Legislative Review of the *Cannabis Act*

What We Heard Report

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Chapter 1

Message from the Panel

We are honoured to have been appointed by the Minister of Health and the Minister of Mental Health and Addictions as the independent Expert Panel to conduct the legislative review of the *Cannabis Act* (the *Act*). As the Expert Panel, we will offer our observations and advice—based on our own expertise—independent of outside influences, including our professional affiliations. We take our mandate, independence, and impartiality extremely seriously, and have devoted significant time to this important work.

After almost a century of prohibition, Canada became the first major industrialized nation in the world to legalize and regulate cannabis when the *Act* and its regulations came into force. The *Act* allowed for the production, sale, and distribution of cannabis. The purpose of the *Act* is to protect public health and public safety, including by providing access to a quality-controlled supply of cannabis, and by enhancing public awareness of the health risks associated with cannabis use.

We recognize that the *Act* and supporting policy framework represents a radical departure from the prohibitory regime that existed for the past century. Other countries are closely monitoring how the new Canadian framework has been implemented, as they consider their own possible reforms to their cannabis laws.

Parliament's decision to mandate an independent review three years after the *Act* came into force in 2018 recognized that there would inevitably be some gaps between what Parliament intended to achieve with the legislation and other supporting measures, and how those elements actually worked. However, it was clear that these gaps, and the modifications necessary to address them, would only become apparent once there had been some practical experience with the new framework. The primary purpose of this review, therefore, is to identify how the new framework is working in practice to date, and to provide recommendations to make it more effective.

However, it is important to note that this review began after only four years of experience with the new regime. It will likely take many years to understand the full impact of this new approach. Therefore, we hope that this is only the first of a series of periodic independent reviews to assess the new cannabis framework.

At the beginning of our work, we were briefed by governmental officials on the new legislative and regulatory framework for cannabis and reviewed available literature to increase our understanding.

We acknowledge that barriers exist for many groups to engage in processes like this review. We have attempted to mitigate some of these difficulties by offering various means of participating and trying to remove financial and logistical barriers to participation. We have also used trusted interlocutors including community leaders and youth advocates to reach out to marginalized or disadvantaged groups. We have also proactively contacted specific groups to hear their perspectives and expertise. We worked to build relationships with all potential stakeholders, and dedicated extra effort to building relationships with those who expressed distrust with our process, given some of their past experiences with engagements related to cannabis.

From December 2022 to June 2023, we held numerous roundtable discussions, one-on-one meetings, and were graciously hosted by a number of stakeholders at their sites. The voices and perspectives reflected in this report come from a wide range of stakeholders and experts who are described in Chapter 3. We would like to extend our gratitude to those who shared their views and experiences with us.

We would particularly like to thank those First Nations, Inuit, and Métis communities that agreed to participate in this process and share their perspectives with us. We adapted our engagement approaches, incorporated feedback, and learned important lessons through engaging with different stakeholders—which we hope shows the value we place in obtaining a broad range of input. We would also like to acknowledge the courage of those who shared very personal stories—whether related to their use of cannabis for medical purposes, past cannabis convictions, and experiences with law enforcement and the criminal justice system, or financial losses incurred in trying to participate in the legal industry. We appreciate that while sharing these stories was not easy, it helped us to understand the impacts of legalization on Canadians.

This report marks the completion of the first phase of our work, which was focused on engaging with stakeholders and experts to consider evidence and collect opinions and perspectives. For the second phase of our work, we will re-engage stakeholders in multi-sectoral roundtables and host other discussions to gain a deeper understanding and fill any knowledge gaps from our first phase. We will then prepare a final report for the Ministers, which is expected to be tabled in Parliament by March 2024 with our advice and recommendations. Our final report will be based on the data that we have gathered and what we have heard.

Specifically, this report outlines the building blocks used to develop the cannabis framework and the resulting measures ("overview of measures"), key data ("data and observations"), and the perspectives, including lived and living experience, that were shared through our engagement to date ("what we heard") related to the themes[1] of our mandate set out in Chapter 2. The views of individual stakeholders are not attributed in this report. We recognize that data related to some themes is more limited in scope or availability, and that our engagement activities are not complete. Our suggestions for reform will by necessity likely go beyond the strict parameters of the *Cannabis Act* and its regulations, as the cannabis framework encompasses associated pieces of legislation, as well as policy and programs, across all levels and areas of government.

In this report, we have included brief summaries of what we have learned though our evidence gathering, and we present a variety of findings from population surveys, research studies, and other sets of data. Although we have endeavoured to be thorough and have invited stakeholders and experts to provide evidence to us, the summaries in this report are limited to key indicators and national-level data that can help characterize the impacts of cannabis legalization. We recognize that the information is imperfect, and often based on self-reported data. In addition, there are areas where there are inconsistencies between different data sources and measures (for example, related to the estimation of legal market share), and we would invite further observations in these areas.

Not surprisingly, we have found that while there continues to be strong support for the underlying public health and safety objectives of the *Act*, opinions are divided on how best to achieve them. We believe that it is important to clearly set out these disagreements. These can point us to areas where further research needs to be conducted to help develop an improved cannabis framework for Canada. We hope that we have captured the breadth and nuances of these perspectives and acknowledge that any errors are our own. We also recognize that there may be alternative points of view that we have yet to hear.

[1] The theme entitled "Impacts on Indigenous Peoples, racialized communities, and women who might be at greater risk of harm or face greater barriers to participation in the legal industry based on identity or socio-economic factors" is included throughout all the chapters.

Chapter 2

Executive Summary

The *Cannabis Act* (the *Act*) requires a review of the impact of the *Act* on public health and, in particular, on the health and consumption habits of young persons with respect to cannabis use, the impact of cannabis on Indigenous persons and communities, and the impact of the cultivation of cannabis plants in a dwelling-house.

In appointing us as the Expert Panel to lead the review, the Minister of Health and the Minister of Mental Health and Addictions broadened our mandate to consider the following themes, which guided our review process, engagement activities, and the organization of our report:

- economic, social, and environmental impacts of the *Act*
- progress towards providing adults with access to strictly regulated, lower-risk, legal cannabis products
- progress made in deterring criminal activity and displacing the illicit cannabis market
- impact of legalization and regulation on access to cannabis for medical purposes
- impacts on Indigenous Peoples, racialized communities, and women, who might be at greater risk of harm or face greater barriers to participation in the legal industry based on identity or socio-economic factors

Building the cannabis framework

For the first time, the *Act* legalized and strictly regulated the production, distribution, sale, import and export, and possession of cannabis for adults of legal age. It is clear that a significant effort has occurred over the last five years to support the development and implementation of a complex and transformative public policy.

This began with the coming into force of the *Cannabis Act* in 2018. The legislation was designed based on most of the recommendations of the Task Force on Cannabis Legalization and Regulation (the Task Force).[2] Distribution and retail systems were built, and a new industry was established to produce a regulated supply of cannabis for adult Canadians. Additionally, changes were implemented to the *Criminal Code* to address cannabis-impaired driving. Public education efforts were launched to raise awareness of the new regime and to help Canadians make informed choices about cannabis consumption. Following legalization, the Canadian Institutes of Health Research (CIHR) led the development of an Integrated Cannabis Research Strategy (ICRS) to help gather information and evidence about the use of cannabis, its health and safety effects, and the behavioural, social, cultural, ethical, and economic implications of the legalization of cannabis.

To address the issue of prior criminal records for cannabis convictions, the federal government instituted a program that allowed individuals who had prior convictions for simple possession of cannabis under the *Controlled Drugs and Substances Act* (CDSA) to apply for a record suspension without a waiting period, and at no cost.

[2] The Task Force report, A Framework for the Legalization and Regulation of Cannabis in Canada, was published in 2016.

In late 2019, the legal sale of edible cannabis, cannabis extracts, and cannabis topicals were authorized under the *Cannabis Act*. Amendments to the *Cannabis Regulations* were introduced to address the public health and public safety risks of these new classes of cannabis.

The federal government has committed to ongoing evaluation of the new cannabis framework and the reporting of these results, both through internal program evaluation and via this independent review.

Scope of our engagement

We have engaged with:

- researchers and academics in various fields (such as public health, public safety, criminal justice, and economics)
- health care professionals and organizations
- people working in the areas of public health and harm reduction
- youth and youth advocates
- First Nations, Inuit, and Métis people (including leaders, governments, community organizations, industry members, and Elders)
- the cannabis industry (including federal licence holders both large and small, distributors, regulators, retailers, and industry associations)
- equity-deserving groups
- people with diverse lived and living experience
- international policy leaders
- cannabis consumers
- various levels of government
- law enforcement representatives
- stakeholders involved in the use of cannabis for medical purposes (such as people who use cannabis for medical purposes, patients and their caregivers, patient advocacy groups, cannabis clinics, and those operating outside of the current medical access system)

We travelled to British Columbia, Manitoba, Ontario, and Quebec to meet with stakeholders in their locations.

As of June 30, 2023, we:

- met with almost 500 individuals from over 200 organizations in nearly 90 meetings
- completed eight sector-based roundtable meetings (public health, justice and public safety, industry, three meetings with patient organizations and advocates, and two meetings with youth and young adult advocates)
- completed five roundtables focused on issues related to diversity, equity, and inclusion (DEI)
- undertook distinctions-based engagement activities with First Nations, Inuit, and Métis
- visited sites of licence holders involved in cultivation and processing, retail stores, harm reduction sites, and cannabis clinics
- engaged with stakeholders operating outside of federal, provincial, or territorial licensing frameworks

What we heard: Public health

There was general agreement that the main objectives of the cannabis framework should continue to be the protection of public health and public safety. Public health stakeholders insisted that the focus of the regime should be on reducing harms associated with consumption, high-potency products, higher-risk product formats, polysubstance use (that is, the consumption of at least two substances), cannabis use during pregnancy and breastfeeding, driving after cannabis use, and cannabis poisonings of children. Public health stakeholders were generally supportive of the precautionary approach—including the 10 milligram delta-9-tetrahydrocannabinol (THC) limit for edible cannabis products and restrictions on promotion of these products. There were some suggestions that further restrictions should be considered such as stricter age limits on who can possess, distribute, and buy cannabis, setting minimum pricing retailers can charge, and restrictions on selling flavoured products.

In contrast, industry representatives suggested that elements of the precautionary approach impede their ability to compete with the illicit market and thus risk sending consumers to the illicit market for unregulated products that may pose greater health harms.

We heard that more public education, drug prevention, and treatment efforts are needed. With respect to public education, we heard about the need for an evidence-based approach that is customized to different populations and audiences and co-created with them. This would include public education on topics such as helping consumers to interpret information on product labels, assess the risks associated with different products, identify legal products and sources (online and in retail stores), and make lower-risk use decisions (such as using non-combustible products instead of combustible ones).

We heard about the need for formal monitoring or evaluation of the effectiveness and impact of the public education activities undertaken by the government. Experts also warned that health education alone would not lead to meaningful behavioural changes. Greater investment to support evidence-based polysubstance prevention and mental health promotion programs was identified as an important need, which stakeholders feel has received inadequate attention since cannabis legalization. Some indicated that these programs would involve giving youth the skills to change their behaviour with respect to cannabis use and supports to manage their mental health.

On research and surveillance (that is, the generation or gathering of new data through studies, surveys, and other means), stakeholders acknowledged that while evidence related to public health impacts is growing, more research is needed. There is frustration and disappointment with the dearth of evidence and a lack of progress in the cannabis research field in many areas, which is partially attributable to the impact of the COVID-19 pandemic and the short period of time since legalization. Many recommended that more data and research on cannabis is needed to inform ongoing assessments of cannabis legalization and its implementation over time. Research is also needed to support developing, evaluating, and updating guidance, including for individuals who use cannabis and health care professionals. Some also expressed frustration regarding the de-prioritization of cannabis research funding after legalization. There is also a lack of disaggregated race-based and distinctions-based data and research on the health, social, and economic impacts of cannabis use. We also heard that there are significant regulatory barriers to conducting research on cannabis, including on the therapeutic use of cannabis. Stakeholders suggested that research, data gathering, and evaluation are critical and efforts in this area must be improved, using a variety of methods, designs, and learnings from other jurisdictions.

What we heard: Impacts on young persons

One of the key goals of legalization was to protect the health and safety of Canadians, to keep cannabis out of the hands of children and youth, and profits out of the hands of criminals and organized crime. However, many of the people we engaged with expressed concern that rates of cannabis use among youth in Canada[3] remains high compared to other jurisdictions, and that legalization has not led to a discernible decrease in youth cannabis use. Some discussed the continuing ease of access to (particularly illicit) cannabis by youth, and the persistence of advertising from illicit sellers that is accessible to youth.

Stakeholders spoke about the increase in exposures to the health care system, such as emergency department visits, hospitalizations, and poison centre calls, due to accidental ingestion of cannabis by young children since legalization.

We heard about the need for more research on diverse populations of youth—including those not in education, employment, or training, and those in the corrections system.

On the topic of public education and awareness, there was discussion on the importance of engaging youth in credible, realistic, and relevant initiatives that are informed and co-developed by youth and their experiences. These should move beyond "one size fits all" abstinence-based approaches to address misinformation and provide tailored resources to promote informed choice. However, public health experts also warned that evidence-based drug prevention programming requires going beyond public awareness campaigns to offer programs that transfer cognitive and behavioural skills to youth, families, and communities seeking to reduce harms.

Those we engaged with noted that a positive effect of the new legislation was a dramatic reduction in the number of youth charged with cannabis-related offences. At the same time, we heard concerns about the long-term and enduring negative impacts on individuals who have been convicted of non-violent cannabis offences under the previous legislation. We intend to hold more engagement sessions with youth and young adults in the fall of 2023.

What we heard: Impacts on First Nations, Inuit, and Métis

Our report addresses separately the issues raised by First Nations, Inuit, and Métis. That is, we applied a distinctions-based approach to our engagement.[4] However, there were a number of themes that were raised by almost all First Nations, Inuit, and Metis representatives who participated in our process. These include frustration about the limited engagement with the federal government during the development of the *Act* and its regulations, and emphasis on the need to reflect the principles of the United Nations Declaration on the Rights of Indigenous Peoples (such as that Indigenous Peoples have the right to participate in decision-making matters that affect their rights and that they have the right to be actively involved in developing programs that affect them).

[3] The *Cannabis Act* defines young person as an individual who is under 18 years of age. National surveys cited in this report define youth as either those aged 15 to 19, 16 to 19, or students in grades 7 through 12 (secondary I through V in Quebec). Other age groups, including children in younger age groups, are specified when referenced.

[4] A distinctions-based approach means working independently with First Nations Peoples, Inuit, Métis Peoples, and Intersectional Peoples in recognition of their unique attributes.

Key areas of interest and concern in relation to the impact of cannabis legalization on First Nations included: jurisdiction, including the recognition of First Nations authority over a range of cannabis activities; public health and public education (such as the need for culturally-appropriate public health resources and services and the funding to support them); public safety (such as the rise of unauthorized cannabis activities in communities and the impact this has on already under-resourced First Nations policing services); economic development (such as the jobs and revenue that could be supported through participation in the legal cannabis industry); and taxation (such as the ability to collect and redistribute taxes).

Inuit representatives highlighted a number of issues including: public health and harm reduction (such as the need for more funding to address substance use and mental health issues, with a focus on prevention); culturally-safe public health education and research that is Inuit-specific and Inuit-led; and issues related to access to quality-controlled cannabis (such as limited legal retail in the North).

Métis representatives shared several areas of interest and concern, including: public health (such as the need for distinctions-based public health education, harm reduction supports, and health care systems, including those for unique populations like youth and 2SLGBTQIA+); research and education (such as calls for Métis-led community-based research and data collection that is funded via long-term, sustainable, and flexible funding); economic development (such as the need for Métis-specific investments, resources, supports, and opportunities to participate in the legal industry); and governance and jurisdiction (such as desires to exercise their right to self-government and be recognized on a nation-to-nation basis). The Manitoba Métis Federation will be exploring key cannabis topics with their citizens and intends to provide their views to us later in 2023.

The views presented in this report are not exhaustive and do not reflect the knowledge, opinions, and beliefs of all First Nations, Inuit, and Métis persons and communities, including those who live off-reserve. They are representative of those with whom we have engaged to date and draw from their distinct cultures, identities, and ways of life. We will continue to engage with interested First Nations, Inuit, and Métis to assess the impacts of the *Act* on their communities, and to outline priority areas for action. Our use of the distinctions-based approach will continue as we formulate recommendations.

What we heard: Trends and impact of home cultivation of cannabis for non-medical purposes

The topic of home cultivation was not raised extensively during our engagement. Overall, most stakeholders who commented on the subject supported the current approach of allowing adults to grow up to four plants at home. Some discussed the need for public education on health and safety issues, such as accidental ingestion, poor air quality from cultivation, and electrical and fire hazards. Some municipalities called for a reduction in the number of plants permitted through home cultivation due to the potential for exposure to youth and damage to rental units.

What we heard: Economic, social, and environmental impacts of the *Act*

While the objectives of the *Cannabis Act* did not include economic, social, and environmental considerations, we heard a great deal about the economic condition of the legal cannabis market. Whereas public health stakeholders advocated for the need to maintain a precautionary approach to cannabis in order to protect public health and safety, industry representatives asserted that a viable industry is a necessary precondition to maintain a safe and legal source of supply and to combat the illicit market. They expressed concern that companies in the legal market are struggling to realize profits and maintain financial viability, noting the burden of taxes, mark-ups, fees, and regulatory compliance costs. Industry members also discussed the excess supply of cannabis and the challenges of competing with an entrenched illicit market. They raised issues such as: the need to increase public possession and THC quantity limits for cannabis; restrictive rules on promotion, packaging, and labelling; and the presence of different federal, provincial, and territorial frameworks with which licence holders must comply. They suggested there are risks of both a consolidated market dominated by a few large players with significant market power and of micro licence holders turning back to the illicit market. We are planning to bring together a group of independent economic advisors to provide us with advice on the economic impacts of the framework in the fall.

Certain communities were, and continue to be, disproportionately impacted by the legacy of historical policies of prohibition. Historically marginalized or disadvantaged groups told us about the difficulties they encountered when trying to enter or operate in the legal cannabis market (for example, challenges accessing capital), and called for social equity programs (for example, licensing prioritization, grants or loans, specialized training) such as those in various states in the United States (for example, New York, New Jersey, Washington, California). Some of these groups also discussed the continued barriers and harms that exist because of the effects of the framework prior to legalization, such as disproportionate involvement with the criminal justice system and over-policing. There are also gaps in the research to understand the impact of cannabis legalization on particular groups, and whether there is ongoing racial discrimination in law enforcement, particularly with youth, where cannabis possession remains illegal. We have heard from various stakeholders about the desire for social equity objectives to be integrated into the framework.

What we heard: Progress towards providing adults with access to strictly regulated, lower-risk, legal cannabis products

We heard differing viewpoints on whether consumer demand was being met and the degree to which adults have access to regulated cannabis products. Many stakeholders noted that price is an important factor for consumers when considering whether to buy from the illicit or legal market. Many industry representatives and others argued there is still consumer demand for products that are not available in the legal market (for example, higher-potency edible cannabis products, or lower-priced cannabidiol (CBD) products in a variety of formats). Conversely, public health stakeholders expressed some concerns with the types of products available in the legal market, notably high-potency extracts, and flavoured edibles.

While the number of locations where cannabis for non-medical purposes can be obtained has increased since the early days of legalization, stakeholders noted that access is not evenly distributed across the country, and that consumers in some rural and remote regions have limited access options (for example, few stores, limited access to online channels, and conditions not suitable for home cultivation). Some suggested that consumer perceptions of product quality are an important factor in adult Canadians choosing to purchase legal cannabis, with definitions of quality ranging from cannabinoid potency (for example, high THC, or known potency because of testing) to a lack of contaminants (for example, pesticides) to the presence of certain visual/sensory characteristics like appearance and scent.

Many stakeholders indicated a need for the development and dissemination of simple, factual information about cannabis. This includes information on the effects of using it, how to reduce risks, and how, when, and where to seek help. For those who choose to use cannabis, information needs to include guidance on dosing (that is, how much to use), clearer product labels, and guidance to help consumers to differentiate legal from illegal products and sellers.

What we heard: Progress made in deterring criminal activity and displacing the illicit cannabis market

Many public safety stakeholders were concerned about the continued involvement of organized crime and criminal networks in illicit cannabis production and sale. This includes through unauthorized retail stores, online channels, and abuse of the personal and designated production of cannabis for medical purposes program. There were mixed views on the legal industry's progress in displacing the illicit market, with some claiming the legal industry is competitive with the illicit market and others arguing that structural barriers exist that make it difficult for the legal industry to compete and therefore may allow the illicit market to persist. Industry representatives suggested that additional enforcement efforts, as well as regulatory reform to ease certain restrictions, would maintain existing legal market share, enable further displacement of the illicit market, and support addressing any abuse of personal and designated production of cannabis for medical purposes.

We heard about barriers to more robust law enforcement. These include a focus on higher priority issues (for example, national security, organized crime, and other illicit substances), jurisdictional complexity, inadequate resources, and inadequate tools. We heard that drug-impaired driving is still a major concern, and there continues to be a need for enforcement resources and tools for law enforcement to detect cannabis use and confirm whether a driver is impaired.

We heard calls for reforms to the provisions that were added to the *Criminal Records Act* to allow for the expungement of criminal records for simple possession of cannabis. Stakeholders criticized the current record suspension program as cumbersome and called for the federal government to make it more accessible. They noted that those most in need of a record expungement are often the least able to access the process (for example, First Nations, Inuit, Métis, and racialized individuals).

What we heard: Impacts of legalization and regulation on access to cannabis for medical purposes

The regulatory framework for medical access dates back to the late 1990s and evolved as result of a series of court decisions. That framework was incorporated into the *Cannabis Act* when it was passed in 2018. The Task Force recommended that the framework be maintained and reviewed after five years of experience with legalization and regulation of cannabis.

Many stakeholders, including patients, researchers, and health care professionals, support maintaining a distinct medical access framework, with major improvements, to facilitate access, affordability, and safety. Individuals suffering from a variety of medical conditions reported deriving therapeutic benefits from both tetrahydrocannabinol and cannabidiol-based products. However, stakeholders acknowledged that like all therapies, the use of cannabis for medical purposes is not a panacea for all health conditions, nor does it come without risks.

Patients told us they want cannabis to be properly recognized as a form of medication in order to address issues related to stigma, affordability, and continuity of care. Many patients expressed their frustration that access to cannabis for medical purposes has not improved since the *Act* came into force. Patients and their caregivers noted challenges with finding knowledgeable and willing health care professionals to authorize, provide counsel, and monitor their use of cannabis for medical purposes, while at the same time providing acceptable health care for other complex conditions. They noted the antipathy of many health care professionals, and the stigma and systemic racism about cannabis use that persists in some sectors of the medical system. Conversely, many health care professionals are uncomfortable with the lack of clinical evidence that is available for many common uses of cannabis.

Despite Health Canada's efforts to develop and disseminate information and tools (for example, the publication of Information for Health Care Professionals) for the medical community and patients, the majority of health care professionals are not knowledgeable about medical cannabis. Stakeholders discussed the need for more education about cannabis for medical purposes for patients and health care professionals, suggesting that education be informed by rigorous clinical science and those with lived and living experience using cannabis for medical purposes.

Notwithstanding a recommendation by the Task Force to support research in this area, there has been little progress made in research on the benefits and risks of cannabis for medical purposes. Accordingly, some researchers called for more research to inform educational efforts and to promote the development and approval of cannabis products with Drug Identification Numbers (DIN). Alternatively, some advocated that safety, efficacy, and quality requirements developed for non-prescription CBD health products could be modelled on those authorized by Health Canada's Natural and Non-prescription Health Products Directorate.

Patients and other stakeholders shared concerns about the affordability of cannabis for medical purposes, noting that excise and sales taxes further compound the lack of affordability and that products from the non-medical market are often less expensive than those from the medical market. Due to the varying needs of patients, stakeholders suggested the need for a greater diversity of cannabis products for medical purposes, including those with higher THC quantities. They recommended more accessible methods to obtain cannabis for medical purposes, such as pharmacies and retail storefronts, to complement the existing mail delivery system. The preservation of access through personal and designated production for medical purposes is crucial to ensure it is affordable for many patients. At the same time, law enforcement, municipalities, and patients have raised concerns about abuse of the personal and designated production program including the risks of fire, mould, odour, criminal activities, and diversion to the illicit market.

Chapter 3

Introduction and summary of engagement process

The *Cannabis Act* (the *Act*) requires a review of the *Act* and its administration and operation three years after its coming into force. It also requires that a report on the review, including any findings or recommendations, be tabled in both Houses of Parliament within 18 months. The provisions of the *Act* require a review of specified areas, including its impacts on public health, in particular on the health and consumption habits of young persons in respect of cannabis use, the impact of cannabis on Indigenous persons and communities, and the impact of the cultivation of cannabis plants in a dwelling-house.

The Minister of Health and the Minister of Mental Health and Addictions appointed us to carry out an independent, factual, evidence-based assessment of the *Act*, and to engage broadly with stakeholders. The Ministers broadened the scope of the review to include these additional areas of focus:

- economic, social, and environmental impacts of the *Act*
- progress towards providing adults with access to strictly regulated, lower-risk, legal cannabis products
- progress made in deterring criminal activity and displacing the illicit cannabis market
- impact of legalization and regulation on access to cannabis for medical purposes
- impacts on Indigenous Peoples, racialized communities, and women, who might be at greater risk of harm or face greater barriers to participation in the legal industry based on identity or socio-economic factors

We are independent from the Government of Canada and we alone decided how to conduct our review. A secretariat housed at Health Canada has officials assigned to take our direction and support our work, and we are grateful for their assistance.

We are carrying out our mandate in a manner that respects the principles of impartiality, transparency, diversity, and inclusion. We are also applying a Sex and Gender-based Analysis Plus (SGBA Plus) lens[5] in our review. This report will use an SGBA Plus lens in the presentation of information (that is, data shared with us and what we heard), including an intersectional[6] analysis, when applicable.

[5] SGBA Plus is an analytical process that uses an intersectional approach to assess how factors such as sex, gender, age, race, ethnicity, socioeconomic status, disability, sexual orientation, cultural background, migration status, and geographic location interact and intersect with each other and broader systems of power.

[6] The interconnected nature of SGBA Plus factors, such as race and gender, which can result in overlapping and interdependent effects.

This report concludes the first phase of our work, which was focused on engaging with stakeholders and experts to gather and summarize different types of evidence and perspectives related to the areas we were asked to assess, including:

1. feedback from engagement activities, including anecdotes and observations from lived and living experience
2. presentations from stakeholders and subject matter experts
3. First Nations, Inuit, and Métis knowledge and lived and living experience
4. written submissions and materials provided
5. available bodies of qualitative and quantitative research, evidence, and data

This report reflects that while there continues to be strong support for the underlying public health and safety objectives of the *Act,* opinions are divided on how best to achieve them. We believe it is important to clearly set out these disagreements. We hope that we have captured the breadth and nuances of these perspectives and acknowledge that any errors are our own. We also recognize that there may be alternative points of view that we have yet to hear.

For the second phase of our work, we will prepare a final report for the Ministers with our assessment of the cannabis framework and advice and recommendations on areas that may benefit from improvement or reform. As set out in the *Act,* the Minister of Health is responsible for tabling our final report in both Houses of Parliament no later than 18 months following the launch of the legislative review. As such, we expect our final report will be tabled in March 2024. In assessing the impact of cannabis legalization and formulating recommendations for the future, we will consider the evidence available to us—which we acknowledge as limited in many areas—and the perspectives that were generously shared throughout the review process.

We acknowledge that the legalization and regulation of cannabis has dimensions which extend beyond the *Act* (for example, taxation, drug-impaired driving, record suspensions). We have noted when we have received feedback and perspectives that relate to other federal legislative and policy frameworks. In some instances, stakeholders have shared their overall impressions about the impacts of legalization, including feedback on aspects that fall within provincial and territorial jurisdiction. For example, while decisions about the authorization and oversight of retail stores are under provincial and territorial control, access to these stores and the legal products they make available impact the broader public health and safety goals set out in the *Act.* Similarly, the economic impacts of the *Act* cannot be assessed without consideration of the range of players in the industry, including various levels of government, the revenues, taxes, and fees they receive, and how the supply chain operates.

Organization of the report

Each chapter in this report is organized to provide:

1. an overview of measures in the cannabis framework, including programs and policies
2. data and other contextual information that we learned about
3. what we heard from stakeholders

We have also identified data and research gaps, as well as perspectives that are missing (that is, stakeholders we have not yet heard from). Each chapter describes a distinct theme, and has been written in a way so that it can be read in isolation from the other chapters. For this reason, there is some repetition with respect to key data and perspectives presented within the report. A glossary that defines key terms used in the report can be found in Appendix A.

Summary of engagement process

We have engaged with:

- researchers and academics in various fields (such as public health, public safety, criminal justice, and economics)
- health care professionals and organizations
- people working in the areas of public health and harm reduction
- youth and youth advocates
- First Nations, Inuit, and Métis people (including leaders, governments, community organizations, industry members, and Elders)
- the cannabis industry (including federal licence holders both large and small, distributors, regulators, retailers, and industry associations)
- equity-deserving groups
- people with diverse lived and living experience
- international policy leaders
- cannabis consumers
- various levels of government
- law enforcement representatives
- stakeholders involved in the use of cannabis for medical purposes (such as patients and their caregivers, patient advocacy groups, cannabis clinics, and those operating outside of the current medical access system)

In our engagement with First Nations, Inuit, and Métis people, we adopted a distinctions-based approach. This included targeted approaches and tailoring aspects of our discussions to the unique goals and priorities of First Nations, Inuit, and Métis, recognizing each has different ways of knowing. We have sought to engage at the individual, community, regional, and national levels.

