not full legalization; it'll be less illegal. There will still be criminal penalties for possession of over 30 grams, for growing over four plants, and for selling. If a 20-year-old sells to a 17-year-old, they're subject to criminal sanctions.

Would you agree with me that Bill C-45 continues to risk disproportionate harm to marginalized and racialized communities by continuing essentially a criminalized approach to some forms of cannabis?

Dr. Eileen de Villa: I think that certainly exists, but there is some question as to how legislation is implemented in reality. There's what's on paper, and then there's what happens in practice. I would agree with you that there is still some potential for that, but as I understand it, this is an initial foray, and in fact there are other areas that are not being regulated under the existing legislation that may subsequently be regulated, and presumably other elements might also be....

● (1755)

Mr. Don Davies: Let me move quickly to that other area in my limited time, because edibles and other concentrates are not covered by this legislation, and I believe you have recommended that those products be regulated. As pointed out by Ms. Hasheminejad, the lesson from Colorado is that people prefer to obtain their products from legal sources. If we keep edibles, concentrates, and other products in the black market, then this bill will not meet its full potential.

What is your position on whether Bill C-45 should include edibles and concentrates in the legalized regulated frame?

Dr. Eileen de Villa: In my comments I talked about how I think this is a reasonable approach for now, and that we should continue to move forward and think about and ensure that we're capitalizing on the experiences of other jurisdictions. It's a question of trying to balance it out, so I agree that people prefer to have access to legal products. The question is how you implement that in a fashion that maximizes the public health principles and minimizes harm and increases public safety. It's always, as I think many of our other colleagues commented, a delicate balancing act, but I am supportive of regulating these products so that we can ensure that public health principles are those that are governing these products and their use.

Mr. Don Davies: Thank you.

Thank you, Mr. Chair.

The Chair: Okay, thanks very much.

That brings to a close our panel for today. Again, I want to thank all of our panellist, on behalf of the committee members, for sharing your information, your knowledge, and your experience with us.

I want to acknowledge our video conference participants, Dr. Le Foll and Dr. Levy. It's difficult to do what you've done today and we appreciate your patience with us and sharing your time with us.

Again, thanks to everybody. You've contributed a lot to our study. You've participated in Bill C-45, and we appreciate it very much.

With that, I'm going to end the meeting, but I just want to say that we're having a fifth panel tomorrow night at six o'clock, from six to eight. The last panel on Friday is moved to tomorrow night.

Mr. Don Davies: Sorry, Mr. Chair, the last panel that was scheduled for Friday has now been moved?

The Chair: It's now tomorrow evening from six to eight. It'll be the fifth panel tomorrow. We'll have five panels tomorrow instead of four.

Okay, the meeting is adjourned.