We will continue to engage with First Nations, Inuit, and Métis organizations, leaders, and representatives to assess the impacts of the *Act* on their respective communities, and to outline priority areas for actions, findings, or recommendations.

We approached stakeholder engagement with humility. We not only listened, but we ensured that we heard. We respect all voices, and acknowledge the value of differing perspectives, including of people with lived and living experience. We acknowledge that barriers exist for many groups in engaging in processes like this review, including historical power imbalances, resource or capacity limitations, and access issues. We have taken measures to address some of these barriers, including offering various modes of participation and making use of trusted interlocutors, such as community leaders and youth advocates, to help facilitate conversations and hear diverse voices.

Before we were appointed, Health Canada launched an online engagement process, supported by two engagement papers, "Taking stock of progress: Cannabis legalization and regulation in Canada" and "Summary from engagement with First Nations, Inuit and Métis Peoples: The *Cannabis Act* and its impacts". The Department received over 2,100 responses to their online questionnaires and over 200 written submissions. We received a briefing on the results of this online engagement process and were provided access to the submissions received. We thank all those who took the time to submit their views in that process.

Overview of engagement activities

We used a range of methods to conduct our engagement. These activities occurred with stakeholders throughout Canada, through in-person meetings, videoconferences, and in a hybrid format. Meetings were held in both English and French, depending on the stakeholder. As we met with stakeholders, we learned more about the areas we were asked to assess, how we should engage with specific stakeholder groups, and we were provided with additional sources of data and people we should engage with. We also heard from individuals and organizations who took the time to put their views in writing. We adapted our engagement activities based on the feedback we received and appreciate those who made suggestions along the way. Throughout this report and in keeping with our commitment to those we engaged with, we have not attributed comments to specific individuals or organizations.

First, we engaged with stakeholders by sector. This afforded stakeholders the opportunity to provide us with comprehensive perspectives on their key issues.

We also met with a range of stakeholders one-on-one, including researchers, federal government officials, provincial and territorial government officials, representatives from national Indigenous organizations, international policy experts, and industry stakeholders.

As part of the distinctions-based approach of engaging with First Nations, Inuit, and Métis organizations, communities, and individuals, we met with 40 individuals from British Columbia-based First Nations, the Mohawk Council of Kahnawà:ke, Williams Lake First Nation, Shxwhá:y Village, representatives of the four Inuit regions, the Manitoba Métis Federation, and the Métis National Council and some of its members (that is, Métis Nation of Ontario, Métis Nation of Alberta, Métis Nation of Saskatchewan, and Métis Nation of British Columbia). Co-developed agendas and facilitated discussions enabled frank sharing on a range of issues.

We held engagements on issues related to diversity, equity, and inclusion (DEI), including women in the industry, people with disabilities, issues specific to Black Canadians, social equity issues, harm reduction measures, and learnings from other jurisdictions. We will continue to prioritize our work in this area as we remain interested in learning from marginalized groups such as the 2SLGBTQIA+ community about their experiences with the legalization of cannabis, including their participation in the industry as consumers and/or as patients and in their interactions with law enforcement officials.

As of June 30, 2023, we:

- met with almost 500 individuals from over 200 organizations in nearly 90 meetings
- completed eight sector-based roundtable meetings (public health, justice and public safety, industry, three meetings with patient organizations and advocates, and two meetings with youth and young adult advocates)
- completed five roundtables focused on issues related to DEI
- undertook distinctions-based engagement activities with First Nations, Inuit, and Métis
- visited sites of licence holders involved in cultivation and processing, retail stores, harm reduction sites, and cannabis clinics
- engaged with stakeholders operating outside of federal, provincial, or territorial licensing frameworks

A list of the stakeholders we engaged with is available in Appendix B.

Our engagement activities in the fall will include, among others, meetings with:

- youth and young adults
- First Nations, Inuit, and Métis

In addition, we intend to hold multi-sectoral meetings, hoping to bring together a diverse range of voices to help us finalize our advice and recommendations.

While significant effort has been made to ensure a broad range of voices in our engagement, we acknowledge that some perspectives have not yet been heard. We will continue to seek opportunities to engage with certain groups, such as the medical community (for example, the Canadian Medical Association, the College of Family Physicians, the Canadian Paediatric Society, the Canadian Psychiatric Association, and provincial and territorial medical regulatory authorities) and other medical profession specialty groups. We note in this report any significant gaps in our engagement where they are relevant. We are eager to fill these gaps, and welcome further input and submissions from all stakeholders to inform our final report.

Finally, we would like to thank everyone who generously gave us their time and energy in sharing their perspectives and answering our questions. We also thank those who helped us organize opportunities for discussion. We hope that this first review marks the beginning of a continuing review process where diverse groups are engaged regularly to assess the legislative framework and its implementation.

Chapter 4

Overview of the cannabis framework

On October 17, 2018, Canada became the first major industrialized nation in the world to legalize and regulate cannabis when the *Cannabis Act* (the *Act*) and its regulations came into force. The purpose of the *Act* is to protect public health and public safety, including by providing access to a quality-controlled supply of cannabis, and by enhancing public awareness of the health risks associated with cannabis use.

The *Act* recognizes federal and provincial and territorial authorities with respect to the production, distribution, and sale of cannabis. These include authorities that enable the federal government (the Minister of Health) to issue licences and permits authorizing activities such as production, import, export, and sale. The provinces and territories have all exercised authority over the distribution and sale of cannabis under provincial and territorial law. The *Act* does not set out authorities related to First Nations, Inuit, or Métis governments.

The federal framework

Under the *Act*, the federal government is responsible for licensing various activities with respect to the production of cannabis (including industrial hemp[7]), including cultivation[8], processing[9], and testing[10], as well as associated activities, such as possession, distribution, sale, and research with cannabis. The federal government also establishes, and oversees compliance with, the rules that apply to cultivating and manufacturing cannabis for commercial sale, including:

- the requirements to obtain a licence (for example, physical and personnel security measures)
- the types of cannabis products that can be made available for sale
- the rules that apply to the production and formulation of cannabis products, including mandatory testing requirements and potency limits
- the packaging and labelling requirements for cannabis products
- the tracking requirements that apply to those authorized to produce and sell cannabis to prevent diversion and inversion of cannabis out of or into the legal system

The federal government is also responsible for overseeing a framework to provide access to cannabis for medical purposes under the *Act*. This framework enables Canadians, including young persons, to access cannabis for their medical needs from commercially licensed sellers or through personal or designated production.

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7 Industrial hemp includes cannabis plants and their parts that contain a small amount of tetrahydrocannabinol (THC) (that is, 0.3% or less) in the leaves and flowering heads. Examples of hemp products include hemp seed oil and hemp flour.

8 Cultivation, in this case, refers to the growing of cannabis crops.

9 Processing, in this case, refers to the synthesis, alteration, or manufacturing of cannabis and cannabis products.

10 Testing, in this case, refers to the analysis of cannabis to confirm its identity, concentration, quality, or purity.

The *Act* prohibits the promotion of cannabis, cannabis accessories, or related services, except in limited circumstances. Prohibited promotions include those that:

- are considered appealing to young persons
- are false, misleading, or deceptive
- are likely to create an erroneous impression about the health effects of cannabis or evoke a positive emotion or image of a way of life (for example, glamour)
- use sponsorship, testimonials, or endorsements
- depict a person, celebrity, character, or an animal

The *Act* does permit promotion under specific conditions to help adult consumers make informed decisions about cannabis. For example, it allows for informational promotion, such as price and availability (that is, information about how it can be obtained), as well as brand-preference promotion (such as promotion on attributes of the cannabis like "sun grown" or "organic"), in material addressed to adults over the age of 18 or in places where youth are not permitted by law.

The *Act* contains a series of criminal offences and penalties (for example, ticketing and imprisonment) to deter illicit activity related to cannabis, with exceptions for certain individuals and authorized parties.

These control measures include:

Restricting youth (people below 18 years of age) from accessing cannabis

- prohibiting youth from possessing more than five grams of dried cannabis (or its equivalent in other classes of cannabis)

Controlling access to cannabis for adults of legal age

- prohibiting individuals and organizations from selling cannabis, unless authorized to do so under the *Act*
- limiting adult possession in public to 30 grams of dried cannabis (or its equivalent in other classes of cannabis)
- limiting home cultivation to four plants per dwelling-house

Protecting public safety

- prohibiting production, distribution and sale, unless authorized
- prohibiting distribution and sale to youth
- prohibiting import and export, with exceptions for licence holders with a permit and only for a scientific or medical purpose (or in respect of industrial hemp)

The implementation of the *Act* and its regulations is supported by various activities related to licensing, regulatory compliance and enforcement, criminal enforcement, research and surveillance, and public education, such as:

- issuing and renewing licences and security clearances
- promoting and monitoring regulatory compliance, including through risk-based inspections of federal licence holders to determine whether requirements are being met (for example, cannabis products have been tested, appropriate records are kept about production and sale). During fiscal year 2022–2023, 821 inspection activities were conducted by Health Canada
- investigations, charges, and court proceedings related to infractions of the criminal offences in the *Act*
- monitoring data to identify and track emerging trends and risks (for example, risks posed by new cannabis products)
- funding research on the public health and public safety impacts of legalization, the therapeutic potential of cannabis, the cannabis plant and its components, and social science research on topics such as stigma, diversity, and inclusion
- providing public education to Canadians to educate and raise awareness of health and safety risks associated with cannabis use, prevent problematic use and promote informed choices

Other elements of the federal cannabis framework are found within other pieces of legislation, including:

- *Criminal Code* [1]: Rules related to impaired driving
- *Excise Act, 2001* [2]: Rules related to the duty payable on cannabis products by federal licence holders
- *Non-smokers' Health Act* [3]: Rules that prohibit smoking and vaping of cannabis in federally-regulated workplaces and certain modes of transportation

While our scope of work is limited to assessing the administration and operation of the *Cannabis Act* and not other pieces of federal legislation, we have been open to hearing perspectives on how various aspects of the cannabis framework work together—or not—and have been asked to consider the economic impacts of the *Act*, among other elements that are broader in nature.

Provincial, territorial, and municipal roles and authorities

Provinces and territories are responsible for overseeing the distribution and sale of cannabis within their jurisdictions. They have established a range of distribution and retail models (that is, public, private, and hybrid[11]). These models have evolved over time, and in certain provinces and territories now include direct delivery to consumers and farmgate sales (that is, direct sales to consumers at federal licence holder sites). The mandate of the legislative review does not involve reviewing the distribution and retail models of the provinces and territories. However, given our mandate to assess issues related to public health, legal access for adults, the extent of displacement of the illicit market, and the economic impacts of the *Act*, we have learned about the different systems and some of the considerations and issues associated with them.

[11] Public retail systems are those in which physical stores and online sales are exclusively government operated, typically through a Crown corporation. Private retail systems are those in which private individuals or enterprises own and manage retail locations. Hybrid systems include a mix of government-run and privately operated retail access points.

Provinces and territories have the authority to establish additional controls, such as:

- increasing the minimum age for adult possession, but not lowering it (all provinces and territories have increased the minimum age to 19, except Alberta where the minimum age is 18 and Quebec where the minimum age is 21)
- lowering the personal possession limit (no provinces and territories have elected to do this)
- creating additional rules for growing cannabis at home, such as lowering the number of plants per residence (for example, home cultivation of cannabis is prohibited in Quebec and Manitoba)
- restricting where adults can consume cannabis, such as in public or in vehicles (all provinces and territories have placed prohibitions or limits on public consumption, with most aligning with their existing rules related to tobacco)
- limiting access to certain types of products (for example, Nova Scotia and Newfoundland and Labrador have restricted certain vaping products, and Quebec has restricted certain types of edible cannabis products)

Local governments and municipalities may develop rules on issues such as zoning, public consumption, and fire prevention.

First Nations, Inuit, and Métis

While the *Act* addresses the role and authorities of provincial and territorial governments, there is no similar recognition of First Nations, Inuit, and Métis governments. Under other established legislation and authorities (for example, the *Indian Act*, the *First Nations Land Management Act*, or municipal authorities), some additional rules or requirements can be created (for example, zoning by-laws), provided the rules do not conflict with the *Act*. We have heard that this does not go far enough. There is a strong desire on the part of many communities for greater self-governance, including over cannabis activities. The scope of what self-governance powers and authorities are desired may differ from community to community.

Social equity considerations

While the framework takes into account societal behaviours and social factors (for example, reducing harms for adult consumers and youth, reducing criminal activity, and allowing adult access to quality-controlled cannabis), there are no social equity objectives or explicit measures for marginalized or disadvantaged groups, with the exception of certain licensing application flexibility and supports for Indigenous and Indigenous-affiliated applicants.

Chapter 5

Public health

Overview of measures

The *Cannabis Act* (the *Act*) is based on a public health and public safety approach that aims to protect Canadians by minimizing the harms associated with cannabis use. Key objectives with respect to the protection of public health include preventing young persons from accessing cannabis; providing access to a regulated supply of cannabis; and enhancing public awareness of the health risks associated with cannabis use.

The *Act* and its regulations contain a series of controls designed to support the achievement of these objectives, including, but not limited to:

- restrictions on sale to youth and possession by youth
- rules regarding the promotion of cannabis, cannabis accessories, and services related to cannabis, including rules to prohibit promotion that is appealing to youth
- rules requiring the production of cannabis in accordance with Good Production Practices (for example, sanitation programs, storage and distribution requirements, testing requirements for microbial and chemical contaminants)
- limits on the quantity of delta-9-tetrahydrocannabinol (THC) that is permitted in certain cannabis products, by class of cannabis
- plain packaging and labelling requirements for cannabis products, including limits on the use of colours and brand elements, as well as requirements for mandatory information to be displayed, such as the standardized cannabis symbol, a health warning message, THC and cannabidiol (CBD) content

In addition to legislative and regulatory controls, the federal government, among others, supports the public health objectives of the *Act* through investments in public education, and research and surveillance activities. In 2017, the federal government committed $46 million over five years to public education and research and surveillance. In 2018, $62.5 million over five years was allocated to Health Canada's Substance Use and Addictions Program (SUAP) to support the involvement of community-based and Indigenous organizations that are educating their communities about the risks associated with cannabis use. In 2022, a further $1.8 million over three years was committed to support additional public education efforts through SUAP to reduce harms associated with cannabis use. Examples of public education campaigns include:

- "Preparing Parents" campaign (social media and targeted sites)—preparing parents to encourage them to talk to their teens about cannabis. During March and April 2017, there were 2,000 engagements[12] on social media

[12] Engagements, in this case, mean the total number of interactions that a user has with a post (that is, a sum of all comments, likes, shares, clicks, etc.).

- "Your Cannabis Questions Answered" campaign (social media, on university and college campuses, and television advertisements)—outreach to Canadians, including youth, about new cannabis laws, impaired driving, impairment in the workplace, travel implications, and how to lower the risk of cannabis use. The first iteration of this campaign reached 50 million accounts/viewers. The second iteration of this campaign reached over 20 million accounts with more than 2 million engagements. The television advertisements garnered 149 million impressions[13]
- "Lower-risk Use" campaign (social media and mobile applications)—educating Canadians about lower-risk use of cannabis, including with edible cannabis products, and the risks of drug-impaired driving. Videos were viewed in full over 25 million times, and over 69.3 million ad impressions were displayed on various social media channels and mobile apps)

Key surveillance initiatives specific to cannabis implemented by the Government of Canada include the Canadian Cannabis Survey and the National Cannabis Survey. These surveys are complemented by other population surveys including: the Canadian Alcohol and Drugs Survey; the Canadian Student Tobacco, Alcohol and Drugs Survey; and the Canadian Community Health Survey, among others. Additional monitoring and surveillance activities include analyzing and reporting on cannabis pharmacovigilance data (that is, adverse reaction reporting, which is mandatory for certain licence holders), ongoing analysis of poison centre and health administrative data, and funding surveillance studies (for example, under the Canadian Paediatric Surveillance Program). These surveillance activities, along with reviews of academic literature, monitor trends related to cannabis use and inform the development of public education campaigns.

Since 2018, organizations such as the Canadian Institutes of Health Research (CIHR), the Mental Health Commission of Canada (MHCC), and the Canadian Centre on Substance Use and Addiction (CCSA) have developed and coordinated national research and surveillance activities on cannabis and made significant investments in cannabis research and surveillance.

For example, the CIHR developed the Integrated Cannabis Research Strategy (ICRS), with $52 million invested in cannabis research and surveillance funding opportunities from 2017–2018 to 2025–2026. The CIHR also partnered with the MHCC and the CCSA (each of which received $10 million in 2018 from the Government of Canada) to fund cannabis research and surveillance activities. Under the ICRS, CIHR (and in certain cases in partnership with the MHCC and the CCSA) funded a series of Catalyst Grants, Team Grants, and Operating Grants to understand the harms and benefits of cannabis, and to develop cannabis data standards.

We understand that the COVID-19 pandemic has affected the development and implementation of some clinical research and public education activities due to public health policies and resource limitations. While the pandemic may have been disruptive, as described below, stakeholders have expressed frustration with the pace of progress on research and public education before the pandemic, and since.

[13] Impressions, in this case, means the number of times that a campaign is viewed during a given time period.

Data and observations

Prevalence of use

Almost seven million Canadians [4] (22% of those aged 15 or older [5]) report past-year use of cannabis, which represents an increase of more than two million people since 2017. [6] The increase in the prevalence of cannabis use suggests a continuation of the rising trend that preceded legalization. While a large share of the increase is attributable to higher rates of use among people over the age of 25, it is notable that more than 40% of young adults (ages 20 to 24) in Canada now report cannabis use in the past 12 months. [5] [7]

About four in 10 Canadians aged 15 or older report having ever used cannabis in their lifetime, which is similar to results from a decade ago, and suggests that some of the increase in past-year use may be among individuals who have previously used cannabis. [7] [8]

Most people who report past-year use of cannabis indicate using it less than once a week, while about one-quarter of cannabis consumers use it often (daily or almost every day). [9] The 1.7 million Canadians [4] (6% of the population aged 15 or older [5]) who consume cannabis daily or almost daily are at greater risk of experiencing harms from their cannabis use (including increased risk of adverse respiratory effects, dependence, psychosis, depression, and anxiety). This intensive pattern of use is most prominent among young adults aged 20 to 24. Among this age group, 10% report daily or almost daily use. [5] Prior to legalization, in 2017 it was estimated that 3.5% of Canadians aged 15 or older used cannabis daily or almost every day, while the estimate for young adults aged 20 to 24 was 9%. [10]

Overall, cannabis use continues to be more prevalent among males than females. The 2021 Canadian Community Health Survey noted higher rates of past-year and daily or almost daily use among males than females (25% vs. 19%; 7% vs. 4%). [4]

Differences in cannabis use prevalence—and other cannabis-related behaviours—have also been noted between a variety of population subgroups. Among the many possible subgroups to consider, the 2022 Canadian Cannabis Survey noted higher rates of past-year cannabis use among respondents identifying as bisexual (61%) and lesbian or gay (39%) than among those identifying as heterosexual (25%). [9]

There are notable differences in the extent of cannabis use across Canada, with past-year use being lower than the national average in Quebec (15%), and higher in Nova Scotia (31%), Prince Edward Island (27%), British Columbia (25%), Alberta (24%), and Ontario (23%). [4] Relatively lower cannabis use rates in Quebec, and higher rates of cannabis use in certain provinces and territories (for example, British Columbia, Nova Scotia) were observed prior to legalization. For example, estimates of past-year cannabis use from the 2017 Canadian Tobacco, Alcohol and Drugs Survey ranged from a low of 11% in Quebec to a high of 23% in British Columbia. [11]

Products used and methods of consumption

Population surveys and market data both suggest that the cannabis products being used are changing. Results from the Canadian Cannabis Survey indicated that smoking (for example, a joint, bong, pipe, or blunt) of any form of cannabis declined from 89% to 70% among past-year users between 2018 and 2022; over the same period reported past-year use of cannabis edibles increased from 41% to 53%, and the use of cannabis vape pens or cartridges increased from 16% to 33%. [9] [12] Market data and other information shared with us suggests higher-potency products are popular—unlike decades ago when dried flower often contained less than 10% THC, cannabis containing 20% THC or more is common in the legal market. [13] A minority of consumers report use of CBD-only (non-THC) products; in 2022, 2% of past-year users reported typically choosing CBD-only products, and 13% reported typically choosing products with higher CBD and lower THC. [9]

For people who choose to use cannabis, consumption of quality-controlled legal products reduces risks associated with illicit cannabis products, including risks that arise from adulteration or contamination (for example, contamination from pesticides and microbial contaminants and possible adulteration with other illicit substances).

Attitudes about use and risks

Concerns were raised prior to the implementation of the *Act* about the effect that legalization would have on the public perception of cannabis. The most recent data available indicate that about half of respondents felt regular cannabis smoking was either "somewhat" or "completely" socially acceptable (45% in 2018, 51% in 2022). [9] [12] Recent results on knowledge and risk perception indicate that, by and large, Canadians have maintained or improved their knowledge of cannabis-specific health effects, and similarly, perceptions of risk have been maintained or improved. However, survey findings also suggest that awareness of education campaigns and public health messages have significantly declined, as 76% of respondents to the Canadian Cannabis Survey reported noticing an education campaign or public health message in 2019, while only 52% reported noticing these efforts in 2022. [9] [14]

Poisonings and health care presentations

Published studies and health administrative data reveal increases over time in the rate of cannabis-related poison centre calls and health care presentations. In 2021, cannabis was responsible for approximately 1% of exposure cases reported to Canadian poison centres, with the number of calls related to cannabis (as a single-substance exposure) doubling between 2019 and 2021 (from approximately 1,200 to 2,400 cases annually). [15] In a report investigating unintended consequences of the COVID-19 pandemic in the period of March 2020 to June 2021, the Canadian Institute for Health Information noted increases in cannabis-related emergency department (ED) visits and cannabis-related hospitalizations (both increased 14%; cannabis-related ED visits rose from 19,009 visits in 2019 to 21,658 in a period of equivalent duration in 2020–2021, while hospitalizations rose from 12,644 to 14,363 when comparing periods of equal duration in 2019 and 2020–2021). The report also noted that ED visits increased more sharply for women than men. Findings related to youth are discussed in Chapter 6. [16]

Academic studies examining cannabis-related health care presentations have varied in geographic coverage, study duration and outcome measures, and results have been mixed. Larger studies include an analysis by Myran and colleagues that found increases in cannabis-attributed ED visits in Ontario (ages 15 or older) over the period from January 2016 to May 2021. Among the findings, it was observed that the average number of ED visits per month increased from 805.5 pre-legalization to 1530.5 after commercial retail expansion in spring 2020. [17] Another large study by Callaghan and colleagues examined ED visits for cannabis-related psychosis and schizophrenia in Ontario and Alberta, and noted a doubling between April 2015 and December 2019. Increases in visits for cannabis-induced psychosis were observed in the lead-up to legalization, but there was no apparent increase coinciding with legalization. [18] Additional studies are reviewed by Myran et al. [19] and Hall and colleagues. [20]

A recent study examining acute care (ED visit or hospitalization) of pregnant individuals related to cannabis use in Ontario between January 2015 and July 2021 found a near doubling in the rate, from 11 out of every 100,000 pregnancies in the pre-legalization period to 20 out of every 100,000 pregnancies post-legalization. There were no changes in acute care for substances other than cannabis. [21]

What we heard

The voices and perspectives reflected include those offered by the public health community, industry, academics, and researchers.

The public health approach to cannabis legalization

Public health stakeholders expressed that they are generally supportive of the cautious public health approach. Many agree that cannabis legalization did not result in widespread negative impacts on public health, while recognizing that the focus of the regime should continue to be on reducing harms associated with cannabis use.

They suggested that the main objective of the cannabis framework should continue to be the protection of public health, and that policies should aim to transition existing consumers from the illicit market to the legal market to reduce health risks associated with illicit products, as opposed to creating new cannabis consumers and more frequent cannabis consumers.

Many argued against making large-scale changes to the framework at this time, instead suggesting that there should be some targeted changes (for example, re-insertion of health warning messages for specific mental health issues such as psychosis). Taking an even more cautious approach, some suggested that the legal age of possession should be raised to 21.

Many public health stakeholders and some provincial and territorial government officials focused on reinforcing the value of existing regulatory controls, such as the THC quantity for edible cannabis products and promotion restrictions, to reduce harms. Public health stakeholders noted that frequent cannabis users do not typically use edibles, and often smoke or vape; as such, the 10 milligram THC quantity for edible cannabis was positioned as a reasonable upper limit for a single package to limit the risk of over-consumption by novice users. They also suggested that most promotion activities by legal companies have been in compliance with the *Act's* restrictions. They indicated that allowing promotional activities directed at the general public would run counter to the *Act's* objectives as youth would be exposed. There were suggestions to simplify and streamline packaging and the information on product labels (for example, removing the requirement to label the quantity of both total THC *and* THC[14] and allowing the use of QR codes to convey more detailed information to interested consumers).

Some argued against any change to cannabis taxation, given the role that pricing can play in protecting public health by reducing demand. There were also suggestions that tax revenue could be a source of funding for public education activities. Conversely, industry stakeholders called for excise tax relief as the tax level impacts their viability. They noted that ensuring industry viability furthers public health goals because a legal market provides consumers with access to a regulated, and safer, supply than the illicit market.

Some industry stakeholders indicated that public health outcomes can be best achieved with more regulatory flexibility in the legal market. For example, they noted that having more ability to communicate with consumers about their products and their effects, as well as on lower-risk use, would help consumers to make more informed choices. Some also pointed to the negative unintended consequences associated with some public health controls (for example, robberies in retail stores with window coverings intended to ensure cannabis is not visible to youth). However, public health stakeholders noted the importance of maintaining public health safeguards to protect against potential harms associated with the over-commercialization of legal cannabis products.

[14] The "THC" amount is the quantity of THC in the product as purchased. The "Total THC" amount is the THC content when the product is used as intended (when all the THC becomes activated, for example, by heating the product).

Minimizing harms

Cannabis use remains widespread in Canada. We heard about concerns regarding harms that can result from use, such as psychosis, depression, anxiety, and dependence. In particular, stakeholders noted these harms can result from:

- frequent consumption of cannabis
- availability of higher-potency products and frequent use of these products
- polysubstance use (that is, the consumption of more than one substance close in time, with overlapping effects)
- cannabis use during pregnancy and while breastfeeding
- driving under the influence of cannabis
- early age of initiation and use

They expressed the need to understand the risks related to smoked or combustible products (for example, joints or bongs) with the risks related to newer, non-combustible products (for example, edibles, vaping products, beverages). This need is especially pronounced when considering transitioning from smoked or combustible products, which carry known risks (such as those to lung health) to non-combustible products with known and emerging risks, for which there is less research and data. Some recommended implementing more rigorous quality assurance standards around vaping products and products containing cannabinoids such as delta-8 THC. Some public health participants suggested restricting the amount of the allowable distribution, purchase, and possession of high-potency cannabis extracts and restricting the sale of flavoured vaping products. In terms of retail, public health stakeholders proposed the implementation of controls on retail density to reduce public exposure and prohibiting the co-located sale of alcohol and cannabis.

They noted the harms, such as poisoning, associated with illicit cannabis products, which are not subject to quality standards or testing. Some noted that testing of seized illicit products has found contaminants such as mould and pesticides. Harm reduction advocates noted concerns about some illicit cannabis being contaminated with street drugs, including opioids, which is particularly problematic for those individuals who use cannabis in conjunction with or as a substitute for other drugs.

We heard about the need for balance in minimizing harms and reducing the stigma associated with cannabis use without normalizing its use and attracting new users. Public health stakeholders and youth advocates highlighted the need to reduce stigmatization in public education messaging by using pragmatic information, dispelling myths, and explaining ways to reduce harm for those who do choose to use cannabis (for example, safer use guidelines). At the same time, some public health stakeholders suggested that there needs to be an expansion of access to, and availability of, clinicians and services specifically intended to support individuals with cannabis use disorder.

Some industry representatives suggested that governments should reconsider the underlying assumption that growth in the cannabis market has a negative impact on public health. They discussed anecdotal observations that, in some situations, consumers use cannabis as an alternative to other harmful substances, including alcohol, tobacco, and opioids. People involved in harm reduction efforts also noted the role that cannabis can play in supporting the transition from other drugs, including during detoxification.

Research and surveillance

It was generally agreed that it is premature to draw conclusions on the overall impacts of legalization, including on public health. More data and research on cannabis is needed to inform ongoing assessments. Public health stakeholders highlighted the ongoing need to support research, as well as evaluating and updating guidance for individuals who use cannabis and health care professionals. Many shared their frustration and disappointment with the lack of progress in research on cannabis and its effects.

Some noted that it has taken decades to understand the public health impacts of the use of alcohol and tobacco. Some jurisdictions (for example, Quebec, Washington) are allocating a percentage of sales from cannabis and alcohol for research efforts, and that this could be a model for the government to consider. Some noted that the early understanding of the impacts on public health has been affected by two major events—first, the introduction of the legal sale of edible cannabis, cannabis extracts, and cannabis topicals one year after legalization, and second, the COVID-19 pandemic. Changes in mental health and substance use resulting from the pandemic, including some studies suggesting the intensification of cannabis use among some users, underscore the importance of closely monitoring patterns.

Specific measures to continue to advance knowledge and support cannabis harm reduction were suggested, including:

- developing a defined measure of a "standard dose" of cannabis to guide individuals who use cannabis, for research, and for epidemiological surveillance on health impacts of use, similar to what has been done for alcohol
- expanding research about driving after cannabis use (including current knowledge, attitudes, and beliefs)
- expanding research on impaired functioning in occupational settings
- bolstering surveillance and research in areas such as: harms from pediatric accidental ingestion, use and harms among key populations (for example, pregnant and breastfeeding individuals, people with a family or personal history of mental health disorders, 2SLGBTQIA+ individuals), long-term implications of use, long-term trends in patterns of use (for example, age of onset, frequency of use), harms from vaping cannabis as well as high-potency cannabis extracts, and polysubstance use
- advancing research on the interactions and effects of THC with CBD and other cannabinoids
- further research on delta-9-THC and products with high quantities of THC, as well as the components and aerosols from inhaled forms of cannabis

We heard suggestions about the need to use a wide variety of research methods including animal and mechanistic studies; epidemiological research; prevention and implementation trials to identify conditions under which evidence-based intervention programs best protect the public; clinical studies to characterize potential therapeutic effects; behavioural research; community participatory research (that is, research activities carried out in local settings in which community members actively collaborate with researchers); and program evaluation.

Some, including industry representatives, patients, and researchers, were discouraged by the dearth of evidence regarding the therapeutic use of cannabis. Many researchers raised challenges of conducting research in this area due to the requirements of the clinical trial framework under the *Food and Drug Regulations,* which precludes using cannabis products produced to the standards under the *Cannabis Act* and its regulations. More information on the challenges researchers are facing is discussed in Chapter 12.

Historically disadvantaged groups underlined the lack of disaggregated race-based data on issues such as interaction with the criminal justice system, youth use rates, and reasons for use. They also highlighted the need for more research to understand the effects of cannabis use on young people and people experiencing homelessness, as well as the social, economic, and health outcomes of people who have been charged with cannabis-related criminal offences.

Public education and health interventions

We heard from various government officials about investments in public education activities—including focused advertising and marketing campaigns, and partnerships with non-governmental organizations—that occurred prior to and at the time of the coming into force of the *Act*. With the reduction in funding and corresponding decline in public education activities since 2018, a decline in exposure to public education has been observed. We also heard from experts who emphasized that public education activities alone are not particularly effective in changing behaviours related to drugs, including cannabis. Some noticed a reliance on broad-based education as the primary public health intervention, as opposed to evidence-based intervention strategies (for example, cognitive behavioural or motivational interventions for problematic and frequent consumers, and youth at risk). We heard that targeted resources would be needed to implement such programs effectively.

While national survey results may provide some insight into trends related to cannabis use behaviours and perceptions as a result of the implementation of public education campaigns, we heard that there are no formal monitoring or evaluation mechanisms to determine the effectiveness and impact of the governmental public education activities.

From a cannabis product perspective, we heard the need for more information on how to interpret risk, including the comparative risk level of different products (for example, edible versus combustible products) and the consumption of THC-dominant versus CBD-dominant products (for example, THC causes the intoxicating effects of cannabis; CBD is not intoxicating but can have effects on the brain, including changing brain activity). Stakeholders emphasized the need for more informative health warning messages that are tailored to the product format, noting that it is not useful to have messages about smoking on edible products, for example. Additionally, they raised the need for public education efforts, based on the most current evidence, that outline how to interpret the cannabinoid content on the label, urging the development of standard THC doses for consumers to use as a reference point, and how to distinguish legal from illicit products and retailers, especially when looking to purchase online.

We heard about the need for more targeted resources towards public education and awareness on the following:

- lower-risk use for people who choose to use cannabis
- harms of illicit cannabis products, as well as how to identify legal sources of cannabis
- impairments caused by mixing THC and other substances
- risks and harms of using cannabis, including warning messages relating to psychosis
- patterns of cannabis use and specific harms among individual First Nations, Inuit, and Métis populations
- targeted public education for sub-populations, particularly youth and equity-deserving groups (for example, racialized communities and 2SLGBTQIA+), as well older adults

Several of the groups we spoke with raised the need to consider who is best placed to provide public education. They noted that a "grey market" exists where people get their information from informal channels, such as family members, friends, peers, people with experience in using cannabis, or people involved in pre-existing networks and with whom there are trust relationships. Some suggested that information from these channels may have greater impact than information delivered from traditional authorities (for example, physicians, government). It was suggested that pharmacists may have a role in providing information on cannabis, given their perceived trustworthiness and presence in many communities. They noted that retail staff ("budtenders") have become an important source of information for consumers. It was noted that while budtenders can provide general information about the cannabis products (for example, potency, terpenes), some consumers look to them for answers on questions related to therapeutic uses and health effects of cannabis, notwithstanding that it is prohibited for those who sell cannabis to provide such information.

Regarding health interventions, we heard concerns about knowledge gaps and discomfort with the subject matter that exists within the health care community. Participants spoke about the need for education for health care professionals. This would better equip them to support individuals with questions regarding the therapeutic uses of cannabis, the specific risk of harms, and those seeking help on issues such as cannabis use disorder. Mandatory basic and clinical education would also ensure that cannabis use can be better understood and managed in all aspects of clinical practice.

Chapter 6

Youth

Overview of measures

One of the key drivers for the legalization and regulation of cannabis in Canada was to protect youth, and as such, the *Cannabis Act* (the *Act*) seeks to restrict youth access to cannabis and to protect youth from inducements to use cannabis. The *Act* and its regulations contain a series of controls designed to support the achievement of these objectives, including, but not limited to:

- restrictions on sale to youth
- offences and penalties related to youth possession over five grams
- rules regarding the promotion of cannabis, cannabis accessories, and services related to cannabis, specifically rules intended to prohibit promotion that is appealing to youth, as well as restrictions on lifestyle promotion, sponsorships, and celebrity endorsements
- restricting permitted forms of promotion to individuals over the age of 18 (for example, direct mail, age-gated websites) and in places where youth are not permitted by law (for example, retail stores or bars, per provincial or territorial legislation)
- plain packaging and labelling requirements for cannabis products, including limits on the use of colours and brand elements, as well as requirements for mandatory information to be displayed, such as the standardized cannabis symbol, a health warning message, delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) content
- a requirement for packaging to be child resistant

In addition to legislative and regulatory controls, the federal government, among others, supports the objectives of the *Act* related to protecting youth through investments in public education targeting youth and their parents. Examples of public education campaigns targeted at youth include:

- "Pursue Your Passion" campaign—an interactive, in-school educational program to educate youth (aged 13–15) about the health effects of cannabis and to encourage them to choose alternative activities rather than consuming cannabis. Phase 1 of the campaign (July 2018 to March 2019) achieved 65,135 engagements[15]; and Phase 2 of the campaign (October 2018 to March 2019) visited 75 high schools reaching over 18,000 students
- "Cannabis and your mental health"—a digital campaign focussed on the health risks associated with cannabis for youth and young adults under the age of 25. Health Canada has published public advisories warning Canadians of the risk of serious harm if children accidentally consume edible cannabis as well as mailed postcards to over five million homes across Canada in March and April 2023.

[15] Engagements, in this case, mean the total number of interactions that a user has with a post (that is, a sum of all comments, likes, shares, clicks, etc.).

In terms of research and surveillance activities, in addition to the Canadian Cannabis Survey, the Canadian Alcohol and Drugs Survey, the National Cannabis Survey, and the Canadian Community Health Survey, other youth specific monitoring and surveillance activities include: the Canadian Student Tobacco, Alcohol and Drug Use Survey; the Canadian Post-secondary Education Alcohol and Drug Use Survey; the Canadian Health Survey on Children and Youth; and the Canadian Paediatric Surveillance Program's ongoing study on Serious and Life-Threatening Events Associated with Non-medical (recreational) Cannabis Use in Canadian Children and Youth 2018–2025.

Data and observations

Prevalence of use

Data gathered from different surveys, over different time periods, and in different populations demonstrate varied results related to the prevalence of cannabis use among youth (aged 15–19) and young adults (aged 20–24) during the pre- and post-legalization periods. [22] In the pre-legalization period, the Canadian Alcohol and Drugs Survey (and its predecessors) revealed a declining trend in the prevalence of past-year cannabis use among youth and young adults between 2008 to 2012, while a period of relative stability was then observed in the years leading up to legalization for youth aged 15–19. However, among young adults (20–24), there was an increasing trend in prevalence of past-year cannabis use beginning in the pre-legalization period from 2012 and onwards, continuing post-legalization. [23] The 2021–2022 Canadian Student Tobacco, Alcohol and Drugs Survey found that 18% of students in grades 7 to 12 (383,000) had used cannabis in the past year, unchanged from the previous cycle in 2018–2019. [24] Daily or almost daily use (that is, four or more days per week) was reported by 4% of students in grades 7 to 12 (approximately 89,000 students), which was similar to the result from 2018–2019. [25]

Evidence suggests the context of cannabis use may be changing. Despite challenges in characterizing the impact of the COVID-19 pandemic on substance use, peer-reviewed studies highlight concerns about people using cannabis alone; pandemic-related public health measures and the use of cannabis to cope with mental health challenges may influence the context in which youth are using cannabis. [26] [27] The 2021–2022 Canadian Student Tobacco, Alcohol and Drugs Survey noted greater prevalence among grade 7 to 12 students with lower self-rated mental health (28% past-year use among those responding fair or poor, compared to 12% among those rating their mental health excellent, very good, or good). It was also observed that the rate of past-year cannabis use was significantly higher among women/girls than among men/boys (19% and 16%, respectively). [24]

Age of initiation of use

Findings related to the age of cannabis use initiation indicate that the average age at which youth begin cannabis use has either stayed the same or increased, although Canadian youth start using cannabis during important stages of brain/neurological development, which continues up to the age of 25. The 2021–2022 Canadian Student Tobacco, Alcohol and Drugs Survey found the average age of cannabis use initiation to be 14.1 years, unchanged from recent cycles. [24] Among respondents aged 16–19, the Canadian Cannabis Survey found an increase in the average age of initiation, from 15.2 years in 2018 to 15.9 years in 2022. [9] [12] Age of initiation is a key indicator, as exposure to cannabis during adolescence may have negative physical, mental, and psychosocial effects (including greater risk for the development of dependence and mental health conditions, impaired brain development, and reduced academic achievement). [28]

Access to and sources of cannabis

Youth continue to report that cannabis is easy to get. A large school-based survey conducted during the 2021–2022 school year found 41% of students in grades 7 to 12 felt cannabis was easy to obtain, which was similar to the result from 2018–2019. About 6% of students reported that it has become easier to get cannabis for themselves since cannabis became legal for adults, which represents an increase from the previous cycle (4% in 2018–2019). [24]

National surveys suggest that youth continue to rely heavily on social sources and the illicit market to gain access to cannabis. The 2022 Canadian Cannabis Survey found that youth aged 16–19 were more likely to obtain cannabis from a friend, or to share among a group of friends, and less likely to obtain cannabis from a legal storefront, compared to other age groups. [9]

Offences and charges

The number of cannabis-related offences involving Canadian youth has fallen. The majority of cannabis-related incidents (that is, occurrence of an alleged criminal offence in a single event) and charges (that is, the number individuals who were charged with having committed a criminal offence) among youth aged 12 to 17 relate to cannabis possession.[16] In 2017, national crime statistics indicate that 1,495 youth aged 12 to 17 were charged with cannabis possession under the *Controlled Drugs and Substances Act*. Following the coming into force of the *Cannabis Act*, the number of cannabis possession charges involving youth fell to 168 in 2022. [29] However, it has been noted that a larger share of youth cannabis possession incidents resulted in charges. [30] We note the absence of disaggregated race-based data in this area.

Poisonings and health care presentations

Peer-reviewed studies and other analyses have noted increases in the number of pediatric cannabis poisonings being reported to poison centres and emergency departments, which in some cases results in hospitalization. While national data is not available, a 2022 study noted the average rate of emergency department visits for cannabis poisonings in Ontario among children up to nine years of age increased from 2.5 visits per month in the period before legalization (January 2016 to September 2018) to 22.6 visits per month after edible cannabis products became widely available (February 2020 to March 2021). [31] Hospitalizations for cannabis poisoning have also increased among children up to nine years of age. A study including Alberta, British Columbia, Ontario, and Quebec found that the combined count of childhood cannabis poisoning hospitalizations rose from 120 in a 45-month period before legalization and increased to 356 in a 21-month period between January 2020 and September 2021, after edible cannabis became legal for sale. Larger increases were noted in Alberta, British Columbia, and Ontario than in Quebec. [32] A related study of the same provinces found cannabis has become an increasingly common cause of childhood poisonings, rising from 3% of poisoning hospitalizations in 2015 (20 out of 651) to 29% in 2021 (179 out of 617). [33] Typically, the source (illicit versus legal) of the cannabis product involved in these incidents is unknown. Common clinical presentations of cannabis poisoning among children include lethargy, coma, confusion, agitation, ataxia, nausea, and vomiting. [34]

What we heard

We have had limited direct engagement with youth thus far. We are planning additional engagement activities with youth and youth organizations before the end of 2023. The perspectives and voices reflected on youth issues below include those from youth, youth advocates and organizations, researchers, and the public health community.

[16] Under the *Cannabis Act*, the possession of less than five grams of cannabis is not a criminal offence for those under 18 years of age.

Minimizing harms for youth and young adults

We heard that youth have a variety of reasons for using cannabis, including: to get high; to relieve emotional, social, and mental distress; post-traumatic stress disorder; trauma; anxiety; depression; loneliness; and stimulating appetite for eating disorders. Youth noted that discussions regarding negative impacts of cannabis are not prevalent in peer conversations; however, some youth highlighted conversations where concerns were raised about the harms of cannabis use, particularly from those who have a family history of schizophrenia or mental illness. Stakeholders also noted the impact of the COVID-19 pandemic on youth behaviour, and the need to consider youth cannabis use in a polysubstance context, especially with respect to alcohol. Some youth shared observations that alcohol use in their peer groups has been displaced, in part, with cannabis use; however, the substances are used in different contexts (for example, alcohol is used more in larger social settings, while cannabis is used more commonly in small group or individual settings). Some youth shared that they equate the quality of cannabis to the quantity of THC in the product and the price point.

We heard concerns about the ease with which youth have access to cannabis, including from illicit sources, such as through dealers and illicit websites that do not verify consumer age. There is also peer access, both in terms of sharing and selling. Youth discussed that they generally do not perceive buying illicit cannabis as a high-risk activity (from the perspective of potential for interactions with law enforcement or the criminal justice system), as they typically purchase it from someone they know in small or moderate amounts.

Some noted that exposure to illicit promotion continues to occur, including from advertisements outside of retail stores and advertisements on social media, especially on applications and websites most commonly used by youth (for example, Instagram and SnapChat). It was noted that the number of cannabis promotions is comparatively lower than in U.S. states where cannabis is legal.

In terms of cannabis-related harms, we heard that there have been increases in health care visits related to cannabis use. Stakeholders highlighted research describing significant increases since legalization in child hospitalizations due to the accidental ingestion of cannabis, particularly edible cannabis. We heard from officials that these increases led to the some of the public education efforts described earlier in this chapter. We were also told that similar to other public education initiatives, there has not been a formal evaluation of the effectiveness or impact of the public education efforts related to youth.

With respect to accidental ingestion by children, while the source of the cannabis is often unknown, it was suggested that some reported incidents could have been caused by improper storage of legal cannabis (including homemade edible products) and there were recommendations to maintain or increase restrictions on edible cannabis products. Some public health participants suggested that to reduce the risk of accidental pediatric ingestion, controls on legal edible products, such as the following, should be maintained and strengthened to minimize harms:

- limiting the maximum concentration of THC in all product forms
- limiting children's access in the home by requiring lock boxes
- requirements for products to indicate cannabis content once removed from outer packaging, such as direct labelling on units of products

Others suggested that illicit products, which are often packaged to mimic conventional food products—like candy—represent a significant share of the incidents.

Cannabis product types are evolving and the impacts of some products (for example, high-potency vaping and edible products) on youth are uncertain. Some discussed areas of concern related to baked goods, chocolate, and candy-like cannabis products, and the appealing nature of flavoured vaping products among youth. We have not yet heard or seen data on the difference in health care harms between different types of cannabis products for ingestion (such as edibles versus extracts).

Research

Available data and research has a number of limitations, including: the short time that has passed since legalization; the impact of the COVID-19 pandemic on the ability to conduct representative surveys with youth to compare post-legalization to pre-legalization data, and the need for longer-term assessments of the COVID-19 pandemic. We also heard that there is a need to supplement school-based studies with research that involves marginalized and under-represented groups of youth and young adults (for example, First Nations, Inuit, and Métis youth, those experiencing homelessness, members of racialized communities, gender diverse people, sexual minorities, youth in the corrections system, and youth not in education, employment, or training), and to explore new research designs that will be more sensitive to policy changes. For example, inter-provincial and territorial comparisons might be more informative than pre-post legalization comparisons going forward.

Suggested research priorities for youth included: further work to understand the motivations or reasons for cannabis use, specific harms and their risks (for example, mental health, ways to limit risks of accidental cannabis ingestion among children from illicit sources and homemade edible products), and increased investments to support a variety of research methods.

Public education

Some participants reiterated the importance of public education and drug prevention initiatives for youth and those directly involved in supporting them, indicating that youth and young adults do not have sufficient access to credible, relevant, or reliable information, or skills, to make informed choices about cannabis. Specifically, youth discussed their lack of awareness of public education initiatives, except for advertisements on cannabis from Mothers Against Drunk Driving. Youth representatives emphasized that there is a need to co-develop evidence-based and non-stigmatizing information with youth.

We heard that youth perceptions of the credibility of information vary between sources, suggesting that the most effective public education is delivered by trusted adults, peers, and people with lived and living experience, compared to figures viewed as authorities, such as physicians or government. Some suggested that pharmacists could have a role in providing information on cannabis given their perceived credibility and presence in many communities.

Views about the framing and tone of public education were offered, with some stakeholders suggesting that current initiatives are too focused on abstinence and certain cannabis-associated risks, noting that the approach to the prohibition of cannabis prior to legalization continues to have lasting influences. Some encouraged a greater emphasis on pragmatic public education that dispels myths about cannabis and meets youth at various life stages and circumstances, starting as young as grade three with the provision of basic information about the cannabis plant. This education should acknowledge the risks of cannabis use while recognizing that some youth will use cannabis, and accordingly provide information on ways to reduce harms.

We heard that that there is a need for interventions beyond public education, such as capacity and resilience building. Some emphasized the need to focus on interventions that build skills and resilience in youth, families, and communities (for example, equipping youth with skills to decline offers to use cannabis, when presented the choice). They also noted that more comprehensive treatment programs are needed. These latter programs were recognized as requiring highly trained and experienced individuals to develop and deliver them. These programs were also recognized as needing sustained and predictable funding. Furthermore, concern was raised about the relative imbalance in reliance on public education relative to other types of interventions in the public health efforts directed at youth so far.

Youth expressed the need for the development of a cannabis-focused advisory body, similar to Health Canada's Youth Leadership Team on tobacco control and vaping, to advise on public education and other issues.

Youth and the criminal justice system

Under the *Act,* possession of less than five grams of dried cannabis (or its equivalent in other classes of cannabis) is not a criminal offence for those under 18 years of age. It was advocated by some that possession limits should be removed entirely, especially for youth, because the harms of criminalization are wide-reaching.

Youth noted that the illegality of cannabis possession for their age group often does not play a factor in their decision to use cannabis, noting similar sentiments for alcohol.

Many of the participants we spoke with noted that the legacy of the prohibitory regime that existed prior to 2018 had resulted in long-term negative impacts on young people that have interacted with the criminal justice system (for example, reduced education and employment opportunities).

We heard that a positive effect of the *Cannabis Act* was a dramatic reduction in the number of youth charged with cannabis-related offences. However, in the absence of disaggregated race-based data, it is difficult to ascertain if some youth remain disproportionately affected by criminal enforcement efforts.

Some participants emphasized that more focus be placed on addressing the underlying issues (for example, mental health, socio-economic status) that drive youth to unlawful activities with cannabis. They suggested improving access to and the delivery of diversion programs and community-based supports, including for mental health. Some indicated criminal enforcement efforts related to youth should focus on distribution and sale to youth by adults, with caution about underlying bias due to race.

Chapter 7

First Nations, Inuit, and Métis

Overview of measures

In June 2016, the Government of Canada appointed the Task Force on Cannabis Legalization and Regulation (the Task Force) to provide expert advice on the key features of a new regime to shape the development of the *Cannabis Act* (the *Act*) and its regulations. While the Task Force undertook engagement with some First Nations, Inuit, and Métis organizations, leaders, and representatives, it is recognized that this engagement was very limited. The Task Force provided recommendations[17] related to First Nations, Inuit, and Métis involvement in the new legal framework, but these did not translate into any specific legislative or regulatory measures.

Under the *Act* and its regulations, a federal licence is required to conduct various activities with cannabis, including cultivation, processing, and sale. Licence holders are responsible for complying with the *Act* and its regulations, as well as other applicable federal legislation, provincial and territorial legislation, and municipal or community by-laws. Under the *Act*, the provinces and territories have authority over the distribution and sale of cannabis under provincial and territorial law. The *Act* does not give authority to First Nations, Inuit, or Métis governments to issue licences for cannabis-related activities (for example, cultivation, processing, distribution, and sale of cannabis).

First Nations, Inuit, and Métis governments can create additional rules or requirements for cannabis-related activities (for example, zoning by-laws) in their communities through other established legislation and authorities such as the *Indian Act*, the *First Nations Land Management Act*, modern treaties and self-government agreements, or municipal authorities. However, these additional rules are limited in scope and must be consistent with, and not conflict with, the *Act* or frustrate its purpose. Health Canada and a few First Nations have entered into arrangements to support a cooperative application of federal and First Nations cannabis frameworks, consistent with the *Act* and its regulations. Health Canada provides support services specifically for Indigenous-affiliated federal licence applicants to assist them with the licensing process.[18]

The Government of Canada has provided funding to support First Nations, Inuit, and Métis governments and organizations to lead initiatives in areas such as research, public education activities, knowledge translation, prevention, harm reduction, treatment programming, and mental wellness services.

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17 The Task Force report, A Framework for the Legalization and Regulation of Cannabis in Canada, recommended that the federal government engage with Indigenous governments and representative organizations to explore opportunities for their participation in the cannabis market as well as with Indigenous communities and Elders to develop targeted and culturally appropriate communications.

18 The following services are available for Indigenous and Indigenous-affiliated applicants: (1) Indigenous Navigator Service: To guide and assist Indigenous and Indigenous-affiliated applicants, and answer requests from applicants for additional information; (2) Cannabis Licensing Advisor: Offers intensive advisory assistance to Indigenous and Indigenous-affiliated applicants that have strong support from the local Indigenous government and where direct benefits for the community are expected; and (3) Two-Stage review process: Indigenous and Indigenous-affiliated applicants may have their applications reviewed without a fully built site upon application. This allows for early feedback on an application that could help with financing and construction.

Data and observations

We recognize that the collection of information about cannabis use and its impacts on First Nations, Inuit, and Métis must be undertaken in a manner that supports and respects data sovereignty.[19] The results we present here have been drawn from a variety of publications, not all of which are distinctions-based or fully embody the principles of data ownership and control. We note the lack of disaggregated data for many indicators, and we recognize that summary statistics and results from national surveys can obscure important variations within and between communities. We acknowledge that communities have varying perspectives on cannabis and have had diverse experiences that are not captured or conveyed by the quantitative data we describe below.

The 2023 review prepared by the National Collaborating Centre for Indigenous Health [35] and earlier reviews [36] [37] provide summaries of the limited evidence that is currently available. All recent reviews underscore the substantial gaps in knowledge that persist, and the lack of research conducted with First Nations, Inuit, and Métis who use cannabis—particularly in the post-legalization period. While the lack of empirical evidence impedes our effort to assess the impacts of the *Cannabis Act* on First Nations, Inuit, and Métis, some sources of data exist and are presented below. However, we will rely heavily on views expressed during engagement activities, which are outlined in the "What we heard" section.

First Nations

Prevalence of, and factors associated with, cannabis use

Data collected by the First Nations Regional Health Survey in 2015–2016 indicated that before legalization, 30% of First Nations adults on-reserve and in Northern communities reported using cannabis in the past-year, while 12% reported daily or almost daily use. Among First Nations youth (aged 12 to 17), the First Nations Regional Health Survey noted a decrease in past-year use of cannabis between 2008–2010 and 2015–2016, from 36% to 27%. [38]

More recently, the Thunderbird Partnership Foundation's Indigenous Community Cannabis Survey has resulted in the completion of nearly 700 adult and youth surveys, collecting data on cannabis use during the COVID-19 pandemic. It found that 40% of respondents who used cannabis were using it more often than before, and 20% of respondents who used cannabis had started using during the pandemic. Respondents cited stress, anxiety, the need to get high, and dealing with trauma among the reasons for using cannabis. [39]

The Thunderbird Partnership Foundation's 2021–2022 annual report presents summary information from the Addictions Management Information System, drawing on data provided by 35 treatment centres that provide services to either youth or adults (through the National Youth Solvent Abuse Program or the National Native Alcohol and Drug Abuse Program). Between April 2021 and March 2022, three-quarters (76%) of adult clients, and 82% of youth clients, reported cannabis use, with cannabis being the second most prevalent substance reported by youth receiving treatment, after tobacco. [40]

[19] Data sovereignty refers to a jurisdiction's authority and right to govern and control the data generated within its jurisdiction.

Inuit

Prevalence of, and factors associated with, cannabis use

The 2020 review by Wolfson et al. summarizes evidence related to cannabis use by Inuit and other Indigenous Peoples in Canada. It highlights evidence related to cannabis use during pregnancy, high rates of cannabis use in Inuit Nunangat[20], potential factors associated with cannabis use (for example, being male, being a youth (15–19 years old), having a lower body mass index (BMI), having a lower income, and having lifetime problem-gambling), and stigma which may present barriers to open discussion of cannabis use. [36] Many of the studies reviewed by Wolfson et al. examining cannabis use rely on data collected before legalization, underscoring the need for up-to-date research.

The 2017 Qanuilirpitaa? Health Survey, conducted on the health status of Nunavimmiut[21] residing in 14 communities in Nunavik, found that nearly two-thirds (63%) of respondents aged 16 or older had used cannabis in the past 12 months, representing an increase from 58% in the previous survey in 2004. Past-year use was higher among men (74%) than women (53%), although the survey noted a significant increase in cannabis use prevalence among women since 2004. Daily use was reported by 32% of respondents and was more common among both younger men and younger women (aged 16–20) than older age groups. [41]

Pauktuutit Inuit Women of Canada shared the findings of their Cannabis in Our Communities project with us, which incorporated information collected through discussion groups, interviews, and an online survey conducted in 2020. Among the findings, it was observed that 92% of respondents to the survey said cannabis use was common or very common in their communities, and 70% believed it was becoming more common. [42]

Métis

Prevalence of, and factors associated with, cannabis use

The May 2023 workshop on Mental Health and Cannabis convened by the Métis National Council created an opportunity for dialogue, including discussion about the current state of evidence regarding the effects of cannabis and cannabis legalization. We look forward to further engagement with the Métis National Council to improve our understanding of the impact of cannabis legalization.

Findings from the 2017 Indigenous Peoples Survey[22] showed that 78% of Métis reported having not used cannabis in the past 12 months and 22% had used cannabis in the past 12 months. Cannabis use was more common among Métis people aged 18–34 (37%), and males were more likely to report use than females (26% vs. 18%). The report suggests that due to the higher prevalence of environmental risk factors among Métis (such as intergenerational trauma, racism and discrimination, poverty), Métis people are at a higher risk for negative mental health outcomes of cannabis use. Common risk factors in youth who reported early and frequent cannabis use were poverty, feeling deprived, and engaging in risk taking behaviours. [43]

In 2019, the McCreary Centre Society published a profile of Métis youth (aged 12 to 19) in British Columbia (BC), which drew on pre-legalization results from the 2018 BC Adolescent Health Survey. Key findings include that 42% of Métis youth in BC had used cannabis in their lifetime (compared to 25% of non-Métis youth), and that lifetime cannabis use prevalence was similar to 2013, but lower than the estimate of 48% from 2008. [44]

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20 Inuit Nunangat includes 4 regions: Inuvialuit (Northwest Territories and Yukon); Nunavik (Northern Quebec); Nunatsiavut (Labrador); and Nunavut.

21 Nunavimmiut refers to Inuit residing in Nunavik.

22 As cited in the 2022 State of Métis Knowledge on Cannabis and Mental Health in Canada report from the Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction, and the Métis National Council.

Supplemental information from general population surveys

Several general population surveys ask respondents whether they identify as First Nations, Inuit, or Métis. These surveys are not representative of the First Nations, Inuit, or Métis population but can provide supplemental information. The Canadian Alcohol and Drugs Survey (which excludes people living on-reserve and does not sample in the territories) found that 30% of approximately 300 respondents that self-identified as a First Nations, Inuk, or Métis person reported using cannabis in the past 12 months in 2019, which was not significantly different from the result of 27% in 2017. Prevalence of cannabis use was higher than it was among people who did not self-identify, for whom the rate was 14% in 2017 and 20% in 2019. [45]

Results of the Canadian Cannabis Survey also suggest that the prevalence of past-year use of cannabis for non-medical purposes was higher among respondents who self-identified as a First Nations, Inuk, or Métis person than it was among those who did not self-identify, with the 2022 cycle finding that 36% of Indigenous respondents reported past-year use, compared to 28% of respondents that did not self-identify. Daily or almost daily use of cannabis for non-medical purposes was higher among those identifying as a First Nations, Inuk, or Métis person (14% of self-identified respondents reporting daily or almost daily use in 2022 as compared to 7% among those that did not self-identify). [46]

Representation in the cannabis industry

Applicants for federal cannabis licences issued by Health Canada can self-identify to indicate whether the company is Indigenous-affiliated.[23] As of March 31, 2023, there were a total of 913 licence holders—55 (6%) were Indigenous-owned or -affiliated companies authorized to cultivate or process cannabis [47], including six located in First Nations communities. Of these six, four were located within First Nations communities in British Columbia, one in Quebec, and one in Ontario. As of the same date, an additional 44 self-identified Indigenous applicants were at various stages of the federal licensing application process, representing 29% of the total number of the 151 applications in the queue. [47] Among more than 900 companies licenced for activities with hemp, 27 (about 3%) are Indigenous-affiliated, with one Indigenous-affiliated hemp licence applicant in queue.

Surveys of the cannabis industry have also asked about the demographics of company leadership, including Indigeneity. A 2020 study, led by the Centre on Drug Policy Evaluation, found that among 700 executives and directors surveyed from 222 organizations, Indigenous individuals were under-represented, constituting 2% of cannabis industry leaders (compared to approximately 5% of the Canadian population). [48] In a subsequent survey of licence holders conducted by Health Canada, 51 companies provided information regarding Indigenous representation in leadership. Forty-four licence holders (13% of the 334 that completed the survey) indicated there was some Indigenous representation in leadership positions. Among these 44 licence holders, 12 indicated that half or more of leadership positions were occupied by an Indigenous person, and 32 indicated that at least one person, but less than half, of their leadership team was Indigenous. [49]

A February 2023 article in an industry periodical suggested that less than 1% (24 of more than 3,300) of the provincially- or territorially-authorized retail stores are operating on First Nations reserves. [50] At the time of the writing of this report, a website maintaining a directory of Indigenous cannabis dispensaries across North America identified hundreds of dispensaries in Canada; [51] while some of these dispensaries may be compliant with community-based laws and regulations, the vast majority do not appear to be complying with federal or provincial laws and regulations.

[23] Self-identification is optional; any person or persons of First Nations, Inuit, or Métis descent, or any community, organization, or company associated with a First Nation, Inuit, or Métis government, organization, or community may identify as Indigenous-affiliated.

Interactions with the criminal justice system

There is a lack of data on the impacts of legalization on cannabis-related interactions between Indigenous individuals and the criminal justice system. Data collected on police-reported incidents and criminal charges does not currently disaggregate by Indigeneity, race, or ethnicity, although work is underway to enhance the collection and reporting of this information. An academic analysis of pre-legalization cannabis arrest data in five Canadian cities[24] found Black and Indigenous Peoples were over-represented among those arrested for cannabis possession, with particularly large disparities in the rate of arrests of Indigenous individuals in Vancouver and Regina. In Vancouver, Indigenous persons accounted for 15.6% of arrests for cannabis possession in 2015, while only 2.5% of the city's population was Indigenous. In Regina, 9.2% of the population was Indigenous, but 31.3% of cannabis arrests in 2015 involved an Indigenous person. In Vancouver, Calgary, Regina, and Ottawa, Indigenous Peoples were between three and six times more likely to have been arrested for cannabis possession than their representation in the city population would predict. [52]

What we heard

Distinctions-based engagement

As mentioned in Chapter 3, we have adopted a distinctions-based approach to our engagement with First Nations, Inuit, and Métis people. We have sought to engage at the individual, community, regional, and national levels.

We recognize the perspectives and recommendations outlined in the Standing Senate Committee on Indigenous Peoples (the Standing Senate Committee) report "On the Outside Looking In: The Implementation of the *Cannabis Act* and its effects on Indigenous Peoples." We have noted the recommendation "that the Expert Panel engage in substantive consultations and propose solutions to the problems raised by Indigenous Peoples related to legal jurisdiction, enforcement, equity and inclusion in the industry, and mental health and substance abuse and that funding be made available to Indigenous Peoples during this process." We acknowledge the Standing Senate Committee's statement that its recommendations are largely focused on First Nations as the Committee was unable to hear from many Inuit and Métis witnesses due to the COVID-19 pandemic. We agree with the Standing Senate Committee that Inuit and Métis perspectives related to cannabis are essential.

Direct engagement has occurred with BC-based First Nations, the Mohawk Council of Kahnawà:ke, Williams Lake First Nation, Shxwhá:y Village, representatives of the four Inuit regions [Inuvialuit (Northwest Territories and Yukon); Nunavik (Northern Quebec); Nunatsiavut (Labrador); and Nunavut], the Manitoba Métis Federation, and the Métis National Council and its members (for example, Métis Nation of Ontario, Métis Nation of Alberta, Métis Nation of Saskatchewan, and Métis Nation of British Columbia). Engagements have been both on- and off-reserve, depending on their suitability or the preference of the groups. We planned these meetings with partners by co-developing agendas to ensure that we were asking questions in the areas that were relevant and important to partners. We would like to extend our sincere thanks to those who partnered with us to co-plan the distinctions-based engagement activities.

[24] This study focused on five large Canadian cities (Vancouver, Calgary, Regina, Ottawa, Halifax) using data on arrests provided by the respective police services under Freedom of Information laws. The authors did not identify why these five cities were selected; however, they did call for further research on the matter.

During these engagement activities, there were a few common themes that were raised by almost all groups. We heard continued frustration about the inadequate engagement with the Task Force and the federal government during the development of the *Act* and its regulations. A theme that was repeated at every meeting was a desire for the principles of the *United Nations Declaration on the Rights of Indigenous People Act* (UNDRIPA) to be reflected in the *Cannabis Act*.

We also heard, as did the Standing Senate Committee, that research needs to be conducted to understand the effects of cannabis legalization on the health of First Nation, Inuit, and Métis peoples. This research should be owned and used by communities to inform public health education and approaches. We note that the Standing Senate Committee recommended that Health Canada and Indigenous Services Canada work with Indigenous Peoples and communities to: (1) establish and fund a research strategy on cannabis and its effects on Indigenous Peoples and communities; and (2) provide funding for the development and update of Indigenous-led public health information on cannabis. The Committee also recommended that Health Canada and the Canada Revenue Agency work with Indigenous Peoples and communities to undertake a review of their application processes for all cannabis-related licences.

The following sections describe in more detail what we heard from First Nations, Inuit, and Métis organizations, leaders, and representatives. The distinctions-based approach to engagement with First Nations, Inuit, and Métis communities provided an opportunity for representatives to raise the issues and concerns that were most important to them; each of the discussions we had with the communities we engaged with was unique and shed light on a distinct set of priorities.

The following information is not exhaustive and does not reflect the knowledge, opinions, and beliefs of all First Nations, Inuit, and Métis, including those who live off-reserve. They are representative of those we have engaged with to date. We recognize that there may be differing perspectives from communities which we have not had the opportunity to engage with. We will continue to engage with interested First Nations, Inuit, and Métis to assess the impacts of the *Act* on their communities, and to outline priority areas for actions, findings, or recommendations.

First Nations

Jurisdiction

Many First Nations organizations, leaders, and representatives noted that the issues of jurisdiction and the recognition of their inherent rights to self-determination are not new for First Nations. First Nation governments took the view that the lack of express authority for First Nations governments is a shortcoming in the *Act* and asserted the need to align the legislation with United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). We note that the Standing Senate Committee heard similar calls and it recommended that the Minister of Health introduce legislation to amend the *Cannabis Act* to permit First Nations to regulate the possession, sale, and distribution of cannabis on their lands.

We heard that many First Nations governments and communities want to assert their sovereignty over cannabis activities in their communities. We also heard that some First Nations governments and communities are already exercising their sovereignty (that is, overseeing cannabis activities such as licensing of cultivation and processing and retail operations outside of federal, provincial, and territorial legal frameworks) in this area. Most apply the same public health and public safety objectives as the federal, provincial, and territorial governments.

We heard concerns that while provincial and territorial frameworks do enable some recognition of, and flexibility for, First Nations decision-making over cannabis activities, this is not adequate. It was suggested that provinces and territories should recognize retail stores authorized by First Nations or that the federal government should allow First Nations to authorize retail sales, similar to how provinces and territories authorize retail, so the stores could sell products produced by federal licence holders. One First Nations community is interested in obtaining federal support for community-regulated cannabis retail stores if it is not able to come to an arrangement with the relevant provincial or territorial government. The community noted that it has no concerns about their ability to issue and oversee licences safely.

This community is also concerned that if it does not provide regulated retail access to community members, illicit sales will proliferate and cause serious problems (for example, issues with illicit cannabis products causing harm to health, the potential for more dangerous criminal activity from undeclared cash-based businesses).

Some First Nations representatives highlighted that not all communities wish to fully replicate or duplicate the various federal and provincial and territorial rules, standards, and oversight of the supply chain (for example, cultivation, processing, and retail) but want recognition of their authority and jurisdiction over industry in their communities. We understand that the scope of authority being sought often depends on the First Nations community and its leadership; as such, there is not a consensus view. We heard from some First Nations that are willing to work within the federal, provincial, and territorial frameworks, and from others interested in working only within the federal framework, while other First Nations want to oversee and have decision-making authority over all cannabis activities in their communities.

While select First Nations governments have negotiated agreements that allow them to control the sale of cannabis, they are still required to collect sales tax for other orders of government. Many continue to advocate for arrangements in which they would receive all, or a share of, cannabis sales and excise tax revenues generated from within their communities in order for the revenues to be reinvested. Some seek tax-sharing agreements with federal or provincial and territorial governments, while others seek amendments to tax laws to provide opportunities for interested First Nations to levy their own cannabis excise tax in their communities. Many argue that federal or provincial and territorial sales tax revenue should be directed back into their communities.

Representatives recommended that the recognition of First Nations authority be embedded in the *Act* to allow for each First Nation to exercise their own sovereignty, governance, and jurisdiction over cannabis activities. Some emphasized that these changes to the *Act* need to be co-developed with First Nations. In the spirit of recognizing the nation-to-nation relationship with the federal government, these changes should include provisions for retail oversight by First Nations rather than the provinces and territories. Representatives noted precedents for such models in other areas, including legislation that recognizes federal, provincial, territorial, and First Nations governments in relation to child welfare.

Public health and public education

Some First Nations raised concerns about the harms of cannabis use (for example, psychosis, depression, anxiety), including for young people, as well as harms associated with unregulated products (for example, potential for mould and pesticides, and incorrect labelling of tetrahydrocannabinol (THC) potency), and harms related to the use of cannabis with other substances (for example, over-consumption and poisoning). Concerns were raised that some youth have more access to cannabis products since legalization, including illicit products.

Some First Nations called for a better understanding of the impacts of historical and intergenerational trauma. Others discussed the need for more data on the effects of the COVID-19 pandemic on cannabis use. They are observing an increase in cannabis use, especially for youth, which is impacting mental health. In addition, some communities are still seeing an increased incidence of thoughts of suicide, domestic abuse, and community violence. One First Nations addictions service has observed an overall negative impact on clients' ability to follow treatment and an increased relapse of cannabis use since legalization, acknowledging that the pandemic has impacted substance use.

One First Nations researcher explained that the most important issue related to public health is the lack of primary health care and public health resources for mental health and polysubstance use, including the lack of resources to support culturally-relevant and trauma-informed cannabis information and public health interventions. We heard that while there are nursing stations in most communities, these stations often do not have sufficient capacity to address substance use issues. We heard that public health interventions for First Nations must be situated within a framework of lived and living experience and consider intergenerational trauma. Some representatives noted that there is a lack of harm reduction and community-based addictions programming in First Nations communities. It was noted that if there was better access and availability of public health resources for First Nations, this would help to increase understanding about cannabis and its effects.

In terms of public education, some First Nations representatives highlighted a need for culturally-appropriate awareness and education about the effects of cannabis use. One community suggested that profits or taxes collected from the cannabis industry should fund programs such as public education, research, and prevention. Another community noted information on cannabis is being shared in a way where traditional knowledge is being mixed with modern understandings of the plant and encouraged this to be considered as a model.

Cannabis for medical purposes

Some First Nations representatives suggested that there is an opportunity to utilize cannabis for medical purposes as an alternative to other Western medicines, pharmaceutical drugs, and other drugs, both for pain relief and as a harm reduction tool. It was noted that some Elders prefer cannabis products over prescription medications to treat pain or post-traumatic stress disorder. Some representatives explained that some people in their community view cannabis as a plant medicine, and therefore encompassed within their traditional knowledge, ways of healing, and inherent rights. They reported that Elders sometimes use cannabis and infuse it with other traditional remedies. Some advocated for recognition of Elders' use of cannabis and other traditional plants. However, some noted that there is also uncertainty about the traditional use and historical place of cannabis in the health of First Nations.

It was also suggested that there has been an improvement in the availability of cannabis for medical purposes; however, concern remains about the cost and lack of reimbursement under drug insurance plans. We note that the Standing Senate Committee recommended that Indigenous Services Canada cover cannabis for medical purposes under the Non-Insured Health Benefits Program (which applies only to First Nations and Inuit).

One First Nations community voiced concerns that the personal and designated production program is not well regulated, that it is too easy to get a medical document from a health care professional, and there is little to no oversight or enforcement, which may result in abuse of the system.

Public safety

First Nations representatives raised several issues related to public safety and enforcement, including the involvement of non-Indigenous investors in certain aspects of the grey market on First Nations land and cannabis products being produced in unregulated facilities, which pose liability and safety issues for grey market operations and the community (for example, inability to secure insurance, contaminated products).

Some First Nations communities and their policing services report they face the same kind of capacity and prioritization issues as non-First Nations police, compounded with the additional challenge of expiring funding agreements. One First Nations community representative highlighted that their Nation is unable to enforce the laws that it passes and needs the Royal Canadian Mounted Police to enforce community laws. They noted that this lack of enforcement capability applies broadly to the community's laws and is not a cannabis-specific challenge. It was noted that the illicit market is still strong in many communities.

Communities are also concerned about other issues related to cannabis (such as break-ins at the homes of company owners as many store cash in their homes due to lack of banking options) and public safety issues resulting from increased traffic from off-reserve individuals coming to their land to purchase cannabis.

We also heard concerns about unauthorized retail stores and how communities are often supportive of enforcement actions taken to disrupt illicit operations on reserves. Unauthorized storefronts are a major problem in some communities, while they present little to no concern in others. Representatives also noted that not all these stores are viewed as illicit by their communities, depending on the community's approach to cannabis legalization.

One First Nations community noted it wished to work collaboratively with governments to be legitimate industry participants. They indicated that working outside of the legal market would limit its access to a regulated supply of cannabis (that is, cannabis produced by a federal licence holder) and the potential for law enforcement intervention, including charges of their employees for being involved in illicit production activities.

We note that the Standing Senate Committee heard calls for increased funding and training for First Nations police services to be able to enforce their own cannabis laws and drug-impaired driving laws. We also note that it recommended the Government of Canada establish legislative mechanisms for the enforcement of band by-laws and other laws related to cannabis by all police services and ensure adequate funding is available to Indigenous communities.

Economic development and taxation frameworks

Many First Nations interested in participating in the legal cannabis market noted that their main objectives for entering it are to create jobs and economic benefits within their communities, and that they view cannabis business opportunities as a form of economic reconciliation. One First Nation shared that people in their community face trauma (for example, violence, elevated suicide rates, missing and murdered women) and poverty every day and that the cost of such trauma and poverty is unquantifiable. They emphasized that efforts to heal should include working towards economic sovereignty.

Some First Nations emphasized that participation in the legal market must be viable and profitable, cautioning that if economic challenges in the industry persist, communities may be forced to close legal operations and return to the grey market. These challenges are not unique to First Nations businesses. Some Indigenous-affiliated small federal licence holders highlighted several issues, including:

- the dependence of smaller companies on larger licence holders, who are competitors, to sell their products to distributors due to the volume required by distributors and federal rules restricting cultivators from selling dried cannabis to distributors
- information requested by Health Canada and the Canada Revenue Agency is burdensome and often duplicative
- competition from the illicit market, including abuse by some individuals who hold registrations within the personal and designated production program
- promotion and packaging requirements are too restrictive and should be amended to allow for information on health effects and Indigenous branding
- the need for more education about the therapeutic properties of cannabis

We heard concerns from some First Nations that, depending on the retail model, the province or territory can be in a conflict of interest as both a regulator and a competitor operating publicly-run retail stores. Some First Nations suggested that provinces and territories are not taking sufficient enforcement actions against illicit stores (for example, using authorities for civil forfeiture). One First Nations federal licence holder asserted that the province would not allow for any competitive advantages for First Nations companies (for example, tax or fee relief, lower mark-ups, freedom to move product between nations).

Some First Nations leaders noted that one of the biggest challenges for First Nations interested in participating in the legal cannabis industry is the cost. They noted that entering the industry is very capital intensive, and discussed the difficulty to obtain insurance, financing, and loans. Some communities that have entered the legal market have not been able to sell product to distributors and have consequently not seen any economic benefit. Some First Nations participating in the industry provided the following recommendations:

- eliminate or reduce taxes and regulatory fees
- invest in the First Nations communities to fund programs for education, research, and prevention
- lessen restrictions on promotion to support brand differentiation and competition
- recognize cannabis as an agricultural product to support easier access to capital and financing
- take more enforcement action with respect to the grey market, coupled with incentives for First Nations communities to transition into the legal market

Some First Nations organizations, leaders, and representatives noted the need for a more advantageous tax arrangement and supports for economic development. Some suggested that financial incentives or relief (such as being exempt from or being eligible for reduced provincial mark-ups or fees) for those participating in the legal cannabis industry would be an act of economic reconciliation and part of the solution to help alleviate economic challenges such as high rates of unemployment. Other representatives emphasized that true commitment to reconciliation involves recognizing First Nations as a constitutional partner and righting the historic wrongs that continue to economically disadvantage First Nations. They pointed to the under-representation of First Nations in the legal industry, arguing that allowing the illicit industry to grow is a much larger risk than the relatively minimal impact of providing some advantages to First Nations. Furthermore, some First Nations representatives discussed the difficulties they face entering and competing in the legal market because they feel other groups have been given a "head start."

The Standing Senate Committee also highlighted the interest of First Nations in participating in the market and having access to revenues generated from it. It recommended that:

- Finance Canada work with First Nations to identify options for the development of an excise tax-sharing framework as part of its discussions on the fuel, alcohol, cannabis, and tobacco tax
- Finance Canada and Indigenous Services Canada work with First Nations communities to identify options for the establishment of a First Nations-led agency to support First Nations participation in the cannabis market

Inuit

Public health and harm reduction

Inuit representatives noted that while the cannabis plant was not traditionally grown in Inuit communities, cannabis use, often in combination with other substances, is common and increasingly normalized in Inuit communities. They noted perceptions among some Inuit, including that:

- cannabis use has both harms (for example, negative impact on healthy brain development, addiction) and benefits (for example, relief from stress, depression, and pain)
- cannabis use is less harmful than alcohol, including for sub-populations such as pregnant people
- cannabis may be contributing to declining use of heroin, crystalline methamphetamine, and gas sniffing

It was also noted that many Elders are not supportive of cannabis use and that youth had more understanding of harms and benefits of cannabis use compared to adults, including Elders.

Some Inuit representatives, including those from Nunatsiavut and Nunavik, highlighted that alcohol is the main substance issue in their regions and is a greater public health and public safety concern. Community police services have noted that criminality is more often linked to alcohol use than cannabis use. Young adults (aged 18+) perceive cannabis as being less unhealthy and less risky than alcohol.

Some Inuit representatives explained that illicit high THC cannabis products (for example, edibles, butter, wax, and vape pens) are increasingly available, and marketed to youth. High volumes of these products are ordered online from British Columbia and shipped via Canada Post, including into regions (for example, Nunavik) where provincial and territorial law prohibits their sale (for example, Quebec).

Some Inuit representatives noted that Inuit youth are believed to be mostly smoking dried cannabis and using solid cannabis extracts (such as hash and shatter). They expressed their concerns about children as young as eight years of age using cannabis and continuing to do so into adolescence, noting that poverty, intergenerational trauma, and a lack of public education contribute to the early use of cannabis. They also shared that there is anecdotal evidence pointing to worsening mental health among youth who use cannabis. They noted that while cannabis use among children and youth was common before legalization, there is a belief that rates of use have increased post-legalization due to the normalizing effect of the legal status of cannabis. Representatives also highlighted concerns about youth mixing cannabis with tobacco, and heating cannabis with knives using butane, which has led to public health and safety issues such as explosions and shed fires.

It was noted that some Inuit communities are abstinence-focused ("dry"), with little harm reduction information available. As such, there is still a stigma about use, which limits discussion of the impacts of cannabis use. However, cannabis is considered as a harm reduction tool for other substances in some Inuit communities. Representatives noted that switching to daily cannabis use was found to be beneficial for some previously-incarcerated individuals with alcohol use issues. Conversations about substance use are needed,

as perceptions are often extreme, with some people perceiving the only options as either abstinence or addiction. It was also discussed that "impact management" may be a more effective term for Inuit than "harm reduction," which implies there is potential harm in every situation.

We heard that there is a need for more funding to support Inuit in addressing substance use and mental health issues, with a focus on prevention, such as for Northern healing centres and for addressing a growing suicide crisis. We also heard about challenges around recruiting and retaining medical staff and health care professionals who are more familiar with Inuit ways of knowing.

Culturally-safe public health education and research

Inuit representatives noted that pan-Indigenous materials are not appropriate for Inuit communities because First Nations and Métis have different relationships to plant medicine and because cannabis was not traditionally grown in Inuit communities. They highlighted that Inuit-specific, culturally-safe, and relevant materials, as well as safe places to discuss cannabis use, are crucial but not widely available. They commented that there is a lack of information and education, especially for children, pre-teens, teens, and Elders. They stressed that public education needs to be distinctions-based and regionally-specific across Inuit Nunangat.

They explained that education should address harm reduction and take a polysubstance approach that accounts for trauma. We heard that it is important that communities be provided with the resources to develop, control, and deliver their own messaging. A multi-method approach that considers the unique context of Inuit communities is required for the transmission of public education messaging. For example, radio is an effective tool in Inuit communities that could be harnessed for public service announcements and discussions. Inuit-led public education and prevention programs are also needed in schools.

Some Inuit representatives highlighted that some Western health care professionals are not trusted sources for cannabis information often because they tend to demonize drugs. There continue to be issues of turnover of health care professionals, a prevalence of racism in health care delivery, lack of cultural competence among providers, and generally negative experiences with health care professionals and systems. Cannabis users are often sought out for information along with older Inuit, those with lived and living experience, and retailers, who are seen as more trustworthy than health care professionals.

Some Inuit representatives explained that Inuit purchase cannabis from both legal and illicit online sources but that it is unclear whether they know how to differentiate between these sellers, arguing for further education for all ages to fill this knowledge gap.

In terms of research, it was noted that more Inuit-led data collection, analysis, interpretation, and data sovereignty is needed, and that Inuit have historically been subjected to Western-led research, resulting in distrust of non-Inuit led research.

Some Inuit representatives explained that while Western researchers and policy makers emphasize the impacts of cannabis through a scientific lens, it is more effective for Inuit to understand cannabis using traditional Inuit approaches. Public education and research must be transmitted in culturally-sensitive ways so that it is more accessible. An approach suggested was to apply examples and analogies already known to Inuit people. One example was given for positioning ways to minimize the risk of over-consumption that would resonate for Inuit, for example, drawing a comparison between consuming too much cannabis with the known cultural warning to not eat too much seal fat for fear of illness. If cannabis is understood as a medicine, it can be treated as such and with respect. However, it was noted by some Inuit representatives that this must be balanced with the understanding that natural medicine is not understood by Inuit to include cannabis so framing it this way may further encourage youth use.

With high rates of fetal alcohol syndrome, some Inuit representatives wondered if fetal risks are lower with cannabis use and suggested that more research on this topic would be useful. In addition, it was suggested that more research, prevention, and public health promotion is needed for pregnant Inuit who may use cannabis.

Accessing quality-controlled supply

Some Inuit representatives noted that barriers to accessing legal cannabis can result in consumers turning to the illicit market. They suggested that, anecdotally, the illicit market has a majority share, but noted that data is unavailable to confirm the percentage of illicit sales compared to legal sales in Inuit Nunangat. They highlighted that there is only one territorially authorized store in Inuit Nunangat and residents often lack access to credit cards and the Internet, which leads to challenges accessing legal supply. Home cultivation in the North is not a realistic or viable option to improve access due to the climate and over-crowded housing conditions. Some Inuit representatives noted that cannabis is generally being accessed through community members or trusted users and not legal retailers. Access to a quality-controlled supply of cannabis is viewed as a harm reduction tool, since if people have cannabis use dependency, they may be more likely to put themselves at risk to secure supply (for example, travel on poor ice).

On price, some Inuit representatives stressed that the government must offer competitive pricing to undercut illicit sales.

It was noted that some people in Inuit Nunangat want greater access to legal retailers but that there is a persistent stigma associated with any type of cannabis sales. It was further suggested that this fear of stigmatization is a barrier for individuals who may want to publicly support legal sales. They also raised the issue of being subject to racism in legal stores in urban centres in the South.

Métis

Public health, including mental wellness and substance use

We heard from Métis National Council representatives that they need to be seen as a distinct group and treated as equals, receiving their own recognition, rights, funding, and resources. Within the Métis Nation, there are also unique regions and communities as well as unique populations (2SLGBTQIA+). Public health and health care systems, supports, and programs need to be distinctions-based, co-developed, and with consideration of a wide range of needs.

Métis representatives reported that there has been an increased use of cannabis by Métis following legalization, with the main reasons being to help with sleep or relaxation, relieve physical pain, socialize, or decrease anxiety. Many noted the higher use of cannabis among youth and 2SLGBTQIA+ people, and how this demonstrates the importance of focusing more research and programming on these populations.

We heard views that cannabis use disorder can have an adverse impact on mental health, which points to the need for culturally-safe and evidence-based treatment that moves beyond education to overall health promotion.

On harm reduction needs, representatives expressed the need for distinctions-based and trauma-informed supports. They highlighted the need for support for collaboration across the Métis homeland with culturally-informed provincial, territorial, and federal partners. They suggested that harm reduction measures and programs must consider the community and family level. Programs must also consider individual needs, including age, gender, and culture. Representatives discussed that some programs and initiatives have been established, such as the Métis Nation of Ontario Community Based Intensive Addictions Program; however, these are often only offered on a short-term basis due to funding. They discussed that long-term, flexible, and sustainable funding is needed to develop, implement, and evaluate harm reduction programming.

Stigma and negative perceptions of cannabis use still exists. Some Métis representatives noted that there is mistrust of the health care system and of law enforcement as people fear negative repercussions if they disclose experiences with cannabis.

Research and education

Métis representatives confirmed that there continues to be a dearth of Métis-specific data, which often results in researchers making inferences from small pieces of data from pan-Indigenous studies. This is partly due to limited prioritization of Métis-specific and distinctions-based research by funding organizations such as the Canadian Institutes of Health Research. Representatives discussed that research on cannabis use trends among Métis must be conducted in culturally-relevant ways that are consistent with Métis ways of doing research (such as, by Métis, for Métis and including the participation of community members within the research process) to accurately understand the patterns of use in communities, and the factors that influence these patterns of use.

There is a need for Métis-led community-based research and data collection. We heard that long-term, sustainable, and flexible funding is needed to generate more specific data, including data on a variety of sub-populations, including the Métis 2SLGBQTIA+ populations, pregnant and parenting Métis, youth, and Elders. We heard that findings from a community-based research study on perspectives on cannabis amongst Métis will be available later this year. Future research should include motivations for cannabis use, intersectionality (such as gender), polysubstance use, and chronic pain.

Métis representatives highlighted that there are gaps in public education as this information is not created or supported by Métis communities and is sometimes not culturally-relevant. They noted that there is a need for Métis-specific public education programs, with targeted, direct, and community-led communications to reach Métis people. They suggested that it is unclear if any of the government funding that was available for public education, such as the $62.5 million provided to community-based and Indigenous organizations through Health Canada's Substance Use and Addictions Program, was allocated to any Métis organizations. They noted that Health Canada's website that includes cannabis resources is not user friendly, not specific to Métis, and not relevant for all Métis youth. They discussed the need for the development of Métis-centered public health materials, anchored in culture, young people's experiences, and harm reduction.

Métis representatives highlighted that health care professionals need to improve their literacy around the medical use of cannabis, including its risks, benefits, stigma associated with cannabis use, and their role in facilitating access. Health care and social services providers also need education and training to improve their understanding of Métis culture, Métis social determinants of health, intergenerational trauma (especially residential and day school trauma), and self-determination.

Economic development

We heard that Métis face barriers to participating in the cannabis industry, and want Métis-specific investments, resources, supports, and opportunities. Some are concerned that it is too late to enter the industry, and that opportunities to capitalize on funding and resources are limited. There is interest in more engagement and consultation with Métis entrepreneurs, leaders, and women to learn more about what supports and points of entry for economic development and participation would be most useful. Representatives suggested that economic development could be supported by a Métis cannabis economic strategy with Métis-lending institutions or affiliates and dedicated business development funds to help Métis business owners navigate cannabis production and retail. Métis National Council representatives noted that there is a general Métis Economic Strategy under development by the Governing members that could be leveraged.

Governance and jurisdiction

Representatives highlighted that many Métis want to exercise their right to self-government and be recognized on a nation-to-nation basis. They also advocated for the Métis Governing members to set policies and deliver programs and services, because they know what their communities need. Métis models of care, created by Métis, for Métis, were also noted as a priority. There needs to be meaningful engagement to ensure cannabis legislation and regulation is more inclusive of the rights and recognition of self-determination of Métis, while respecting diversity and distinctions among members. This requires more funding and resources, including for consultations with flexible timelines, as well as meaningful partnerships of mutual benefit. They also noted that there needs to be more clarity on jurisdictional roles and responsibilities, including defining relationships between Métis and provincial, territorial, and federal governments. We recognize a need for further discussion to understand more specifically what authorities Métis communities are asking for.

Manitoba Métis Federation

We respect the necessity to distinguish the views of the Manitoba Métis Federation (MMF) from those of other Métis governments and organizations as per their request. The MMF emphasized that the distinct perspective of the Red River Métis should be reflected in the review separate from the perspectives of other Métis in Canada. The Manitoba Métis Federation will be exploring key cannabis topics with its citizens including:

- the impacts of cannabis on youth
- the impact of punitive criminalization of their people
- addictions and mental health, including impacts on youth, women, and pregnant people
- jurisdiction
- public education
- economic development and participation in the cannabis and hemp industries
- research, including data gaps, findings from a 2022 Red River Métis public health survey, and the need for distinctions-based data, data sovereignty, and research funding
- cannabis for medical purposes use, including palliative use and involving traditional healers
- use of cannabis for harm reduction

The MMF intends to submit a report to us in December 2023, following engagement with its citizens. We will then follow up with the MMF based on the contents of the report.

Future First Nations, Inuit, and Métis engagement activities

We will continue to engage with interested First Nations, Inuit, and Métis organizations, leaders, and representatives to assess the impacts of the *Act* on their communities, and to help us outline priority areas for actions, findings, and recommendations.

Chapter 8

Home cultivation

Overview of measures

The *Cannabis Act* (the *Act*) permits home cultivation of up to four cannabis plants per dwelling-house by adults. There is no federal limit to how much cannabis (obtained from their plants or other legal sources) an adult can store at home, and adults are permitted to share up to 30 cannabis seeds and four non-flowering plants with other adults.

Adults are able to use cannabis produced from home cultivation to make other cannabis products (for example, edible cannabis); however, they are prohibited from using organic solvents (for example, butane) when producing cannabis at home, given the explosive and highly flammable nature of these solvents.

Provinces and territories are able to establish further restrictions on the home cultivation of cannabis. For example, Quebec and Manitoba prohibit the home cultivation of cannabis, and Newfoundland and Labrador and the Northwest Territories prohibit outdoor home cultivation. Many provinces and territories have allowed tenancy and condominium agreements, as well as municipalities, to place further restrictions on home cultivation.

Data and observations

Prevalence of home cultivation

Population surveys demonstrate that a small portion of the Canadian public grows cannabis at home, notwithstanding the increasing commercial availability of legal cannabis for adults. The 2022 Canadian Cannabis Survey found that 6% of all respondents reported that someone had grown cannabis in or around their home in the past year. Among people who reported using cannabis in the past year, the estimate was higher, with 14% reporting that someone had grown cannabis in or near their home. [9] A recent peer-reviewed study examined home cultivation across Canadian provinces and territories using data from the International Cannabis Policy Study and found lower rates of home cultivation in provinces where home cultivation was prohibited (that is, Quebec and Manitoba). [53]

When the 2022 Canadian Cannabis Survey asked people who use cannabis where they *usually* obtained their cannabis, 8% indicated that they grew their own, or had someone grow it for them. [9] This is similar to the result from before legalization (2018), when 7% of cannabis consumers reported home cultivation as their usual source. [12]

Survey responses suggest home cultivators are generally compliant with the four-plant limit, with the 2022 Canadian Cannabis Survey finding people reported growing an average of 3.5 plants. [9]

Demographically, a recent study using survey data from 2018 and 2019 found home cultivation was more prevalent among respondents who were male or aged 35 or older. [54] Similarly, the 2022 Canadian Cannabis Survey found that home cultivation was more commonly reported as a usual source of cannabis by males than females and among those aged 25 or older. [9]

Academic studies have noted higher rates of home cultivation among frequent consumers of cannabis, and among individuals who report use of cannabis for medical purposes [54] or those with a medical authorization. [53]

Reasons for home cultivation

Research on the reasons why someone would choose to grow cannabis at home is limited. People may choose to engage in home cultivation of cannabis due to personal preferences, for experiential reasons, due to participation in the legacy market, or because of barriers to accessing cannabis in rural and remote communities. Earlier research has identified factors including quality, strength/potency, reduced cost, and avoiding risks associated with illegal sources of cannabis, [54] as well as ideological choice. [55]

Access to starting materials for home cultivation

People who choose to grow their own cannabis may buy seeds or plants from the legal market, share seeds or non-flowering plants with another adult, or cultivate new plants from cuttings and the propagation of clones. Plant sales (for example, seedlings, clones) for the purpose of home cultivation are extremely low. For all of 2022, authorized retailers sold fewer than 100 vegetative plants nation-wide to adults. In the same period, the sale of approximately 13,000 plants were reported by medical sellers to those registered for personal or designated production. Sales of packaged seeds are also quite low compared with the number of units sold for all other classes of cannabis, for example, in 2022, 77,000 packages of seeds were sold, compared to 111 million packaged units of dried flower and 43 million packages of edibles. [56] However, sales reports do not directly reflect the extent of home cultivation in Canada because they only include commercially sold starting materials and do not account for the full extent of socially shared seeds, cuttings, or non-flowering plants.

Public safety impacts

There is limited information available to characterize the public safety consequences of home cultivation. Police-reported crime statistics related to the possession and distribution of plants or cannabis production may pertain to different types of illicit growing operations (commonly referred to as "grow ops"), and do not provide insights related to the public safety impacts of small-scale home cultivation. Anecdotally, media reports have described thefts of homegrown cannabis, and it has been noted that plants grown outside may be targeted when they are ready to be harvested.

What we heard

While there was significant debate during the Parliamentary process for Bill C-45 (the *Cannabis Act*) about home cultivation, including concerns that children would have easy access to cannabis at home, and that it would be difficult to enforce the four-plant limit, we did not hear many comments on home cultivation.

Comments received on this topic have largely been in support of allowing adults to grow up to four plants at home. Stakeholders noted the benefits of home cultivation including cost and access to legal supply. Some suggested that there is a need for more public education on the health and safety issues that can arise from home cultivation, including youth exposure, indoor air quality issues, and electrical and fire hazards. Law enforcement and public safety organizations acknowledged that the four-plant allowance has not been problematic from a law enforcement perspective. One provincial government suggested that the Supreme Court decision to uphold the provincial law banning home cultivation in Quebec demonstrated that home cultivation can harm public health and safety. A small number of municipal governments and landlords called for a reduction in the four-plant limit because of the possibility of youth exposure and possible damage to rental units (for example, mould). As mentioned in Chapter 7, we also heard that home cultivation in the North is not a realistic or viable option to improve access due to the climate and over-crowded housing conditions.

Other comments, including from law enforcement and public safety organizations, with respect to the cultivation of cannabis within a dwelling-house were related to larger-scale cultivation taking place under the personal and designated production of cannabis for medical purposes program. More information on this topic can be found in Chapter 12.

Chapter 9

Economic, social, and environment impacts

Overview of measures

Economic

The objectives of the *Cannabis Act* (the *Act*) centre around preventing young persons from accessing cannabis, protecting public health and public safety, and deterring criminal activity. However, one of the necessary elements of the regime is having an industry that can provide access to a quality-controlled supply of cannabis to adult consumers and thereby displace the illicit market.

The *Cannabis Regulations* outline the different types of licences required for individuals and organizations to conduct activities with cannabis, including production, packaging, sale, research, distribution, and analytical testing. Depending on the activities for which authorization is sought and the scale of those activities, there are various costs associated with applying for a licence. For example, an applicant for a cannabis cultivation or processing licence must have a fully built facility.[25] The applicant incurs carrying costs associated with the facility while awaiting licence approval.[26] Once approved, licence holders incur various costs to maintain a licence—including regulatory compliance costs (for example, product testing, maintaining records, and reporting to Health Canada) and paying fees and taxes that are specific to cannabis.

The *Industrial Hemp Regulations* govern the administration of licences, permits, and authorizations for persons in Canada engaged in the cultivation, distribution, importation, exportation, and processing of industrial hemp. Industrial hemp is defined as low-THC (0.3%) cannabis; no restrictions exist with respect to the amount of CBD. Industrial hemp can be sold for a variety of purposes, including for use in fibres, textiles, and food; it can also be sold to a licensed processor for use in cannabis products.

The *Cannabis Fees Order*, which is a ministerial order under the *Act*, subjects certain licence holders to fees to recover federal government costs (for example, licensing, regulatory enforcement).[27] These include application fees, security clearance application fees, annual regulatory fees, and import/export permit application fees, as applicable.

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[25] Indigenous and Indigenous-affiliated applicants may have their applications reviewed without a fully built site upon application. This allows for early feedback on an application that could help with financing and construction.

[26] Health Canada has service standards for various licensing approval processes.

[27] Cultivation (including nursery), processing, and medical sales licences are subject to fees. Analytical testing, research, and industrial hemp licences are exempt from fees, as well as medical sales licences where sales are exclusively for medical purposes.

The *Excise Act, 2001*, which is under the responsibility of the Minister of Finance, requires licence holders to pay an excise duty (that is, tax) when providing cannabis products to a distributor, retailer, or consumer. With a few exceptions (for example, low-delta-9-tetrahydrocannabinol (THC) (<0.3%) cannabis products, cannabis products destined for export), a cannabis excise stamp must be present on all cannabis products available for purchase, which indicates the excise duty has been paid. The rate of excise duty for different cannabis products is set out in schedules to the *Excise Act, 2001* and its regulations (for example, the combined federal, provincial, and territorial duty on dried cannabis is $1 per gram, or 10% of the price, whichever is greater, and the combined federal, provincial, and territorial duty on edible cannabis, cannabis extracts, and cannabis topicals is set at $0.01 per milligram of THC). The combined rates of duty take into account federal and provincial and territorial shares, with 25% retained by the federal government and 75% by the provinces and territories.[28]

Social

The *Act* and its regulations take a public health approach to regulating cannabis. While the framework considers societal behaviours and social factors (for example, reducing harms for adult consumers and youth, reducing criminal activity, and allowing adult access to quality-controlled cannabis), there are no social equity objectives.

Environmental

There are no objectives in the *Cannabis Act* and its regulations that are specific to environmental protection. Like company owners in other sectors, federal licence holders are subject to various requirements and restrictions at the federal, provincial and territorial, and municipal levels to protect the environment (for example, responsible waste management and chemical usage). Cannabis production, processing, and distribution relies on electricity utilization, water consumption, packaging, transportation, and, in some cases, pesticide utilization, which can result in a range of environmental impacts, including greenhouse gas emissions, air pollution, cannabis-derived odours, and packaging waste, among others.

Under the regulations, cannabis product packaging is required to meet certain standards to protect children and youth from accidental consumption and inducements to use, including being child-resistant, being opaque or translucent, and being a single colour. Labels must also display extensive information (for example, list of ingredients, a health warning message, and THC and CBD content) that can add to the amount of packaging required; however, there are no prescriptive requirements for the packaging material itself. The *Act* permits outdoor commercial production of cannabis (with appropriate security measures), which is typically more sustainable compared to indoor production with respect to power and water use; however, outdoor production is impractical across much of the country due to the climate.

[28] Manitoba is the only province that does not apply a provincial rate, meaning that the excise duty in Manitoba is only the federal share (25%).

Data and observations

Economic impacts

Two recent reports have examined the economic impacts of cannabis through very different lenses. A report by Deloitte estimated the legal industry had generated $11 billion in sales between 2018 and 2021, that $29 billion in capital had been invested over this period, and that overall—estimating a broad range of direct, indirect, and induced contributions—the cannabis sector had created 98,000 jobs and added $43.5 billion to Canada's gross domestic product (this total number includes the value of labour income, in addition to sales and capital spending). [57] The "Canadian Substance Use Costs and Harms" report from the Canadian Centre on Substance Use and Addiction and the Canadian Institute for Substance Use Research describes a different type of economic impact, detailing a specific series of costs, including health care costs, lost productivity, and criminal justice costs. This report suggests that for 2020, the costs attributable to cannabis were equivalent to approximately $2.4 billion (criminal justice: $1.067 billion; lost productivity: $491 million; other direct costs: $443 million; health care: $381 million), which represented an increase of 5.2% from 2007. More specifically, per-person costs of cannabis use increased by 16% between 2007 and 2018 and then decreased about 9% between 2018 and 2020 following legalization. [58]

Household expenditures

Data available from Statistics Canada on household expenditures suggest that almost $8 billion was spent on cannabis in Canada in 2022, with $5.1 billion of expenditures in the legal market, $2.4 billion in the illicit market, and $0.4 billion on cannabis for medical purposes. [59]

Taxes and duties

For fiscal year 2021–2022, federal excise taxes and customs duties amounted to $160 million, provincial and territorial excise tax totalled $592 million, and sales taxes (that is, harmonized sales tax, goods and services tax, provincial and territorial sales taxes) amounted to $458 million. [60]

Impact of COVID-19

Research examining the impact of the COVID-19 pandemic on the progression of the legal market found that legal cannabis sales appeared consistent with ongoing market expansion, with no clear interruption in the growth of the legal market in March 2020. A slight acceleration in monthly sales growth was noted through 2020 and 2021, which Armstrong et al. suggest may relate to the availability of new product classes (that is, edible cannabis, cannabis extracts, cannabis topicals). [61]

Federal licence holders

The *Act* establishes that an application for a licence must be submitted to Health Canada and must include the information required by the Minister (for example, information about the site and key personnel associated with the application). At the time of legalization, approximately 100 companies were licensed to produce cannabis. As of March 31, 2023, there were 913 total licence holders authorized for cannabis activities including cultivation or processing. [47]

Licence holders vary in size and licences are issued as either a "standard" licence or a "micro" licence (for smaller operations with reduced physical security requirements and fees).[29] Approximately 400 licence holders are in the micro category, although they account for a very small share of total annual production. Across the sector, a small number of companies are responsible for a large share of production. For 2022, 15 companies were responsible for 56% of dried cannabis production, while 42% of dried cannabis production was split among the remaining standard licence holders, and 2.1% of dried cannabis was produced by micro licence holders. Two-hundred thirty-three companies licensed for cultivation reported no production during 2022. [62] This could be due to a variety of reasons, including being licensed at the end of the year and spending time to equip a site or time needed to purchase supplies and grow first crops.

As of December 2022, estimates of typical potential indoor and outdoor yields suggest licensed cultivators had capacity to produce more than five million kilograms (kg) of dried cannabis annually. Data from Health Canada's Cannabis Tracking System, the national system to which federal licence holders, distributors, and provincially and territorially authorized sellers must report, indicates actual production was less than 40% of that, at two million kg. [62] In the period immediately after legalization, there were widely publicized product shortages and supply chain disruptions, but over time the concern has shifted from shortages and bottlenecks to oversupply and challenges achieving profitability.

Market situation

Investment in the cannabis sector in the lead up to legalization resulted in a proliferation of new companies and increases in many company valuations; however, in subsequent years downward pressure on revenues (for example, competition for market share, price compression) and expenses associated with market participation (for example, annual regulatory fees, distributor mark-ups and fees, taxes) have contributed to company closures and investment losses. Fourteen of 35 applications under the *Companies' Creditor Arrangement Act* in 2022 were from the cannabis sector, [63] and Health Canada informed us that as of April 2023, 166 licence holders had exited the market, representing 15% of licences issued to date. [47] As of March 2023, almost half of licence holders (141 of 305) with excise duty payable in the past year had more than $25,000 owing, with a cumulative debt of $192.9 million. [64] Additionally, Health Canada reports that for the current fiscal year (2022–2023), $63.1 million in regulatory fees were charged to licence holders, and at the time of writing this report, $7.6 million were in arrears. [65]

[29] A micro-cultivation licence allows licence holders to produce cannabis plants and seeds, fresh and dried cannabis within a grow surface area (plant canopy) of up to 200 square metres. A micro-processing licence allows licence holders to produce all types of cannabis; these licence holders can possess up to 600 kg of dried cannabis (or its equivalent amount) in a calendar year.

Provincial and territorial distribution and retail

Different distribution models have been implemented by the provinces and territories, and the public financial reports made available by government-owned distributors (Crown corporations) indicate most have profitable operations (tabulated below). [60] [66] [67] Provincial and territorial distributors play an important role as the principal buyers of cannabis and most are considered monopsonies (that is, the sole buyer in a market).[30] However, sales by licence holders, who supply cannabis to distributors, have been unequal. Information submitted to Health Canada's Cannabis Tracking System indicates that 46% of revenues recorded in 2022 were collected by 15 companies. Data collected by Health Canada also indicates that at the end of 2022, 559 federal licence holders had reported no sales. [62]

Provinces and territories have exercised their authority over cannabis retail, and jurisdictions have implemented a mix of public, private, and hybrid[31] retail models. In September 2022, over 3,300 stores were open nation-wide. [68] It has been noted that the number of stores per capita varies by a factor of about 16, with Alberta having the greatest number of stores per capita and Quebec having the fewest.

Table 1: Provincial and territorial retail density and net income

Jurisdiction	Retail model	No. of stores (September 2022) [68]	Stores per 100,000 population [68]	Net income of cannabis authorities (distributors/ regulators) (2021–2022) [60]
Canada	-	3305	10.1	$ 332.3 million
Alberta	Private	757	20.4	$ -4.4 million
British Columbia	Hybrid	465	10.1	$ -3.4 million
Manitoba	Private	162	14.1	$ 24.8 million
New Brunswick	Hybrid	26	3.7	$ 16.5 million
Newfoundland and Labrador	Hybrid	41	9.0	$ 9.1 million
Northwest Territories	Private	6	16.3	$ <1 million
Nova Scotia	Public	45	5.1	$ 28.6 million
Nunavut	Private	1	3.6	$ <1 million
Ontario	Hybrid	1552	12.1	$ 184.4 million
Prince Edward Island	Public	4	2.8	$ 2.6 million
Quebec	Public	91	1.2	$ 75.7 million
Saskatchewan	Private	149	15.5	$ -3.0 million
Yukon	Hybrid	6	16.4	$ <1 million

30 In the province of Saskatchewan, licence holders sell directly to retailers.

31 Public retail systems are those in which physical stores and online sales are exclusively government operated, typically through a Crown corporation. Private retail systems are those in which private individuals or enterprises own and manage retail locations. Hybrid systems include a mix of government-run and privately operated retail access points.

Consumer pricing

Consumers were initially confronted with prices in the legal market that were considerably higher than in the illicit market, but in the years since legalization the price gap has narrowed. Findings from the International Cannabis Policy Study indicate the price paid per gram of dried cannabis from legal sources declined from $10.70 in 2019 to $6.12 in 2022, while the price paid for illicitly sourced cannabis decreased from $7.22 to $4.62 over the same period. [69] Consequently, the price difference between legal and illicit dried cannabis has fallen by more than half, to about $1.50 per gram. While dried cannabis constitutes the largest share of the market, pricing and price differences between legal and illicit sources may vary between products and in different jurisdictions.

Social impacts

Interactions with the criminal justice system

The social consequences of legalization are challenging to characterize and vary within and between different populations. Criminal charges or convictions for cannabis-related offences are contributing to lasting negative social consequences, including stigmatization, fragmentation of family units, loss of employment and barriers to employment, loss of travel privileges or housing, among others. [70] Crime statistics indicate that possession charges were brought against 13,715 individuals in 2017 under the *Controlled Drugs and Substances Act,* and that the number decreased to 624 persons charged for possession under the *Cannabis Act* in 2022. [29] Further information on interactions with the criminal justice system is presented in Chapter 6 (for youth), and Chapter 11.

Racial disparities

Historically, drug laws and policing disproportionately impacted racialized communities, especially Black and Indigenous communities. [71] While work is underway to collect more information in the future, to date racial and ethnic data are not systematically collected in national crime statistics.[32] Studies relying on regional data from the Peel, Durham, and York regions of Ontario found persistent racial bias in the rates of cannabis possession charges in the period from October 2018 to December 2020 (for example, while there were declines for all racial groups following legalization, the rate of cannabis possession charges per 100,000 population remained four, seven, and 19-times higher among Black people than White people in Peel, Durham, and York, respectively). [72]

Representation in the cannabis industry

The limited evidence available suggests that demographic composition of industry leadership in the cannabis sector does not reflect the diversity of the Canadian population. A 2020 study by the Centre on Drug Policy Evaluation describes the over-representation of White males in the leadership positions of a sample of 700 executives and directors from 222 federal licence holders and parent companies (84% White, 86% male). [48] A more recent survey of federal licence holders conducted by Health Canada also found that of the 334 companies that responded to at least part of the survey, 82 (25%) indicated that half or more of their leadership team were women. Most companies chose not to provide information on the representation of Indigenous or racialized individuals on their leadership team.[33] [49]

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[32] Statistics Canada has indicated that the introduction of race-based data points will begin in 2024.

[33] Fifty-one companies (15% of those that responded to the survey) provided information on Indigenous representation on their leadership team. Forty-four companies indicated there was Indigenous representation, including 12 indicating that half or more of their leadership team identified as Indigenous. Seventy-nine companies (24% of those that completed the survey) provided information on representation of racialized groups on this leadership team. Seventy-four indicated that they had members of racialized groups on their leadership team, including 32 that said half or more of this leadership team were people from a racialized group.

Environmental impacts

Evidence is lacking on the environmental impacts of cannabis legalization. While a number of academic studies have identified impacts that cannabis production could have on the environment (for example, emissions/pollution, energy use, packaging waste, water use, land use), we have not identified any robust sources of data that permit characterization of the actual impacts of cannabis legalization on the Canadian environment. [73] [74] We note that Canada's climate requires seasonal adaptations to support cannabis production and logistics, such as the use of indoor cultivation and the resulting heating, ventilation, air conditioning, and lighting considerations.

Packaging waste has been a leading concern raised throughout the first phase of our work, although even in this priority area, no reliable quantitative information has been located. Estimates circulating shortly after legalization suggested that between 5.8 to 6.4 million kg of plastic packaging waste had been generated in the first year of legalization. [75] Based on data reported to Health Canada through the Cannabis Tracking System, 193 million packaged units of the three most popular classes of cannabis (that is, dried cannabis, edible cannabis, cannabis extracts) were sold in 2022, which represents an increase over previous years (152 million units in 2021, 99 million units in 2020). [76] The limited evidence available suggests only a small share of plastic cannabis packaging is recycled, and there has been growing focus on vaping cartridges and batteries, which pose additional challenges for recycling due to the presence of metal, glass, electronics, and batteries.

What we heard

Economic impacts

To gather views on the economic, social, and environmental impacts of the framework, we conducted roundtable discussions and one-on-one meetings. The views reflected here include those from: cannabis industry representatives; diversity, equity, and inclusion (DEI) researchers and advocates; provincial and territorial government officials; and representatives of First Nation, Inuit, and Métis communities.

Stakeholders recognized that the cannabis framework was developed on the basis of a public health and public safety approach. However, many underscored that a diverse and sustainable legal cannabis industry is a necessary pre-condition to meet the *Act's* public health objectives.

Economic viability

One of the main messages from industry representatives was that, despite the growth of the legal cannabis market, companies across the supply chain are struggling to realize profits and maintain financial viability. Specifically, they noted that the hyper-competitive cannabis market for producers and retailers, combined with the various regulatory fees, distributor mark-ups and fees, and taxes are stifling companies of all sizes. Some noted that other industries, such as alcohol and tobacco, are not subject to federal regulatory fees and that they pay less mark-ups and taxes (for example, beer). Some stakeholders proposed that Health Canada move towards an "a la carte" model for regulatory fees (that is, transactional fees for specific services) and remove the annual regulatory fee. Others felt that the government should adopt a progressive excise tax framework, whereby the tax rate is connected to the size of the firm or the price of the product. Others suggested adjusting the tax rate to 10% for dried cannabis, as opposed to the current model of $1 or 10% per gram, whichever is greater.

Many industry representatives discussed the lack of service standards associated with Health Canada's licensing process and noted that the lack of timely approvals for security clearances and permits negatively impact their ability to hire staff and to export their product, among other issues. Some also cited the carrying costs associated with having to maintain built facilities while waiting for licence approvals.

We heard numerous comments that, without immediate financial relief, companies will be forced to exit the market. We also heard that efforts to move unpaid excise tax debts into collections could also force market exits. Some suggested that the result would be market consolidation, ultimately increasing prices, reducing product diversity, and driving consumers to the illicit market.

While there is consumer demand for their products, the excess supply of cannabis in the market is particularly challenging for micro licence holders. Micro-cultivators cited a number of challenges, including difficulties in finding buyers (whether processors or distributors) for their products due to the small quantities of their harvests. Some micro-cultivators told us that they have stopped growing cannabis, given that they have several years of harvested cannabis in storage, unsold. Others reported being offered prices by processors that were below their production costs. These micro-cultivators suggested that they be able to package and sell dried cannabis directly to distributors.

In terms of competing with the illicit market, we heard a number of issues, including:

- the 10 milligram THC quantity for edible cannabis per package being too low
- restrictions on promotion, packaging, and labelling
- the price of legal cannabis products compared to those in the illicit market
- inconsistent enforcement, especially with respect to activities in the illicit market
- the presence of multiple levels of rules, and the time and cost associated with navigating the various requirements
- lack of risk-based rules for different product classes
- the 30 gram public possession limit, which impedes consumers from purchasing a variety of products at one time
- unintended safety risks (for example, store robberies) due to restrictions that require cannabis products to not be visible to youth

Similarly, industry stakeholders raised issues around competition and innovation within the legal market, noting the lack of ability to differentiate themselves from other companies due to stringent promotion, packaging, and labelling restrictions. There was also some concern that Health Canada's guidance is not always clear, and that Health Canada inspectors are not always consistent in their observations, reports, and application of the rules.

Industry stakeholders questioned why governments are hesitant to acknowledge and promote the economic benefits of the cannabis industry. A number noted that Health Canada, the regulator, does not have an economic mandate. This has consequences on their ability to receive support to help grow their businesses (for example, to export their product to other markets), and some questioned why cannabis companies are often not eligible for the same funding supports that are available for other industries.

We heard about the challenges faced by cannabis companies when attempting to set up a bank account with reasonable fees, asserting that many banks will not service them due to the perceived risk profile of the company and concern about compliance with U.S. laws.

Industrial hemp

Some industrial hemp industry representatives noted their significant contribution to the Canadian economy and argued that the legalization of cannabis has had a negative impact on their sector because the focus of governments has been on activities related to the regulation of cannabis and the cannabis industry. They argued that industrial hemp should not be controlled as cannabis, but rather as an agricultural commodity, and called for the transfer of oversight of the hemp regulatory framework from Health Canada to Agriculture and Agri-Food Canada. They also recommended that the definition of industrial hemp should be changed to increase the maximum THC concentration from 0.3% to 1% because they believe that the current limit is too low and the proposed limit is still low enough not to present any harm.

Barriers for disadvantaged groups

Equity-deserving industry stakeholders noted the financial burden of starting and operating a cannabis company. They discussed the significant challenges they have faced in accessing and raising affordable capital, and in paying upfront costs relating to building production facilities, retrofitting retail space, and the security bond for the excise taxes. They shared the difficulties they experienced in applying for and receiving loans from financial institutions, noting the unique constraints they face (for example, lack of existing networks and relationships with banks, lenders, and investors). They also discussed the complex licensing pathways that present barriers for some in these groups (for example, presence of criminal convictions unrelated to cannabis). Some endorsed the need for a navigator service, similar to the Indigenous Navigator Service (see more details in the Overview of measures section of Chapter 7), to guide them through the licensing process.

Some representatives of disadvantaged groups expressed the view that the low level of diversity in leadership roles in the cannabis industry may be worse than the situation in other sectors. They speculated that this is due to historic discrimination and racism associated with cannabis prohibition. They also observed that the current downsizing and market corrections in the cannabis industry are disproportionately impacting departments within cannabis companies that are involved in social justice and sustainability and indicated that these departments tend to be led by women. Some suggested that the Government of Canada should implement diversity audits (for example, on gender, race) of the cannabis industry, and proportionally reduce fees for companies with diverse workforces to lower barriers to market participation. At the same time, we were told about efforts within the industry to employ a more diverse workforce. These include social equity programs and initiatives such as, funding, and strategies to support diverse industry partners in entering the market, understanding gaps in representation, and maintaining diverse workforces.

Discussions with regulatory officials from New York, New Jersey, Washington, and California that have integrated social equity policies into their frameworks revealed that the driving force for some of these policies was the desire to repair the harms created by the "War on Drugs" (for example, systemic racism and marginalization of equity-deserving groups). Many of these jurisdictions have used some combination of the following criteria to prioritize production or retail applicants for licensing:

- people (or family members of people) who were arrested and/or convicted of certain crimes related to cannabis
- people living in communities disproportionately impacted by cannabis prohibition
- people whose income falls below a certain income threshold
- people who are applying on behalf of small or medium-sized companies
- people from certain populations (for example, women, minority groups)

Beyond licensing prioritization, examples of social equity programs or initiatives that U.S. states have created for priority applicants and licence holders include:

- company technical assistance programs
- grants and loans
- job fairs
- incubation and acceleration services
- regulatory compliance training
- reduced licensing and regulatory fees or deferrals

Some U.S. state officials noted that, due to the novel nature of their social equity programs, there was a lack of data on the uptake and efficacy of the social, economic, and public health programs. Some data suggest that social equity efforts have been inaccessible for their target audience and inadequate in reaching their objectives. [77]

Social impacts

While racial and ethnic data has not been systematically collected in crime statistics,[34] stakeholders expressed the belief based on their lived and living experience, that disadvantaged and marginalized groups, especially racialized groups, continue to face disproportionate harms related to cannabis. Specifically, they expressed that these groups continue to be disproportionately impacted by over-policing and cannabis-related law enforcement. Some Black Canadians discussed concerns with respect to the capacity of young Black men to make informed decisions about cannabis use given the disproportionate impact of police enforcement. Some noted that the cannabis industry has been constructed as a new expression of racial inequity. They noted that a single cannabis possession offence has long-lasting social impacts on individuals and their families, which results in them being unable to engage in the labour market, volunteer in their communities, and/or obtain housing. Stakeholders called for a more accessible record suspension process (previously referred to as pardons) and remediation of past harms from cannabis-related convictions. Many of these stakeholders discussed that individuals who have encountered the criminal justice system experience mistrust dealing with government.

Several stakeholders recommended expanding the objectives of the *Act* to include principles of social equity and diversity in order to acknowledge and help redress the continued negative effects of the historically racist and discriminatory nature of cannabis prohibition. Stakeholders also discussed the need for culturally responsive and targeted research and education on the harms and therapeutic benefits of cannabis for racialized communities that is co-developed by members of these groups. Additionally, they called for education for racialized communities on key elements of the legislation and regulations (for example, possession amount, where cannabis can be used, how to identify legal stores) to protect them from police enforcement. Some suggested that a portion of licensing fees or excise tax revenues be set aside for social equity programs and initiatives.

[34] Statistics Canada has indicated that the introduction of race-based data points will begin in 2024.

As mentioned in Chapter 5, some expressed concerns about the normalization of cannabis use due to cannabis legalization, while others highlighted the need to continue to reduce stigmatization surrounding cannabis, in addition to balancing the harm reduction objectives. For example, Black Canadians noted that due to negative systemic and structural experiences with health services, many Black youth use cannabis to cope with emotional and mental distress and mental health conditions, including anxiety disorders, traumatic experiences, and attention deficit hyperactivity disorder (ADHD).

We were also told about the challenges women face in accessing product from the legal market due to provincial and territorial restrictions that prevent children from entering retail stores, thereby making the illicit market potentially more accessible for women caring for children.

Environmental impacts

A few stakeholders raised concerns about the environmental impact of cannabis product packaging, including issues with single-use plastic packaging and limited use of packaging composed of cannabis plant by-products; however, the environmental impact of cannabis legalization was not a direct point of focus during engagement. Some discussed innovative approaches to reducing the environmental footprint of cannabis cultivation, including the use of organic and regenerative farming practices, and the use of cannabis as a bio-accumulator (to help remediate the soil). Suggestions were also made about solar energy use and the secondary use of waste.

Chapter 10

Adult access

Overview of measures

The *Cannabis Act* (the *Act*) is based on a public health and public safety approach that aims to protect Canadians by minimizing the harms associated with cannabis use. Key objectives with respect to providing adults with access to strictly regulated, lower-risk, legal cannabis products include deterring illicit activities in relation to cannabis through appropriate sanctions and enforcement measures, and providing access to a quality-controlled supply of cannabis.

The *Act* and its regulations contain a series of controls and authorizations designed to support the achievement of these objectives, including, but not limited to:

- rules to permit a broad diversity of quality-controlled cannabis products
- minimum standards related to the provincially and territorially authorized sale of cannabis (for example, selling product produced by federal licence holders)
- restrictions related to age of possession for youth
- restrictions related to adult possession and sale (for example, adults are permitted to possess 30 grams of dried cannabis or its equivalent in other classes of cannabis in public; provincially and territorially authorized retailers can only sell to those over 18 years of age and in accordance with the legal age limit set by provincial and territorial law)
- rules governing the production of cannabis and cannabis products

To help ensure adult Canadians have access to a quality-controlled supply of a diverse range of products, the federal government regulates the production of cannabis, while provinces and territories have oversight over cannabis distribution and retail sale within their jurisdictions.

In designing the licensing framework with its various licence classes and subclasses, the federal government sought to facilitate the establishment of a legal industry comprised of both large and small players able to supply the legal market.

Irrespective of their size, licence holders must meet the production and product requirements of the regulations. These include Good Production Practices (for example, sanitation programs, storage and distribution requirements, and testing requirements for microbial and chemical contaminants) and cannabis product standards (for example, prohibitions on substances like nicotine, ingredient restrictions for edible cannabis and cannabis extracts, and delta-9-tetrahydrocannabinol (THC) limits). Adherence to such requirements is validated in a number of ways, including reporting and inspections by Health Canada. The Compliance and Enforcement Policy for the *Act* provides information on Health Canada's approach to regulatory compliance and enforcement. [78]

Data and observations

Views on legal access

In the period since legalization, population surveys have collected information on the perceived accessibility of legal cannabis. In 2022, the Canadian Cannabis Survey found that 93% of people who use cannabis believe that they have reasonable access to cannabis from a legal supplier, an increase from 90% in 2021. [9] [79] This finding notwithstanding, we note national data may not generalize to some more rural or isolated areas of provinces and territories.

Sourcing legal cannabis

Surveys also collect information on where people obtain cannabis. In the first post-legalization cycle of the Canadian Cannabis Survey in 2019, about half (52%) of people who used cannabis reported obtaining at least some of their cannabis from a legal source. [14] The most recent data indicate that 85% of cannabis users had obtained some of the cannabis they had used from a legal source, including 63% who report mostly or always obtaining from a legal source. [9]

Legal retail

The number of retail locations has increased in the period since legalization. As of September 2022, there were over 3,300 physical retail locations nation-wide, with brick-and-mortar access points in all provinces and territories. [68] However, the density of retail locations varies within and between the provinces and territories; stores tend to be concentrated in urban centres, and different distribution and retail systems have led to markedly different regional store densities. For example, a recent study found that, as of September 2022, Quebec had about one retail store per 100,000 residents, while Alberta had more than 20. In terms of geographic density, it is noted that in certain parts of the country there are a small number of retail stores in jurisdictions with large land areas (for example, one store in Nunavut, six in the Northwest Territories, and six in the Yukon). Nonetheless, the study also noted that four years after legalization, 59% of neighbourhoods were within a five-minute drive from a cannabis retail store. [68]

Proximity to retail stores is particularly relevant to characterizing the level of access to legal cannabis, as survey data suggest that physical retail stores are the most popular way to obtain cannabis. The 2022 Canadian Cannabis Survey found that nearly two-thirds (61%) of people who use cannabis reported usually obtaining it from a legal storefront. The second most common response was obtaining cannabis from a friend, reported by 10% of people who had used cannabis in the past 12 months. Eight percent reported usually obtaining cannabis from a legal online source. [9]

While not a direct measure of access, the growth in legal sales—and the decline in illicit sales—indicates that consumers are migrating to legal suppliers (more information on the displacement of the illicit market is included in Chapter 11). Estimates of legal market share vary, but suggest that more than half, and up to as much as three-quarters, of cannabis is being obtained from legal sources (for example, in 2022, one survey found 63% of cannabis users always or mostly accessed legal sources [9], another observed cannabis consumers bought 82% of the cannabis they used from legal sources [69], and 68% of household spending on non-medical cannabis was attributed to legal sources [59]).

Factors related to sourcing

Information collected from people who buy cannabis illegally suggests that, while there are a variety of drivers for purchasing from the illicit market, perception of price is the leading factor in their decision about where to purchase cannabis. The 2022 Canadian Cannabis Survey found that price was the most frequently cited reason that determined where cannabis was obtained (ranked first by 30% of cannabis users), followed by safe supply (ranked first by 23% of cannabis users), and quality (ranked first by 12%). [9] Recent findings from the International Cannabis Policy Study similarly noted price as the most common reason for purchasing cannabis from an illicit source, cited by 26% of consumers who had purchased illicit cannabis in 2022. [69]

Sourcing and product types

A recent study using data collected by the International Cannabis Policy Study examined the sourcing of different types of cannabis products and found that the extent of legal sourcing varied by product type. In 2021, less than half (49%) of consumers of solid concentrates (for example, shatter, wax) reported obtaining all of the solid concentrates they consumed legally, while 82% of cannabis beverage consumers reported sourcing only from the legal market. For the most prevalent types of cannabis products—dried cannabis, edible cannabis, and vaping products—exclusively legal sourcing was reported by 54%, 68%, and 69% of consumers, respectively. Complementary findings indicate that exclusive sourcing from the illicit market was uncommon for most product types, with 9% of dried cannabis consumers, 10% of vape oil consumers, and 15% of edible cannabis consumers reporting that they had sourced "none" of these products from the legal market in 2021. [80]

What we heard

This chapter presents differing views we heard on meeting consumer demand and whether adult Canadians have sufficient access to legal cannabis.

Comments with respect to the displacement of the illicit market are covered in Chapter 11. Reasonable access to cannabis for medical purposes is an important issue for patients and many other stakeholders, and views on accessing cannabis for medical purposes are found in Chapter 12. Access to legal cannabis in First Nations, Inuit, and Métis communities is discussed in Chapter 7.

Several factors influence Canadians' decision to choose to access legal cannabis. These include price, product availability, proximity to retail stores, quality of the cannabis (for example, perceptions of quality such as THC quantity, sensory and visual attributes such as the terpene[35] profile, bud (dried flower) size, and presence of trichomes[36]), and access to information about products.

[35] In terms of cannabis, terpenes are generally understood to be naturally occurring aromatic chemical compounds found in cannabis plants. For example, terpenes are what make certain strains of cannabis smell or taste different from others.

[36] In terms of cannabis, trichomes are generally known as fine outgrowths or appendages on cannabis plants that are responsible for producing cannabinoids, terpenes, and other flavonoids that make cannabis strains potent and unique.

Why consumers choose the legal market

Product price

Stakeholders provided differing views on the price competitiveness of cannabis products in the legal and illicit markets and the impact on adult access. Some stakeholders, including those in industry, public safety organizations, and provincial and territorial government officials, highlighted that price is a primary driver for consumers in choosing between the legal and illicit markets, with the illicit market remaining price competitive and generally having lower prices.

Some noted that promotional and labelling restrictions hindered their ability to differentiate their products, and as a result, consumers may seek products from the illicit market due to the lower price point.

Others we heard from, including academics and distributors, suggested that the price of legal cannabis is competitive with the illicit market and is generally consistent across provinces (prices in the territories being an exception). These stakeholders, who in some cases cited publicly available data, argued that prices in Canada have decreased significantly. Public health sector representatives held the view that pricing controls are an effective way to reduce harms, noting that reductions in cannabis product prices could lead to increases in consumption. Others indicated price is often correlated with THC quantity (that is, products with higher THC quantities are more expensive than those with lower quantities). Some public health stakeholders suggested that prices proportional to THC quantity could encourage the consumption of lower-potency products.

Access to products

Public safety and industry representatives argued that consumers are seeking some products that are not available in the legal market. These products include those that do not comply with the legal cannabis framework and therefore are only found in the illicit market due to their format, safety risks, potency, or other elements (for example, ingredients that could pose a risk of injury to the health of the consumer). Industry representatives highlighted several restrictions in the federal regulatory framework that they feel impedes their ability to meet consumer demand and thus compete with the illicit market.[37]

Industry stakeholders indicated that the 30 grams of dried cannabis or its equivalent public possession limit impedes some consumers from purchasing a variety of cannabis products in a single visit to a legal store. Some provincial governments noted that an exemption or increased limit for public possession could help improve access in Northern, rural, and remote communities, including First Nations, Inuit, and Métis communities, particularly communities where all goods must be shipped during the summer months.

Industry stakeholders noted that an increase in the THC quantity would allow for the production of edible products that are more competitive with products in the illicit market. They also noted that an increased ability to promote their products, including through the information on packages and labels, would allow them to better compete with the illicit market, and thereby improve access to a legal, quality-controlled supply of cannabis. They further stressed that if the framework does not address key concerns, the legal market will lose consumers to the illicit market.

[37] Stakeholders acknowledged that provincial restrictions apply as well, thus impacting products available in the legal market (for example, Quebec rules related to certain edible formats and products with over 30% THC).

Some provincial and territorial distributors and governments noted that, according to their data, there is a demand for edible cannabis products in the legal market with more than 10 milligrams of THC per package and that these products are readily available in the illicit market. Some licensed cannabis processors responded to consumer demand for higher THC edible cannabis by selling "ingestible extracts" (cannabis extracts are subject to a 1,000 milligram limit of THC per package, and 10 milligrams per unit (for example, capsule)) until Health Canada released guidance clarifying that products intended to be consumed in the same manner as food are excluded from the definition of cannabis extracts and therefore prohibited from being sold as cannabis extracts. [81] Industry stakeholders noted that before the guidance was issued, these products were popular among consumers.

Further, we heard from some provincial and territorial distributors who argued that consumers who prefer high THC products do not purchase legal edible cannabis products because it is cost prohibitive to buy several packages at once. They called for an increase in the quantity of THC per package of edible cannabis. In addition to being cost prohibitive, it was noted that some consumers do not wish to ingest more units of product to access more THC. Some researchers suggested that it is rare that higher dose edibles drive consumers to purchase illicit cannabis as consumers often cite convenience, price, and quality as reasons for purchasing illicit products.

Conversely, some public health stakeholders supported a framework that minimizes product diversification and maintains restrictions on the legal market. They also raised concerns about novel products with different types of intoxicating cannabinoids for which the risks are not well understood. We heard calls for additional research and testing to understand and mitigate the potential health risks associated with new and emerging intoxicating cannabis products coming to market.

Most public health stakeholders agreed that the THC quantity limits for cannabis products, particularly for edible cannabis products, should be maintained or decreased. They raised concerns about the risks and harms that high THC quantity products can pose (such as the severity of unintentional poisonings and intoxication in children, need for more invasive medical interventions, unknown long-term consequences of childhood exposure, and mental health concerns like dependence) and therefore supported requirements that minimized these harms. Some public health stakeholders suggested restricting the amount of allowable distribution, purchase, or possession of high-potency extracts such as shatter, rosin, and resin.

Retail access

Although the number of retail access points to cannabis has increased significantly since legalization, stakeholders noted several areas where retail access could be improved, such as in rural and remote regions. Some noted that while online retail access can bridge the gap where there is lower retail density, there can be economic barriers to this type of access for Canadians if they do not have internet access, credit cards, or stable addresses. Some public health stakeholders recommended that there be a maximum density for retail stores, which they acknowledged would be under the authority of provinces and territories to implement. They noted that such a restriction would help to reduce public exposure to cannabis and also minimize risks that increased availability of products would lead to more demand.

Some industry stakeholders and consumers argued that the viability of legal retailers is key to achieving the framework's objectives regarding adult access to quality-controlled products.

They argued that access to legal cannabis would be improved if the legal market were more diverse and called for changes to the framework to make it easier for racialized Canadians and First Nations, Inuit, and Métis to enter the legal market. We heard suggestions that some consumers would prefer to support members of their own community when purchasing cannabis, even if it means buying from the illicit market. Some Inuit representatives noted the racism Inuit have experienced in retail stores, especially those in the South, and called for more legal stores in their communities staffed by Inuit.

Some researchers suggested that retail density is sufficient to meet consumers' access needs, in conjunction with elements such as online retail, same day pick-up, and next day delivery. However, they acknowledged exceptions in rural and remote areas. It was also noted by some in the research community that access to legal cannabis is more challenging in places with more extensive controls or restrictive measures (for example, higher legal age or the prohibition of home cultivation) or where there are limitations applied (for example, limited retail store hours and locations or long mail delivery times for online orders). They noted that such issues could lead some consumers to continue to choose the illicit market.

Access to a quality-controlled supply of cannabis products

Consistent with survey data, some stakeholders suggested that consumer perceptions of product quality are an important factor in adult Canadians choosing to purchase legal cannabis.

Some provincial government officials similarly indicated that the meaning of "quality" varies depending on the frequency of cannabis use of the consumer. They indicated that frequent consumers perceive cannabis products to be of higher quality based on sensory and visual characteristics (for example, terpene profile, bud size, trichomes), whereas occasional consumers tend to prioritize products that are regulated and tested. Industry representatives indicated that the quality of cannabis products could be improved in the legal cannabis market through more standardization of cannabis testing methodologies. They highlighted that Health Canada does not prescriptively regulate testing for potency and contaminants, nor provide variability limits applicable to the labelled amount of THC and CBD in dried cannabis the way that such rules apply for edible cannabis and cannabis extracts. They were concerned that the lack of testing standards has contributed to the inflation of labelled THC quantities.

Adult access to promotions and awareness

We heard a wide variety of views on the federal framework's impacts on promotion, product labelling, and awareness.

We heard from some researchers and public health stakeholders who recommended more specific education on the labelling of cannabis products to help adult consumers access better information about the quantity of THC and the benefits of accessing legal quality-controlled products. In addition, they suggested improvements to increase effectiveness of packaging and labelling by including product-specific labelling requirements and health warning messages, and more informative THC labelling (for example, the health impacts of high THC concentrations). Concerns were also raised about the decision to remove messaging on the risk of psychosis on packaging. Some public health representatives recommended that product information and health warnings be in the format of tables, similar to information found on prescription drug labels.

Some provincial governments noted that consumers lack information on how much cannabis they can safely consume (that is, dosing) and the effects to expect after consumption of a certain dose. They suggested that the framework be amended to allow retailers and labels to provide information on responsible use, dosing, and expected effects.

Some industry representatives and provincial distributors shared the view that the promotion restrictions in the *Act* have resulted in consumers focusing on THC quantity as a factor for purchasing decisions. They also argued that consumers are not able to differentiate between the relative risks of different cannabis products (such as between intoxicating and non-intoxicating products) and called for changes in the framework to allow for this type of consumer education.

To improve adult consumers' access to cannabis information and introduce new alternatives to THC quantity as factors for purchasing decisions, industry stakeholders recommended that producers and retailers be permitted to communicate more information to consumers on product packages and labels and in the in-store environment. They provided examples of information that could be included on cannabis product labels such as cannabis testing results, information on terpenes, brand narratives (for example, family-run company), the ability to highlight product attributes (for example, made with organic ingredients), or the agricultural practices used in the production of cannabis (for example, sun grown). We heard from Health Canada officials that these examples are all permissible provided they do not contravene federal requirements (for example, are not false or misleading, are not appealing to youth, or do not engage in lifestyle promotion) or any requirements that provinces or territories impose.

Our engagement suggests that there is considerable ambiguity amongst key players as to who should be responsible for educating the public on specific characteristics of cannabis, including THC quantities. Federal licence holders and retailers noted uncertainty as to whether they are permitted to provide education on characteristics of cannabis, or whether this would be in contravention of promotion rules.

Chapter 11

Deterring criminal activity and displacing the illicit cannabis market

Overview of measures

Canada's approach to cannabis legalization and regulation includes a range of measures designed to protect public safety and to deter those who operate outside the legal framework. The primary focus of the federal government's strategy to combat the illicit cannabis market is to provide adult consumers with the ability to purchase cannabis from legal, regulated sources. Recognizing that there would continue to be activity outside of the legal framework, the *Cannabis Act* (the *Act*) provides law enforcement with the authority to act against illicit cannabis activities.

Criminal offences related to unauthorized activities with cannabis include, but are not limited to:

- public possession of more than 30 grams of dried cannabis or its equivalent in other classes of cannabis
- unauthorized distribution or sale of cannabis
- producing cannabis beyond the home cultivation limit of four plants
- taking cannabis across Canada's borders
- giving or selling cannabis to youth
- using a youth to commit a cannabis-related offence

Depending on the offence, maximum penalties include fines, jail time, or both, with the most serious offences subject to a maximum penalty of 14 years in jail. The *Act* does provide for a ticketing scheme for certain minor offences (for example, possession of up to 50 grams of legal dried cannabis or its equivalent, or production of up to six plants in a dwelling-house). Diversion proceedings[38] or mechanisms for young persons under the *Youth Criminal Justice Act* may also be applicable.

The *Act* is complemented by other pieces of federal legislation that provide additional means of taking action against unauthorized activities related to cannabis, including:

- The *Excise Act, 2001,* [2] which prohibits the sale of cannabis products lacking excise stamps
- The *Customs Act,* [82] which enables the Canada Border Services Agency (CBSA) to seize cannabis on behalf of Health Canada and provides for monetary penalties to be issued for undeclared cannabis entering Canada
- The *Criminal Code,* [1] which establishes criminal offences related to drug-impaired driving

The *Act* and its regulations also contain several provisions designed to address the risk of diversion of cannabis from the legal industry to the illicit market, including personnel security requirements, physical security requirements, and record keeping and reporting requirements (for example, inventory tracking, loss, and theft reporting).

[38] Diversion programs are designed to allow offenders to avoid criminal records for minor offences. They include intervention programs such as substance abuse treatment, education, and mental health supports, among other initiatives.

Governments have also run educational campaigns to encourage consumers to choose legal products. Several of these campaigns have focused on quality issues identified in illicit products seized by law enforcement, such as labelled delta-9-tetrahydrocannabinol (THC) inaccuracies and the presence of contaminants.

Data and observations

Information available on criminal activity and the illicit market is not comprehensive and is of varying reliability. Law enforcement suggested organized crime groups have continued to be involved in many aspects of the illicit cannabis market since legalization, including sale, production, export, and import. Furthermore, these organized crime groups have been linked to violent activities, such as firearms and weapons offences, extortion, intimidation, assault, homicide, armed robberies, and home invasions.

Criminal offences: incidents and charges

The implementation of the *Act* led to several changes in police-reported incidents[39] and criminal charges. Before October 2018, under the *Controlled Drugs and Substances Act* (CDSA), criminal activities related to cannabis fell into four main categories of offences (that is, possession, trafficking, import/export, and production), and the majority of incidents (that is, occurrence of an alleged criminal offence in a single event) and charges (that is, the number individuals who were charged with having committed a criminal offence) were related to possession. The *Act* retains prohibitions related to each of these four categories of offences; however, a major difference is the legalization of possession by an adult of up to 30 grams of dried cannabis (or its equivalent in other classes of cannabis). The table below summarizes the four main categories of cannabis-related offences, in 2017 and 2022 [29]:

Table 2: Cannabis-related offences in 2017 and 2022

Offence category		2017 (CDSA)	2022 (*Cannabis Act*)	% change
Possession	Incidents	38,779	1,285	-97%
	Charges	13,715	624	-95%
Trafficking (captured as distribution and sale under the *Act*)	Incidents	5,940	1,417	-76%
	Charges	3,973	825	-79%
Import/export	Incidents	2,734	7,203	+163%
	Charges	30	18	-40%
Production	Incidents	2,294	460	-80%
	Charges	837	248	-70%

[39] In this context, an "incident" refers to the set of connected events usually constituting an occurrence report by law enforcement. Incidents are tracked by Statistics Canada's Uniform Crime Reporting survey.

In the post-legalization period, the only category of criminal offence that has increased in absolute terms is the number of incidents related to the import or export of cannabis, which has coincided with an increase in cannabis interdictions at the border reported by the CBSA. Approximately 20% of interdictions are believed to be associated with organized crime or criminal activity and contravene both the *Act* and the *Customs Act*. However, the remaining 80% relate to cannabis that is properly declared to CBSA but lacking an appropriate permit from Health Canada. [83] This latter group is believed to be mainly individuals who are unaware of the *Act*'s restrictions on cannabis imports and exports (for example, those who bring personal amounts of legally obtained cannabis products across the border, or who purchase cannabis products from international sellers).

Impaired driving

Another area of criminal activity related to cannabis is drug-impaired driving. Self-reported driving after cannabis use declined in the years following legalization, from 27% in 2018 to 18% in 2022. [84] Among drivers who were injured and reported to a participating trauma centre, researchers in British Columbia noted an increase in the share of drivers who had blood levels of THC ≥2 nanograms per millilitre following legalization (from 3.8% of drivers pre-legalization to 8.6% post-legalization, based on data collected from January 2013 through March 2020). [85]

Racial disparities

While systematic, national data on the race of individuals who receive charges for cannabis-related offences does not exist, data available from some jurisdictions both pre- and post-legalization suggests that Black and Indigenous individuals continue to be over-represented relative to individuals of other ethnicities (see Chapters 7 and 9). [86] [72] We look forward to reviewing additional input and evidence on this issue.

Record suspensions

To address the issue of prior criminal records for cannabis possession, the Government of Canada instituted a program in 2019 that allowed individuals who had convictions under the CDSA related only to the simple possession of cannabis to apply for a record suspension without a waiting period and at no cost. Prior to this, there had been a $645 fee and a five-to-ten year waiting period. [87] Cannabis record suspension results in criminal records for cannabis possession being set apart from other criminal records, which may help individuals find work and educational opportunities; however, it does not remove the presence of the record. The onus is on applicants to collect relevant records and documents before applying. Uptake of the program has been limited, with 1,094 applications for cannabis record suspensions received by the Parole Board of Canada, and of these, 706 cannabis record suspensions ordered as of April 3, 2023. [88] The Government of Canada had previously estimated that 10,000 Canadians could be eligible for cannabis record suspensions. [89]

Estimates on the size of the illicit market

Emerging data suggests that the illicit domestic market has decreased in size. Based on data available from Statistics Canada on household expenditures, annual spending of $2.4 billion on illicitly sourced cannabis is about half the estimate from 2017, when $4.9 billion was spent on illicit cannabis products. [59] The International Cannabis Policy Study indicates that the share of all cannabis products purchased from a legal retail source increased from 61% to 82% between 2019 and 2022. [69] Illicit sourcing of edible cannabis has been a topic raised throughout engagement—the recent publicly available submission made by the Competition Bureau draws attention to the consumer demand for higher-potency edible cannabis products as a driver of the illicit market, in part based on customer feedback collected by the Ontario Cannabis Store. [90] However, data collected through the International Cannabis Policy Study suggests that in 2021, only 15% of edible consumers sourced exclusively from the illicit market, while an additional 17% sourced from both the legal and illicit markets. [80]

There have been some attempts to quantify the size of the illicit online market, which is made difficult by the variety of online platforms used, including "clear web" retail websites, social media listings, and the dark web. One study found nearly 500 listings for illicit cannabis products on social media websites, including Instagram, Twitter, and Facebook. [91] Law enforcement agencies have also conducted investigations in this space, with estimates ranging from 2,800 to more than 10,000 illicit cannabis websites in 2021. [92]

Sourcing illicit cannabis

Illicit websites, illicit storefronts, and dealers were cumulatively reported as the usual source of cannabis by 4% of past-year cannabis users in the 2022 Canadian Cannabis Survey. Certain other responses, such as "from a friend" are ambiguous about whether the cannabis originated from the legal or illicit market. Among respondents who indicated that they had sourced any cannabis from the illicit market in the preceding 12 months, 53% reported buying from someone they knew (for example, friend, family, acquaintance); 21% reported buying from an illegal website; 19% reported buying from a dealer; and 15% reported buying from an illegal retailer/storefront. [9]

What we heard

To gather views regarding criminal activity and the displacement of the illicit market, we heard from public safety experts,[40] public health researchers, academics, federal, provincial and territorial officials, the cannabis industry, Black community representatives, equity-deserving groups, youth, and representatives of First Nations and Inuit communities.

Criminal activities

Many public safety stakeholders were concerned about the persistence of the illicit market and the continued involvement of organized crime and criminal networks in illicit production and sale. They noted concern about criminal networks abusing the personal and designated production program to produce and divert cannabis to the illicit market, both domestically and via international exports, the latter of which often occurs at large-scale and in combination with other illicit commodities (for example, other drugs and firearms). This may include the exchange of illicit Canadian cannabis for different drugs from other countries (for example, cocaine). The abuse of the personal and designated production program is explored further in Chapter 12.

We also heard how proceeds from illicit cannabis create a need to obtain firearms for protection. Organized crime groups involved in the illicit cannabis trade also engage in money laundering operations, which in turn subsidize other activities of organized crime groups.

Feedback from individuals who have transitioned into the legal market suggests they had to overcome numerous barriers such as challenges in accessing capital, dealing with multiple levels of government and the regulations and policies imposed, and have had difficulties in realizing profits. Many cultivators report being unable to sell their harvests to processors, and those that can sell often receive very low prices in return. Many now have considerable and growing debts due to joining the legal market despite having been profitable while operating illicitly. They also noted that their struggles serve as a cautionary tale that discourages other legacy producers from transitioning into the legal market.

[40] We consulted broadly across a range of public safety experts including police services and front-line law enforcement officers from various communities, public prosecutors, defence lawyers, former judges, advocacy organizations, and officials from government departments within the public safety portfolio.

Illicit online sales

We heard how some illicit cannabis sales occur online, including through retail websites and social media, although it is difficult to quantify the extent of these sales. Stakeholders estimated that there are thousands of illicit websites selling cannabis in Canada. It was noted that illicit production and online illicit sales are often connected, with police investigations directly linking illicit producers to specific illicit retail websites. One provincial government official discussed the presence of criminal organizations that sell illicit cannabis through e-commerce and highlighted that while investments have been made to control online illicit trade, cross-provincial and territorial sales are difficult to control.

We heard how it can be difficult for consumers to differentiate between legal and illicit online retailers, leading to some unknowingly purchasing illicit cannabis. However, there is a subset of consumers who are aware that some retailers are illicit but nevertheless purchase from them.

Illicit copycat products

Governments and law enforcement are also trying to control copycat illicit cannabis products that are made and packaged to look like food products (for example, candy, snack foods), or illicit products that are made to look like legal cannabis products (for example, displaying a cannabis symbol).

Illicit physical retail stores

We also heard concerns about unauthorized physical retail stores. Despite measurable progress in closing illicit storefronts, large urban centres like Toronto report that they are struggling to shut down illicit stores. In addition, some First Nations also expressed concern related to illicit operations in their territory following the legalization of cannabis, and how the presence of these stores can attract organized crime groups and other criminal activities to their communities. However, in some communities, these stores may not be viewed as illicit depending on the community's approach to cannabis legalization and participation within the federal and provincial and territorial frameworks. Retail operations in First Nations communities, and the intersection with governance and jurisdiction, is discussed more in Chapter 7.

Displacement of the illicit market

On the question of displacement of the illicit market, we heard varied estimates from different stakeholder groups; it is clear that there is no agreed upon measure. This may be attributed to the variety of indicators and methodologies used to estimate the legal industry's market share (for example, Statistics Canada's household expenditures survey, cannabis use surveys, and industry data) and difficulties in tracking purchases from illicit sources.

Academic and public health stakeholders generally hold more positive views, and say data suggests the legal market has displaced between two-thirds to three-quarters of the illicit market nationally and that the legal industry is competitive with the illicit market. They pointed to other indicators, such as the trajectory of growth in the legal market and reported consumer behaviours, to demonstrate the displacement of the illicit market.

Conversely, industry and public safety stakeholders hold less positive views, arguing that structural barriers exist within the framework that make it difficult for the legal industry to compete. They also expressed concern about the persistence of the entrenched illicit market.

We heard contrasting views about how best to continue displacing the illicit market. One view was to increase enforcement efforts, thus increasing the cost to operate in and purchase from the illicit market. This was supported by industry stakeholders, who indicated that inconsistent enforcement of the illicit market presents a challenge to the legal industry, noting that authorized alcohol retailers do not face challenges related to unauthorized retailers. Others held views that enforcement efforts will struggle to make significant impacts, and that the greater impact will come from influencing consumer demand and behaviours.

We also heard about the importance of creating conditions for the legal market's success (for example, through relaxing restrictions on promotion, packaging and labelling, increasing the THC quantity for edible cannabis, increasing remote and after-hours access to cannabis, and removing the possession limit to allow higher volume purchases). Many industry stakeholders advocated for this approach, arguing that the many struggling legal companies need support to continue offering a legal, regulated alternative to illicit products, and that restrictions drive consumers to the illicit market as noted in Chapter 10.

Enforcement and prosecution

We heard about how criminal enforcement is a key factor that influences how long it takes to displace the illicit market. However, it was noted that law enforcement priorities are currently not focused on cannabis, but rather on higher priority issues like national security and other drugs (for example, other illicit substances). This has resulted in a reallocation of police resources away from cannabis-related initiatives. Stakeholders also discussed how cannabis-related offences are a lower priority for federal prosecutors, decreasing the likelihood of conviction and willingness of law enforcement to conduct criminal enforcement activities.

Public safety stakeholders noted that police investigations and enforcement operations related to illicit cannabis production and trafficking have become more complex (for example, due to overlapping jurisdictions and the shift to illicit online sales) and expensive, post-legalization. Law enforcement expressed challenges due to insufficient capacity (for example, funding, personnel, and other resources) that prevent effective enforcement of the *Act*, including further actions against unauthorized retail stores. The abuse of the personal and designated production program also adds a layer of complexity to police investigations, as it provides a means for criminal actors to hide in plain sight by resembling legitimate producers. Police also highlighted that they often face delays in their investigations while waiting for information on personal and designated production registrations from Health Canada.

We heard recommendations for actions to help combat the illicit online market and strengthen enforcement activities, including educating consumers to help them distinguish between legal and illicit websites and stores, increasing testing of illicit products, improving communication about quality issues in illicit products, working with financial institutions to disrupt payments to illicit sellers, shutting down illicit web domains, and increasing undercover law enforcement operations. Some also suggested eliminating or restricting the personal and designated production program. Additionally, some suggested that excise tax revenues should be allocated to supporting criminal enforcement actions under the *Act*.

We also heard about the need for more resources to deliver and update training materials and testing tools for law enforcement officers, particularly to support smaller forces that may not be well-equipped to develop such materials internally.

Public safety stakeholders discussed challenges related to enforcement in First Nations and Inuit communities. Each community is unique with respect to their enforcement capacity, intervention thresholds, desires, and needs. This is further explored in Chapter 7.

Some questioned the need for limits on public possession, especially for youth, as they consider the harms associated with criminalization greater than those of cannabis use. These harms are addressed in more detail in Chapter 6. In contrast, we heard that law enforcement officers find the existing provisions in the *Act* valuable, as the provisions provide them the authority to approach youth, and use discretion to seize cannabis and provide interventions, instead of laying charges. Stakeholders also highlighted that more data is needed to understand how youth are impacted by the criminal justice system, including data related to why police pursue charges against some youth and not others. During these discussions, we heard concerns about the discretionary treatment of youth and the public possession limits possibly contributing to continued racial biases in policing, an issue that also lacks systematic data.

Influencing consumer demand and behaviour

In terms of product choice, we heard from public safety and industry stakeholders that the consumer demand for higher amounts of THC in edible cannabis products creates a gap that the illicit market is filling. Provincial and territorial distributors and industry stakeholders also noted that edible cannabis comprises a larger share of the illicit market than it does of the legal market.

In contrast, academics said that their research suggests that the primary consumers of edible cannabis are infrequent users, most of whom find 10 milligrams of THC to be sufficient. They also noted that edible cannabis products are the most difficult type of cannabis product to regulate, as a balance must be found between moving existing consumers away from the illicit market and enticing new consumers to the legal market. Public health stakeholders opposed changes that would loosen existing restrictions on allowable ingredients and product formulations, and that prioritize the elimination of the illicit market over the protection of public health, arguing that reducing public health restrictions to capture the remaining illicit market would create more public health harm (for example, new consumers, increased potential for over-consumption, increased risk of accidental poisonings in children).

Academic researchers noted an increase in consumers who report sourcing cannabis from stores on First Nations reserves, although they note that existing surveys generally do not differentiate between legal and unauthorized stores in First Nations communities. Similarly, some Inuit consumers receive cannabis via the mail due to the lack of legal retail stores in Northern communities, and it can be difficult to determine if the cannabis is from legal or illicit sources.

Other issues

Companies that support the illicit market

Public safety stakeholders raised concerns about ancillary companies that support the illicit market. These include companies that produce packaging and labelling materials, delivery services, and otherwise legal enterprises that serve illicit cannabis operations. To combat this, some suggested increasing public education in this space and leveraging alternative enforcement methods such as administrative penalties.

Impaired driving

We heard that impaired driving is still a major concern, and there is a continued need for enforcement and tools to detect cannabis use and confirm impairment in drivers. We also heard that law enforcement agencies across the country have inequitable access to the tools, training, and personnel necessary to address this issue. Enforcement of cannabis-impaired driving also suffers from a lack of research and established limits (akin to the blood alcohol content limits that exist for alcohol-impaired driving). Additionally, it was suggested that more public education is needed around impairments caused by THC (such as, risks after consumption and duration of effects), and specifically by the combination of THC with alcohol.

Expungement

Finally, stakeholders called for the expungement of simple cannabis possession charges, noting the lower-than-expected uptake of the existing record suspension program and the enduring harms caused to individuals by cannabis prohibition. While the program is now offered at no direct cost to applicants, some have criticized the process as being cumbersome. They made repeated calls for the federal government to simplify the process and make it more accessible.

Chapter 12

Access to cannabis for medical purposes

Overview of measures

Prior to the coming into force of the *Cannabis Act* (the *Act*), the possession, production, and distribution of cannabis were generally prohibited. In 1997, in response to a constitutional challenge by a person producing cannabis for their own medical use, the Ontario Court ruled that the cannabis prohibitions infringed their rights under Section 7 of the Canadian Charter of Rights and Freedoms.[41] The Court held that an exemption should be read into the legislation (the *Controlled Drugs and Substances Act*) to allow the use of cannabis for medical purposes without criminal sanctions. This exemption-based regime was subsequently found insufficient by the courts in 2000 for those with a defined medical need, resulting in the establishment of the *Marihuana Medical Access Regulations* (MMAR) in 2001, followed by the *Marihuana for Medical Purposes Regulations* (MMPR) in 2013 and the *Access to Cannabis for Medical Purposes Regulations* (ACMPR) in 2016. Each new set of regulations was developed and implemented as the result of a court decision finding that the previous regime was too restrictive.

When the *Act* and its regulations came into force in 2018, the medical access framework established in the ACMPR was largely maintained. Some of the changes that were made to the regulations include access to a broader range of permitted products (for example, edible cannabis), and removal of the limits on how much cannabis a person could store.

The current medical access program under the *Act* remains a distinct way to access cannabis for medical purposes. However, not all adults who use cannabis for a medical reason choose to register in the program. Instead, they may choose other legal means to access cannabis through non-medical channels. For example, they can purchase their cannabis from a legal retail store, grow up to a maximum of four plants in their home (subject to some provincial prohibitions and restrictions), or receive cannabis from, or share it with, other adults. The medical access program is the only legal option for a young person, who is less than the legal age limit required to purchase cannabis in their province or territory, to obtain cannabis.

Patients who wish to use the medical access program must have a medical document from a health care professional[42], which includes an authorized daily amount based on medical need (set out in grams of dried cannabis per day); however, there is no limit to how much cannabis a health care professional can authorize. Medical documents provide an authorization that is valid for a maximum of up to one year, after which the patient must renew it with a health care professional.

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41 Section 7 of the Canadian Charter of Rights and Freedoms sets out that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice". These principles are determined by the Court and form the basis of the Canadian legal system. The principles of fundamental justice include the principles against arbitrariness, overbreadth, and gross disproportionality.

42 In this case a health care professional means a medical practitioner or nurse practitioner.

Once a patient has a medical document, they can register with a federally licensed medical seller to purchase regulated cannabis products. These cannabis products are generally the same as those available in legal retail stores. Once registered, patients can place orders and receive their products through the mail or by courier. The price of these products is set by licensed sellers and can vary between different sellers. Some companies offer compassionate pricing programs to reduce the cost of cannabis for medical purposes for particular populations, such as children or people whose annual income is lower than a certain threshold. Unlike cannabis products that are sold in provincially or territorially authorized retail stores, there is no storefront access, and the provincial and territorial distributors are not involved in medical sales.

Instead of purchasing cannabis from a federally licensed medical seller, patients also have the option to register with Health Canada to grow cannabis or designate someone to grow it on their behalf; this is referred to as personal or designated production. The authorization amount on a person's medical document determines how many plants they can grow; in accordance with a formula in the regulations, this generally is five plants per gram for indoor growing and two plants per gram for outdoor growing. There is no limit to how many plants a person can grow, as long as it aligns with the authorization amount set by their health care professional.

Licensed medical sellers are subject to the same security and quality controls as other federal cannabis licence holders. Some of these requirements are outlined in Chapter 4.

However, those who grow cannabis for themselves or others as part of the personal and designated production program (that is, "registrants") are not subject to the same controls as commercial licence holders. Core controls on these individuals include:

- eligibility restrictions related to convictions for certain drug-related offences (for example, they must not have been convicted of a sale, distribution, or export offence while having been authorized for personal or designated production in the past 10 years)
- designated producers may only grow for up to two persons holding a medical authorization
- a maximum of four registrants may produce at the same site
- outdoor cultivation cannot be adjacent to a school, public playground, or daycare
- applicants must attest to taking reasonable steps to secure the cannabis they produce

Cannabis products for medical purposes are separate and distinct from prescription drugs containing cannabis (that is, unlike prescription drugs containing cannabis, cannabis products for medical purposes are not subject to a pre-market review to determine whether they have met Health Canada's safety, quality, and efficacy standards as set out under the *Food and Drugs Act* and its regulations). Although cannabis products are produced and sold for medical purposes, they cannot make health claims. Furthermore, cannabis products are subject to excise and sales tax unlike prescription drugs which carry a Drug Identification Number (DIN) and are therefore exempt from tax.

Data and observations

Prevalence of use of cannabis for medical purposes

Millions of Canadians report using cannabis for medical purposes.[43] In 2017, prior to legalization, an estimated 1.6 million Canadians self-reported that at least some of the cannabis they consumed was intended to manage symptoms, or to treat a disease or medical condition. [6] Following legalization, the 2019 Canadian Alcohol and Drugs Survey suggested 2.3 million people (36% of cannabis users) were using cannabis for medical reasons, which is similar to the share of users reporting medical use in 2017 (37%). [23] More recent data collected through the Canadian Cannabis Survey showed no statistically significant change over time in self-reported medical use (13% of all respondents in 2022, not significantly different from 12% in 2017). [9] [93] Most people who use cannabis for medical purposes also use it for non-medical reasons (that is, "recreationally"). In 2022, 39% of cannabis users responding to the Canadian Cannabis Survey indicated they used it for medical purposes, including 17% reporting using exclusively for medical purposes, and 23% reporting use for both medical and non-medical reasons. Sixty-one percent of users reported consuming cannabis for non-medical purposes only. [9] Earlier findings from national surveys and academic research suggest that prior to legalization, the majority of people who reported medical use were also using cannabis recreationally. [12] [93] [94]

Although the prevalence of cannabis use tends to decrease with age, the share of cannabis consumers who report using cannabis for medical purposes is higher among older age groups. For example, the 2022 Canadian Cannabis Survey found that among 16- to 19-year-olds, only 5% of cannabis consumers reported exclusive medical use, while among cannabis consumers aged 55 or older, 34% reported using cannabis for medical purposes only. [9] [95] The 2022 Canadian Cannabis Survey also found exclusive medical use to be more commonly reported by females than males; 6% of all female respondents to the survey indicated exclusive medical use, compared to 4% of all male respondents. [9]

Reasons for medical use

According to the 2019 Canadian Alcohol and Drugs Survey, the most common medical conditions that respondents reported using cannabis for were anxiety (reported by 33% of those who used cannabis for medical purposes), followed by arthritis (21%), and depression (8%). Thirty-two percent indicated using cannabis for other medical conditions. [7] Data collected by the Canadian Cannabis Survey since 2018 suggests that, among those that completed the medical portion of the survey, the most common medical conditions[44] cannabis was being used for included anxiety, insomnia, depression, arthritis, and pain from injuries or migraines. Participants who completed this part of the survey were also asked to identify symptoms, and common responses included sleeping difficulties, acute pain, chronic pain, and headaches/migraines. [96]

Cannabinoid content of products used

Among those who completed the medical section of the 2022 Canadian Cannabis Survey, 17% reported typically using cannabis with higher THC and lower CBD, 14% reported equal amounts of THC and CBD, 29% indicated higher CBD and lower THC, 17% reported using CBD only, and 9% were unsure. [9] The Medical Cannabis Access Survey, a targeted online survey of more than 5,000 medical users conducted in 2022, found that more than half (50–73%, depending on the product) of people who used cannabis for medical purposes were unable to report on the amount of THC or CBD they consumed each day. [97]

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[43] In population surveys, use of cannabis for medical purposes is self-declared, and is based on an individual's beliefs or intentions. Some people who use cannabis for medical purposes consult with, and/or receive an authorization from a health care professional; however, most do not. Some people who use cannabis for medical purposes obtain cannabis through the medical access framework described above, but most do not.

[44] Note the Canadian Cannabis Survey uses the term "diseases/disorders".

Authorizations and registrations within the medical access framework

Most people who use cannabis for medical purposes do not possess an authorization from a health care professional and access cannabis for medical purposes outside the medical access framework. Among those who completed the medical portion of the 2022 Canadian Cannabis Survey, 26% reported having a medical document authorizing cannabis use, while 74% did not. Of those who said they had a medical document, 14% reported accessing cannabis outside of the medical access system. [9]

The number of individuals registered to obtain cannabis for medical purposes from a licensed medical seller has declined from a peak of almost 380,000 in September 2020 to around 213,000 in March 2023. Active registrations for personal or designated production of cannabis for medical purposes peaked around 47,000 in September 2021, and have subsequently decreased to approximately 19,000 in March 2023. [98] The majority of registrations for personal or designated production are for personal production; there are approximately 300 registrations for designated production nation-wide (a decrease from the more than 1,300 registrations for designated production at the time of legalization). [99]

Medical access market

In October 2018, 35 licence holders were actively selling cannabis for medical purposes to patients. More recently, in 2022, 97 companies reported active sales to registered patients. As with the non-medical market, sales of cannabis for medical purposes are concentrated among a small number of companies. Ninety-five percent of sales of cannabis for medical purposes are obtained by 10 companies, with the top two companies being responsible for more than half of all medical sales. [62]

Authorized amounts

The amount of cannabis authorized by health care professionals for daily use by patients differs widely between the 213,000 medical clients registered to purchase cannabis directly from a licence holder and the 19,000 individuals registered to grow cannabis under the personal or designated production program. As of March 2023, the average amount of cannabis authorized for daily use among those buying from licensed medical sellers was 2.2 grams per day; the authorized amount has remained relatively constant since October 2018. In comparison, the average daily amount authorized for those registered for personal or designated production was 35.5 grams per day as of March 2023, which represents a decrease from the peak in September 2021, when the average daily amount exceeded 45 grams per day. [98]

As of March 2023, 5,760 health care professionals issued medical authorizations in the past year for patients who obtain cannabis directly from federally licensed sellers, and 1,185 health care professionals issued authorizations linked to active personal or designated production registrations. Among those associated with personal or designated production registrations, 259 had authorized amounts equal to or above 25 grams per day, and 20 had authorized amounts equal to or above 100 grams per day. [98] We understand that Health Canada has undertaken additional oversight, and actively seeks further information from health care professionals to substantiate the amount of cannabis authorized in some instances. Additionally, in certain cases the information about authorization practices of health care professionals has been passed on to the relevant regulatory colleges.

Pricing and reported spending

The price per gram charged by licensed medical sellers has decreased since legalization. As described by Shim et al., prices obtained from the product catalogues of licensed medical sellers reveal decreases in the prices of most dried cannabis and cannabis oil products offered from 2016 to 2022; they further note that the consumer price index for "medicinal cannabis"[45] declined by almost one-third between January 2019 and October 2021. [100]

The Canadian Cannabis Survey sought to collect data on monthly spending on cannabis. While the cannabis described in the survey may have originated from a variety of sources (legal or illicit), when asked about spending in the past 30 days on cannabis for medical purposes, the median[46] amount spent was $40.00. In response to a similar question about cannabis for non-medical purposes, the median amount was $25.00. [9] The costs to people who use cannabis for medical purposes frequently (for example, every day) may be considerably higher than the median costs.

The Medical Cannabis Access Survey, a targeted online survey involving more than 5,000 people who used cannabis for medical purposes, conducted collaboratively by patient advocacy groups and researchers in 2022, reported different spending numbers. It noted median spending by medical users of $125 per month, with 39% of respondents spending more than $200 per month. Among 204 respondents who had discontinued the use of cannabis for medical purposes, almost half (48%) said they stopped because cannabis was too expensive. A group of 760 respondents who formerly had authorizations to use cannabis for medical purposes indicated they declined to renew their authorization because the legal market meant there was no need (68%), or the cannabis from licensed medical sellers was too expensive (48%). [97]

Insurance coverage

A small fraction of patients who use cannabis for medical purposes receive insurance coverage. The 2022 Canadian Cannabis Survey found that only approximately 3% of respondents who completed the medical portion of the survey indicated they had full insurance coverage and 5% said they were partially covered. [9] Veterans Affairs Canada, one of the few public insurers, reimburses veterans for up to three grams per day[47] of dried cannabis (or equivalent), up to a maximum of $8.50 per gram. [101] In fiscal year 2021–2022 (the most recent year for which data is available), benefits of over $153 million were paid to approximately 18,000 patients. [102]

Prescription drugs

A small number of prescription drugs containing cannabis or cannabinoids are currently authorized for sale in Canada under the *Food and Drugs Act*. Sativex® contains THC and CBD (1:1) and is approved for symptomatic relief of spasticity in patients with multiple sclerosis. [103] Several formulations containing nabilone, a synthetic analogue of THC, are currently marketed for the treatment of nausea and vomiting resulting from cancer treatment. [104] Other pharmaceutical products containing cannabis are available in other jurisdictions but have not received a market authorization in Canada, including Epidiolex® [105], a prescription drug containing CBD that is used to treat epilepsy resulting from certain conditions. Another product, Marinol® (dronabinol), which contains a synthetic form of THC used to treat anorexia in AIDS patients and nausea and vomiting associated with chemotherapy, had previously been approved for use but was voluntarily withdrawn from the Canadian market by the manufacturer. [106]

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45 Cannabis for medical purposes is described as "medicinal cannabis" in Statistics Canada's Consumer Price Index (CPI) data.

46 The median amount means that half of respondents spent more than this amount, and half spent less.

47 Veterans who require larger amounts can request a higher limit (up to a maximum of 10 grams per day).

What we heard

To gather views on the medical access program and more broadly on how people access cannabis for medical purposes, we conducted a series of one-on-one meetings, roundtable discussions, and in-person visits. The views reflected here are based on engagement with patients and their caregivers, health care professionals, patient advocacy groups, researchers, harm reduction groups, cannabis clinics, compassion clubs (organizations that provide cannabis for medical purposes), law enforcement, and various levels of government. Throughout this engagement, we heard patients' general disappointment with the medical access program and the state of access to it.

Patient views on the medical access program

Many patients we heard from, along with their caregivers, researchers, and health care professionals who work with patients, spoke about the impact cannabis for medical purposes has had on their lives. They spoke about the benefits it has had on their health, quality of life, autonomy, and ability to care for themselves and their family members. Some patients, such as those living with rare diseases (for example, children suffering from intractable seizures), and their caregivers, described how cannabis has been more effective for the treatment of their medical conditions than other pharmaceutical interventions they tried, while others used cannabis in conjunction with other medical therapies.

Many of these stakeholders strongly support maintaining a patient-centric, distinct medical access framework, with improvements. They point to the benefits it provides, such as oversight by a health care professional, access for youth, insurance coverage (for some), access to product categories that may not be available in all provincial or territorial retail markets (for example, if that province or territory does not allow its sale, such as cannabis topical products in Quebec), compassionate pricing, legal accommodations in employment (for example, to use cannabis for medical purposes during working hours if it is deemed medically necessary and safe to do so), and tax deductions.

We heard from patients and health care professionals about the reported benefits many patients derive from cannabis use, and their reliance on cannabis on a daily basis. We heard about how cannabis use can help a patient to be a productive employee, present and engaged for their family, and a contributing member of their community. Patients told us about how they use cannabis to manage a range of health conditions and symptoms, including for conditions such as: post-traumatic stress disorder, epilepsy, chronic pain, arthritis, anxiety disorders, sleep disorders, cancer, and brain disorders. We also heard from organizations involved in harm reduction programming that in some instances, patients have been able to substitute the use of opioids with cannabis.

We also intend to speak with people who have not benefited from, or who have been negatively impacted by, the use of cannabis for medical purposes. We heard some examples of adverse effects that patients faced while self-dosing cannabis for medical purposes outside the clinical monitoring framework, such as symptoms of anxiety and paranoia.

Many patients also expressed their frustration that access to cannabis has not improved under legalization. They noted that the issues they faced prior to legalization—lack of affordability, difficulties in accessing care, the limited evidence on which to make decisions, stigma—all remain. Some patients feel that access is worse, noting that the cannabis industry's primary focus is on supplying legal retail stores. Accordingly, they provided recommendations on how medical access could be improved, such as better/more reliable retail access points, more product types, higher THC quantity, protections from product shortages or products being discontinued, longer timeframes for the validity of a medical document, more knowledgeable health care professionals, and the integration of the physician authorizing their cannabis into their general care so that they do not have to see multiple health care professionals. These stakeholders shared that despite their tireless advocacy, they have fears that the government and the medical system will never acknowledge their perspectives and the challenges they have faced.

Patients also spoke about their concerns that the pharmaceutical industry is not interested in engaging in cannabis-based research and drug development because this could displace the sales of other drugs. One researcher suggested that pharmaceutical companies tend to be conservative in facilitating research, and if the regulatory pathway is unclear, they are unlikely to participate in conducting research. We have not been successful in efforts to engage the pharmaceutical industry to understand their perspective on this issue, but would welcome their input.

Involvement of health care professionals

Patients and their caregivers shared with us their frustrations with the challenges and obstacles they face in finding a health care professional willing to authorize cannabis for medical purposes or one with sufficient knowledge to help them navigate how to use cannabis to meet their often complex medical needs. Some patients shared that even once they found a supportive health care professional, they experienced stigma from their employers or coworkers about their use of cannabis, or from other health care professionals. They noted challenges overcoming the view that cannabis is not a legitimate therapy when accessing care in hospitals.

Some patients reflected that the messaging on cannabis products (for example, a health warning message about the addictive potential of cannabis) can also be stigmatizing towards individuals using cannabis for medical purposes.

Some patients noted that systemic racism within the medical system, along with the stigma associated with cannabis use, further prevents some patients from accessing cannabis for medical purposes. They detailed the long-lasting negative impacts these experiences can have on patients and their mental and physical well-being.

Many patients view health care professionals who authorize cannabis for medical purposes as playing an important role in their circle of care. Some patients shared stories about seeking information about the different forms of cannabis products available, as well as dosing regimens, with little to no support from their health care professional. Many health care professionals are uncomfortable with the lack of clinical evidence that is currently available for many uses of cannabis.

To address this, some stakeholders called for improved education and guidance for health care professionals regarding cannabis (including information about product selection, dose, and drug interactions and the endocannabinoid system), including ensuring that current knowledge about cannabis is incorporated into medical school curricula. Others suggested that the federal government should lead the development of a comprehensive education and training framework for health care professionals by collaborating with provincial and territorial medical regulatory authorities and the various medical associations. They noted that patient education resources should be developed that are reflective of the evolving evidence and the new cannabis products available. Patients and patient advocacy groups underscored that any resources developed for health care professionals or patients should ultimately be informed by those with lived and living experience using cannabis for medical purposes and be freely available to patients.

Health care professionals, cannabis clinic operators, and patient advocacy organizations also called for updates to be made to the current medical document that health care professionals must fill out to authorize cannabis for medical purposes. They noted these changes would help patients better understand how to use the products and prevent misuse of products (for example, accidental over-consumption). Suggestions were made to require the inclusion of information about the recommended product form (for example, cannabis oil or dried cannabis), the dosage (for example, amount of cannabis oil per day, in millilitres), and cannabinoid concentration for both THC and CBD.

Research barriers and gaps

We heard from researchers about the barriers that exist to conducting clinical trials on cannabis and how this impacts the development of prescription drugs containing cannabis which would have a Drug Identification Number (DIN). They shared that improved research processes would advance the critical information needed for patients and health care professionals on the therapeutic benefits, adverse effects, and suitability for specific sub-populations (for example, youth and pregnant people). Some of the barriers they noted include difficulties surrounding:

- obtaining a research licence through the *Cannabis Regulations* as well as authorization under the *Food and Drug Regulations*
- the limited availability of cannabis products and suppliers that meet the Good Manufacturing Practices under the *Food and Drug Regulations*
- navigating complex compliance protocols for handling, possessing, storing, and destroying cannabis during research
- meeting data standards under the *Food and Drug Regulations* (for example, the need for pre-clinical studies and detailed, product-specific information about the cannabis being studied)
- inconsistencies (for example, cannabinoid content) between batches, especially when using plant materials
- the inability to conduct multiple research projects under one licence
- the lack of incentives for companies to invest in research in this area, given the presence of the legal non-medical market

Alternatively, some stakeholders believe that aiming to obtain the status of a pharmaceutical (that is, DIN drug) is not a realistic goal given the challenges with conducting clinical trials. They advocated for a regulatory approval regime for non-prescription CBD health products that adopts the model used by Health Canada's Natural and Non-prescription Health Products Directorate to determine the safety, efficacy, and quality of natural health products. Some researchers are currently reviewing the evidence on the use of cannabis for medical purposes to treat certain conditions compared to the use of other pharmaceutical options, such as opioids. A number of patients commented on their own experience of being able to eliminate or reduce their use of opioids and other prescription medicines with the use of cannabis, particularly CBD-dominant products.

Some public health experts emphasized the need to advance research and understanding on the prevalence of, reasons for, and consequences of the use of cannabis as a self-management tool for mental distress and disorders.

A recurrent theme was the need for more information about cannabis for medical purposes. Stakeholders noted that, unlike drugs that have precise and well-defined compositions, cannabis can take many different forms depending on the genetics of the plant, the cannabinoids present, and their concentrations. This can make it very difficult when conducting research to determine which constituent, or combination of constituents, in cannabis could be responsible for therapeutic or adverse effects. This in turn hinders the ability to produce data and evidence that can be replicated over time.

Addressing patient safety and public safety concerns

We heard from the research community that the current framework does not enable the collection of long-term data on the safety of cannabis for medical purposes, such as adverse reactions, in the same way as the framework for pharmaceutical drugs allows. They noted that this data is necessary to develop safety information and appropriately counsel patients on the benefits and harms of cannabis use. Stakeholders noted the importance of providing patients with adequate information about potential adverse effects of cannabis and how certain cannabis products (for example, products with THC) can impair driving. Some health care professionals with experience authorizing cannabis for medical purposes shared the importance of modifying dosage and titration recommendations for particular patient populations where there may be additional risks to using cannabis (for example, older adults, new cannabis users, or patients taking prescription medications that can negatively interact with cannabis).

Cannabis clinics

We heard about the role that cannabis clinics play in the medical access framework and how they can provide in-depth knowledge about the use of cannabis for medical purposes, especially for patients who may be new to using it or who may be managing multiple complex health conditions. Stakeholders also shared that not all cannabis clinics place patient safety as a priority or comply with the policies put in place by provincial and territorial medical regulatory authorities. For example, not all clinics ensure that the health care professional establishes a legitimate medical relationship with the patient prior to providing an authorization, which means that they may have little to no information about the patient, nor do any follow-up care. They shared concerns that patients who visit such clinics may access cannabis in formats (for example, combustible products like dried cannabis or pre-rolls) or with cannabinoid concentrations (for example, high THC products) that may not be suitable for their medical condition or health status.

Other stakeholders noted that when cannabis clinics are owned or associated with licensed medical sellers, or if the clinics or the health care professionals associated with them receive financial incentives based on the amount of cannabis authorized, it can create a conflict with the best interest of the patient. Recognizing the role of both the provinces and territories and the medical regulatory authorities in the oversight of health care services and health professionals, some stakeholders suggested all groups should work together to create and enforce stricter standards for cannabis clinics and health care professionals.

Personal and designated production

We heard from law enforcement stakeholders, municipalities, cannabis clinics, and landlords about the public safety concerns associated with the personal and designated production program, particularly when individuals have authorizations to grow large amounts of cannabis. They noted the public safety risks the program poses to neighbours, landlords, and communities including fires, robberies, and gang-related crimes that may take place in and around properties used for growing large amounts of cannabis. Law enforcement also presented evidence of instances where personal and designated production sites were used as a cover for illicit production and subsequent diversion of cannabis to the illicit market.

We heard that the controls within the framework for personal and designated production are not sufficient to protect public health and public safety. Some recommended Health Canada move towards eliminating the personal and designated production entirely given adult access provided by legal retail and home cultivation, while others felt that new or strengthened controls could help address public safety concerns.

Some stakeholders recommended additional requirements as part of the application process to deter those who seek to abuse the program, including:

- a more robust criminal record check and automatic refusals if the applicant has a conviction for illegally importing or producing cannabis
- only one personal and designated production site be permitted at an address to prevent the proliferation of multiple sites in one area
- requiring additional information from health care professionals on the need for medical cannabis and the required dosage
- a maximum daily dosage that can be authorized
- requiring municipal approval for the number of plants and location of the production site
- filing a copy of the registration certificate with local law enforcement agencies

Some law enforcement groups recommended that Health Canada strengthen its compliance activities and conduct more inspections of personal and designated production sites. They presented evidence of instances where registrants were growing thousands of plants, which was far beyond the number they were authorized to grow and at a scale that would be profitable in the illicit market. They recommended that registrations be suspended or revoked with no possibility of re-applying in the future when a criminal offence or serious regulatory violation (for example, over-production) is confirmed by Health Canada inspectors or law enforcement. They felt that multiple minor violations of the regulations should also result in suspension of the registration if an applicant is found to be non-compliant, and that Health Canada should administer fines for infractions.

To further help address over-production and diversion to the illicit market, some stakeholders recommended that police be granted inspection powers under the *Act* for personal and designated production. Others recommended implementing additional controls so that registrants found to be over-producing could have their entire crop seized. They also noted that Health Canada should develop and provide police access to a searchable database to conduct inquiries during an investigation in relation to personal and designated production.

Despite these concerns, other stakeholders, namely patients and patient advocacy groups, emphasized that the ability to grow one's own cannabis (or designate someone to do so) can be a helpful method of access for some patients, particularly when cost is a concern. They felt that more could be done by the government to address problematic authorization practices while still maintaining this access channel for patients.

Affordability and accessibility

Cost, tax, and insurance issues

Stakeholders noted that affordability continues to be a major concern for some patients. They note that in some cases, products in the medical market are more expensive than the non-medical market and this may encourage patients to seek out cannabis from a retail store or an illicit source rather than going to their health care professional and registering in the medical access program. Some patients told us that they pay thousands of dollars (one patient noted as much as $20,000) a year for their cannabis for medical purposes. Patients want cannabis for medical purposes to be treated like prescription drugs, which are generally exempt from excise and sales tax. Patients also suggested that the federal government extend greater insurance coverage for these products. They noted that while some small gains have been made to obtain coverage, individual patients and their advocates do not have the capacity to drive large-scale change with public and private insurers. Some pointed to the insurance coverage for Canadian veterans as a model for better insurance coverage. However, we have heard that this model could be subject to abuse as some individuals may use it to access no cost or low-cost cannabis for non-medical purposes.

Product availability issues

It is apparent that patients utilize a broad range of cannabis products at varying cannabinoid concentrations to meet their needs. Some recommended allowing certain higher-potency products to be sold in the medical market, such as edible cannabis with more than 10 milligrams of THC per package and suppositories with more than 10 milligram of THC per unit, noting that patients do not want to consume multiple units to obtain their required amount.

Patients spoke about issues they face with product shortages, products being discontinued, and challenges in their interactions with licensed sellers. A caregiver for a pediatric patient told us that orders frequently can only be partially filled, and how there is no advance notice of product shortages. Other patients spoke about the frustration faced when learning that a product which they have come to rely on—often after a long period of trial and error—is no longer available to them from their medical seller, yet can be found in legal stores, sometimes at cheaper prices. They called on the government to put in place measures to prioritize the needs of patients. Many patients noted that there has been a great deal of turnover among licensed sellers. They noted that when a licensed medical seller goes out of business or is bought out, patients may lose access to a product they had been using for years. Some stakeholders also discussed challenges they faced due to not being able to travel internationally with their cannabis for medical purposes.

Pharmacy access

Many patient groups supported maintaining the ability to access cannabis for medical purposes through the mail order delivery system or through personal or designated production, but they also spoke of the benefits of allowing additional methods of access such as through pharmacies. They felt that accessing products at a pharmacy, where patients could speak to a pharmacist about drug interactions or adverse effects, would be beneficial, and more akin to the process for other medications. Others noted that pharmacy access would help alleviate cases of mail order delays and interruptions in access to cannabis. Some stakeholders suggested that while pharmacy access would be beneficial, pharmacists may not be able to provide adequate and comprehensive counseling due to time constraints. In addition, they noted that in order for some pharmacists to feel comfortable distributing cannabis for medical purposes, they may require more evidence on the safety and efficacy of cannabis or may only feel comfortable if cannabis products are given identification for tracking purposes (for example, a Drug Identification Number or a different unique identifier). Other stakeholders felt that pharmacists may be well placed to work collaboratively with other health care professionals as well as provide advice on products, dosing, and contraindications with other medications.

Role of compassion clubs

Some stakeholders, especially those who work in harm reduction, noted that some patients still struggle to use the medical access program. They noted that those without access to a health care professional, without a fixed address, or who do not have access to the Internet or a credit card, face barriers. They noted that creative solutions, such as the incorporation of compassion clubs (organizations that provide cannabis for medical purposes) into the legal system, could address these gaps in access for marginalized populations.

Chapter 13

Next steps

The next phase of our work will focus on providing advice and recommendations to the Minister of Health and the Minister of Mental Health and Addictions on areas of the legislative framework and its implementation that may benefit from improvement or reform. We will also look to advise on improvements or reforms to related policies and programs that, in our view, should be considered for the legislative framework to operate in an effective manner. We will conduct additional engagements in fall 2023 to help finalize our advice and recommendations, including with advisors to provide us with advice on the economic impacts of the *Cannabis Act*. We welcome further input and information as we continue our review.

In accordance with our mandate, we will prepare a final report for the Ministers with our assessment of the framework and our advice and recommendations. As set out in the *Act*, the Minister of Health is responsible for tabling this report in both Houses of Parliament no later than 18 months following the launch of the legislative review (that is, by March 2024).

Appendix A

Glossary

Adults: Individuals who are 18 years of age or older.

Canadian Alcohol and Drugs Survey (CADS): A biennial, nationally representative cross-sectional general population survey of Canadians aged 15 or older that collects information on substance use, including alcohol, cannabis, and illicit drugs.

Canadian Cannabis Survey (CCS): A cannabis-focused, cross-sectional annual population survey of Canadians aged 16 or older designed to obtain detailed information about knowledge, perceptions, and behaviours related to cannabis use.

Canadian Community Health Survey (CCHS): A large, nationally representative, cross-sectional annual population survey of Canadians aged 12 and over that collects a wide range of health data, including information on cannabis use and related indicators.

Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS): A large school-based biennial survey administered to students in grades 7 to 12 (secondary I-V in Quebec) that collects data on substance use, mental and physical health, and bullying.

Cannabidiol (CBD): A non-intoxicating (does not produce a "high") cannabinoid found in cannabis. It has been associated with certain effects on the brain including modifying blood flow in the brain and some types of brain activity.

Cannabinoid: Groups of structurally-related chemical compounds initially identified in the *Cannabis sativa* plant and from which the name "cannabinoid" derives. Some of these cannabinoids are known to bind and interact with "cannabinoid receptors" that are distributed throughout the body and responsible for mediating some of the effects of cannabis. Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) are two of the most well-studied and abundant cannabinoids in cannabis products.

Cannabis: The *Cannabis sativa* plant, as well as all products that contain cannabis, such as edible cannabis and cannabis extracts. Under the *Cannabis Act*, the definition includes all parts of the cannabis plant as well as any cannabinoids produced by or found in the cannabis plant, including derivatives of those cannabinoids, irrespective of their origin (for example, cannabis cannabinoids synthesized outside of cannabis plants). The legal definition of cannabis excludes the control of certain parts of the cannabis plant that contain very low quantities of cannabinoids, such as non-viable seeds, roots, and stalks. Also known as "marijuana" or "marihuana".

Cannabis for medical purposes: Cannabis that is consumed with the intent to treat a disease/disorder or to improve symptoms. Individuals who use cannabis for medical purposes may or may not have a medical authorization from a health care professional, and cannabis used for medical purposes can be acquired in a number of ways, depending on whether the individual has a medical authorization. If purchased from a legal source, cannabis for medical purposes conforms to the same standards as the cannabis products sold to adults in provincially and territorially authorized stores. These cannabis products are distinct from prescription drugs containing cannabis (that is, products that have a Drug Identification Number (DIN)) since they have not been reviewed for safety, quality, or efficacy, and cannot make therapeutic claims.

Cannabis for non-medical purposes: Cannabis that is consumed for enjoyment, pleasure, amusement or for spiritual, lifestyle, social, or other non-medical reasons. This is sometimes referred to as recreational cannabis or recreational use.

Delta-9-tetrahydrocannabinol: see THC.

Distinctions-based: Acknowledges that each community has a unique culture, territory, history, and relationship with the Government of Canada, as well as unique strengths to build on and challenges to face. A distinctions-based approach means working independently with First Nations Peoples, Inuit, Métis Peoples, and Intersectional Peoples in recognition of their unique attributes.

Distributor: The entities that sell cannabis products to legal retailers for sale to adult consumers, and which are under provincial and territorial control. All provinces and territories except Saskatchewan operate distributors.

Drug Identification Number (DIN): An eight digit number found on the label of prescription and over-the-counter drug products that have been evaluated and authorized for sale in Canada. A DIN uniquely identifies the following product characteristics: manufacturer; product name; active ingredient(s); strength(s) of active ingredient(s); pharmaceutical form; and route of administration.

Equity-deserving groups: Groups that identify barriers to equitable access, opportunities, and resources due to historical, social, or environmental disadvantage, marginalization, and/or discrimination, such as, but not limited to, women, racialized persons, persons with disabilities, persons with mental illness or impairment, persons that are economically disadvantaged, First Nations, Inuit, Métis, and 2SLGBTQIA+.

Frequent consumer: Generally refers to individuals who use any cannabis (irrespective of cannabinoid content) daily (seven days per week) or almost daily (for example, at least five or six days per week).

Home cultivation: The non-commercial growing and harvesting of cannabis in a private residence or dwelling. The *Cannabis Act* establishes the legal right for adults to grow up to four plants at one time, per dwelling-house. This does not refer to the growing of plants under a personal or designated production registration issued by Health Canada, subsequent to a medical authorization from a health care professional.

Illicit cannabis: Cannabis that is sold, produced, or distributed by an individual or organization that is not authorized under the *Cannabis Act,* a provincial or territorial Act, or that was illegally imported.

Illicit market/source: Cannabis that is obtained from a source that is not authorized under the *Cannabis Act,* a provincial or territorial Act, or that was illegally imported. This includes buying cannabis from a person or organization that does not hold a federal licence under the *Cannabis Act,* or that is not a provincially or territorially authorized distributor/retailer (for example, buying cannabis from the "grey market", dealers, unlicensed cannabis dispensaries, online stores).

International Cannabis Policy Study: A cannabis-focused, cross-sectional annual survey conducted with participants aged 16 to 65 years, in order to collect detailed information about knowledge, perceptions, and behaviours related to cannabis use.

Legal cannabis: Cannabis produced, distributed, and sold from a legal, regulated source that is authorized under the *Cannabis Act,* a provincial or territorial Act, or that was legally imported.

Patient: In the context of this report, refers to someone who uses cannabis for medical purposes and is often under the care of a health care professional. A patient may or may not be registered under the access to cannabis for medical purposes system set out in the *Cannabis Regulations*.

Personal or designated production: The legal cultivation of cannabis for medical purposes. Patients with a medical authorization from a health care professional may register with Health Canada to legally produce a certain amount of cannabis for their own medical purposes ("personal production") or they may designate an adult to produce it for them ("designated production").

Potency: The quantity or concentration of THC or CBD (or other cannabinoids) in cannabis. In dried cannabis, this is often cited as a percentage of THC or CBD (or other cannabinoids) by weight. In cannabis extracts, this is often cited as the quantity of THC or CBD (or other cannabinoids) per unit volume, and in edible cannabis by the amount of cannabinoid per unit.

Promotion: Any method that a company, organization, or individual with a commercial or financial interest in cannabis may use that is likely to influence and shape attitudes, beliefs, and behaviours related to cannabis, including anything on the label of a product. Promotion is generally prohibited, with specific, limited exceptions under the *Cannabis Act*.

Quality/quality-controlled: Legal cannabis that is produced according to Good Production Practices and meets the quality testing requirements of the *Cannabis Regulations*. Quality control testing includes testing for potency and to verify that microbial and chemical contaminants, such as mould, heavy metals, and pesticides, among other contaminants, are controlled.

Record suspension: Allows people who were convicted of a criminal offence, but have completed their sentence and demonstrated that they are law-abiding citizens for a prescribed number of years, to have their criminal record kept separate and apart from other criminal records. Generally means that the suspended criminal record will not show up in a search.

Tetrahydrocannabinol (THC): Also referred to as delta-9-tetrahydrocannabinol. While there can be many forms of THC, such as delta-8 tetrahydrocannabinol, the *Cannabis Regulations* define THC as the delta-9 form. THC is the cannabinoid mainly responsible for the psychoactive and intoxicating effects of cannabis. Among other things, THC has effects on the brain and nervous system, including on memory, mood, thinking, concentration, coordination, and sensory and time perception.

Young adults: Generally used to refer to individuals aged 20–24 years old.

Young person: Under the *Cannabis Act*, a young person is someone younger than 18 years old, except for certain possession, distribution, and production offences, which only apply to someone at least 12 years old and less than 18 years old. The legal definition of "young person" is distinct from the definition of youth.

Youth: In the context of this report, generally refers to individuals between the ages of 15 and 19. The definition of youth is distinct from the legal definition of "young person".

Appendix B

Stakeholder list

We would like to recognize the many individuals and organizations who shared their time and expertise with us. To protect the privacy and confidentiality of the individuals (individuals, members of the public, and patients) we met with or who provided written submissions, their names will not be disclosed, unless otherwise stated.

We met with almost 500 individuals from over 200 organizations in nearly 90 meetings.

The names of all the organizations and academic experts engaged with are listed below:

1286455 BC Ltd

420 Cannabis Court

Adams Lake Indian Band

Afro BudSistas

Aitchelitz First Nation

Alberta Gaming, Liquor and Cannabis Commission

Alberta Municipalities

Alcohol and Gaming Commission of Ontario

All Nations

Antidote Processing

Aqualitas

Dr. Michael Armstrong, Brock University

Arthritis Society

Assembly of First Nations

Association québécoise de l'Industrie du cannabis

Atlegay Fisheries

AUBE Patients

Aurora

Auxly

Dr. Lynda Balneaves, University of Manitoba

Dr. Daniel Bear, Humber College

Dr. Neil Boyd, Simon Fraser University

British Columbia Assembly of First Nations

Dr. Jason Busse, McMaster University

C-45 Quality Association

CAFCAN: Caribbean African Canadian Social Services

Canada House Wellness Group Inc.

Canadian Association of Chiefs of Police
Canadian Association of Elizabeth Fry Societies
Canadian Centre for Policy Alternatives
Canadian Chamber of Commerce
Canadian Hemp Farmers Alliance
Canadian Hemp Trade Alliance
Canadian Mental Health Association
Canadian Paediatric Society
Canadian Pharmacists Association
Canadian Police Association
Canadian Public Health Association
Canadian Students for Sensible Drug Policy
Canadian Therapeutic Cannabis Partners Society
Canadian Vaping Association
Canadian Women in Cannabis
Cannabis Council of Canada
Cannabis NB
Cannaworld Ventures
Cannibble Foodtech Ltd.
Canopy Growth Corporation
Dr. Alexander Caudarella, Canadian Centre on Substance Use and Addiction
Centre for Addiction and Mental Health
Centre of Excellence for Women's Health
Certicraft
City of Calgary
City of Toronto
City of Yellowknife
Dr. Hance Clarke, University Health Network
Dr. Nina Cluny, Canadian Institutes of Health Research
Community Futures Central Kootenay
Covenant House
Data Communications Management
DiversityTalk
Dr. Jennifer Donnan, Memorial University of Newfoundland and Labrador
Ekosi Health
Faded Living 420
Final Bell

Dr. Yaron Finkelstein, University of Toronto, The Hospital for Sick Children

Fire & Flower Holdings Corp.

First Nations Leadership Council

Food, Health & Consumer Products of Canada

Dr. Chelsea Gabel, McMaster University

Government of Alberta

Government of British Columbia

Government of Canada (Canada Border Services Agency)

Government of Canada (Finance Canada)

Government of Canada (Health Canada)

Government of Canada (Innovation, Science and Economic Development Canada)

Government of Canada (Privy Council Office)

Government of Canada (Public Health Agency of Canada)

Government of Canada (Public Prosecution Service of Canada)

Government of Canada (Public Safety Canada)

Government of Canada (Statistics Canada)

Government of Canada (Veterans Affairs Canada)

Government of Manitoba

Government of New Brunswick

Government of Newfoundland and Labrador

Government of Northwest Territories

Government of Nova Scotia

Government of Nunavut

Government of Ontario

Government of Prince Edward Island

Government of Quebec

Government of Saskatchewan

Government of Yukon

Green Wynds Farm Ltd

Greenleaf Medical Clinic

GreenPort Global

Greentone Cannabis

Gwa'sala Nak'wax'da'xw Nation

Haisla Nation

Dr. David Hammond, University of Waterloo

High Hopes Foundation

High Tide Inc.

Dr. Carol Hopkins, Thunderbird Partnership Foundation

Amy House, York University

HVSTR Cannabis Inc.

Dr. Elaine Hyshka, University of Alberta, Royal Alexandra Hospital

Institut national de santé publique du Québec

Inuit Tapiriit Kanatami

Inuvialuit Regional Corporation

IWK Health Centre

John Howard Society of Canada

Justice for Children and Youth

Dr. Didier Jutras-Aswad, Centre hospitalier de l'Université de Montréal

Kahnawà:ke Policing Functions

Kahnawà:ke Shakotiia'takehnhas Community Services

Dr. Lauren Kelly, The Canadian Collaborative for Childhood Cannabinoid Therapeutics

Khowutzun Development Corporation – Cowichan Tribes

Kootenay Aeroponic

Kwaw-Kwaw-Apilt First Nations

Lasqueti Cannabis Corp

Les Femmes Michif Otipemisiwak

Liquor, Gaming and Cannabis Authority of Manitoba

Los Angeles Department of Cannabis Regulation

Dr. James MacKillop, McMaster University

Manitoba Liquor and Lotteries

Manitoba Métis Federation

Media Smarts

Medical Cannabis Canada

Mental Health Commission of Canada

Métis Nation – British Columbia

Métis Nation of Ontario

Métis Nation – Saskatchewan

Métis Nation of Alberta

Métis National Council

Mohawk Council of Kahnawà:ke

Nanoose First Nation

National Association of Pharmacy Regulatory Authorities

National Indigenous Economic Development Board

Neskonlith Indian Band

New Jersey Cannabis Regulatory Commission

New York Office of Cannabis Management

NORML Canada

Nunalituquit Ikajuqatigittut

Nunatsiavut Government

Nunavik Health Board

Nunavik Police Services

Nunavik Regional Board of Health and Social Services

Nunavut Tunngavik Incorporated

Oceanic Releaf

Okanagan Indian Band

Okpik Consulting

Ontario Cannabis Store

Ontario Provincial Police

Ontario Public Health

Organigram

Origine Nature

Eugene Oscapella, University of Ottawa

Ottawa Inner City Health

Ottawa Public Health

Dr. Akwasi Owusu-Bempah, University of Toronto

Dr. Rosalie Pacula, University of Southern California, International Society for the Study of Drug Policy

Partners for Youth Inc.

Pauktuutit Inuit Women of Canada

Penticton Indian Band

Pine River Institute

Premo Packaging and Design Co.

Pure Sunfarms

Qarjuit Youth Council

Quebec Craft Cannabis

RAND Drug Policy Research Centre

Dr. Andrew Reid, Douglas College

Retail Cannabis Council of Ontario

Retired Ontario Court of Justice

Rosebud Cannabis Farms

Royal Canadian Mounted Police

Royal College of Physicians and Surgeons of Canada

Santé Cannabis
Saskatchewan Liquor and Gaming Authority
Secluded Wellness Centre
Service de police de la Ville de Gatineau
SheCann
Shoppers Drug Mart Inc.
Shxwhà:y Village
Shxw'ōwhámel First Nation
Siska Indian Band
Six Nations Police
SNDL
SOLID Outreach
Squamish First Nation
Sûreté du Québec
Sweetgrass Trading
Tantalus Labs
The Cannabis Nurses
The Cronos Group
Dr. Phil Tibbo, Dalhousie University
Timixw Holdings
Tl'azt'en Nation
TRACE Youth Cannabis Research Program
Transform Drugs
Ts'il Kaz Koh First Nation
Union of British Columbia Indian Chiefs
Upstream Ottawa
Valhalla Craft Cannabis
Victoria Cannabis Buyers Club
Victoria Cannabis Company
Village Bloomery
Ville de Laval
VoxCann
Washington State Liquor and Cannabis Board
We Wai Kai Nation
Weaving Wellness Centre
Western Arctic Youth Collective
Wholeland Enterprises

Williams Lake First Nation

World Class Extractions

YMCA Youth Cannabis Awareness Program

Youth Leadership Team (Tobacco Control and Vaping)

YouthRex

Zelca

We would also like to recognize the individuals and organizations who played an active role in supporting our engagement activities through the organization of meetings and outreach activities.

We would like to extend special thanks to the Elders and Knowledge Keepers who shared their wisdom with us: Elder Reepa Evic-Carleton, Elder Reta Gordon, and Knowledge Keeper Sheryl Rivers.

Daniel Afram, Inuit Tapiriit Kanatami

Chief Leslie Aslin, Tl'azt'en Nation

Dr. Lynda Balneaves, University of Manitoba

Sarah Blyth, High Hopes Foundation

Ashleigh Brown, SheCann

Fred Cameron, SOLID Outreach

Julia Cameron, Pure Sunfarms

Bilal Cheema, Shxwhà:y Village

Leanne Davies, Government of British Columbia

Joanne DiNardo, Arthritis Society

Andrea Dodds, Village Bloomery

Kirk Dressler, Williams Lake First Nation

Dr. Sarah Edwards, Métis Nation—Ontario

Daphnée Elisma, AUBE Patients

Rick Garza, Washington State Liquor and Cannabis Board

Chelsea Giesel, Pauktuutit Inuit Women of Canada

Chief Robert Gladstone, Shxwhà:y Village

Ginny Gonneau, Métis National Council

Dr. Lorraine Greaves, Centre of Excellence for Women's Health

Dr. David Hammond, University of Waterloo

Rachel Huggins, Ontario Provincial Police

Suzanne Jackson, Mohawk Council of Kahnawà:ke

Jeremy Jacob, Village Bloomery

Lanny Jacobs, Mohawk Council of Kahnawà:ke

Paul Kelly, Community Futures Central Kootenay

Olena Kloss, Manitoba Métis Federation

Alex Kroon, Canada House Wellness Group Inc.

Jasmine Langhan, Manitoba Métis Federation

Lydia Lobbezoo, Union of British Columbia Indian Chiefs

Dr. Caroline MacCallum, Greenleaf Medical Clinic

Sami Majadla, Certicraft

Hon. Anne McLellan, (Former Chair) Task Force on Cannabis Legalization and Regulation

Sheldon Mellis, Mental Health Commission of Canada

Isabella Modesto, Inuit Tapiriit Kanatami

Max Monahan-Ellison, Medical Cannabis Canada

Rosy Mondin, World Class Extractions

Chief Tonya Perron, Mohawk Council of Kahnawà:ke

Dr. Alexandre Petiquan, Inuit Tapiriit Kanatami

Joanna Prince, British Columbia Assembly of First Nations

Erin Prosk, Santé Cannabis

Shannon Ross, Antidote Processing

Kyp Rowe, Victoria Cannabis Company

Chief Willie Sellars, Williams Lake First Nation

Rob Shannon, Victoria Cannabis Company

Mary Shaw, Government of British Columbia

Dr. Jason Simmonds, Manitoba Métis Federation

Ted Smith, Victoria Cannabis Buyers Club

Marc Storms, British Columbia Assembly of First Nations

Regional Chief Terry Teegee, Assembly of First Nations

Dr. Eduardo Vides, Métis National Council

Ali Nasser Virji, Ontario Cannabis Store

Dr. Mark Ware, (Former Vice-Chair) Task Force on Cannabis Legalization and Regulation

Ika Washington, DiversityTalk

Appendix C

Panel biographies

Morris Rosenberg (Chair)

Morris Rosenberg, O.C., is a Canadian lawyer and former senior civil servant with the Government of Canada.

Mr. Rosenberg served as Deputy Minister of Foreign Affairs (2010–2013), Deputy Minister of Health (2004–2010), and Deputy Minister of Justice and Deputy Attorney General of Canada (1998–2004). He began his public service career with the Department of Justice in 1979. From 1989–1993, he served as Assistant Deputy Minister in the Department of Consumer and Corporate Affairs. From 1993–1996, he served as Assistant Secretary to the Cabinet, Economic and Regional Development Policy, Privy Council Office. He was appointed Deputy Secretary to the Cabinet (Operations) in 1996. After retiring from the government in 2013, Mr. Rosenberg served as President and CEO of the Pierre Elliott Trudeau Foundation from 2014–2018.

Mr. Rosenberg holds a B.A. from McGill University, an LL.L. from the Université de Montréal and an LL.M. from Harvard University. He was appointed Member of the Order of Canada in 2015.

Dr. Oyedeji Ayonrinde

Dr. Oyedeji Ayonrinde is an Associate Professor in the departments of Psychiatry and Psychology at Queen's University. He is also a Consultant Psychiatrist and Clinical Director at Providence Care, where he has provided community mental health care over the past five years. Prior to these roles, he was a consultant at the Bethlem Royal and Maudsley Hospitals (UK) and lectured at the Institute of Psychiatry for nearly 20 years. He holds a specialist Fellowship in both general Psychiatry and Addictions from the Royal College of Psychiatrists (UK), an MSc (Research in Psychiatry) from University College London, and an Executive MBA from Imperial College, London. Dr. Ayonrinde is a member of the Canadian Psychiatric Association, Fellow of the American Psychiatric Association and Royal College of Psychiatrists. His peer-reviewed publications focus on risks with gestational cannabis use, cannabis and psychosis, and safety issues with cannabinoid-based medicines. Dr. Ayonrinde has received healthcare and university education awards, as well as national and international awards for cannabis-related scholarship.

Dr. Patricia J. Conrod

Dr. Conrod is a registered clinical psychologist, a Full Professor in the Department of Psychiatry and Addiction at the University of Montreal, and researcher at the Sainte-Justine Mother and Child University Hospital Centre (CHUSJ), where she holds a Tier 1 Canada Research Chair in Preventative Mental Health and Addiction and runs a research laboratory focusing on understanding, preventing and treating neurodevelopmental risk factors and consequences of substance use and misuse. She co-leads the Fonds de recherche du Québec (FRQS) Research Network on Suicide, Mood Disorders and Related Conditions, the Canadian Institutes of Health Research (CIHR) Canadian Cannabis and Psychosis Research Team, and the CHUSJ IMAGINE Centre for pediatric neuroimaging. She is also Director of the University of Montreal Neuroscience and Mental Health Strategy. She holds a PhD in Psychology (clinical) from McGill University and has published over 247 articles.

Lynda L. Levesque

Lynda Levesque is a proud nehiyaw iskwew and member of the Fisher River Cree Nation in Manitoba, Treaty Five territory.

Ms. Levesque is a criminal lawyer, with experience practicing from both the prosecution and defence perspectives. Since 2018, she has worked as a Crown Prosecutor in Calgary and surrounding rural areas. From 2014–2018, she worked as a duty counsel lawyer with Legal Aid Alberta, serving Calgary and surrounding rural areas. From 2005–2014, she worked as a duty counsel lawyer with Legal Aid Ontario in Toronto. Throughout her legal career, she has maintained a passion for Indigenous justice issues and an interest in better ensuring access to justice for marginalized persons.

Ms. Levesque holds a B.A. from the University of Calgary and an LL.B. from the University of Windsor.

Dr. Peter Selby

Dr. Selby is the Giblon Professor, Vice Chair of Research, and Advisor to the Head of the Mental Health and Addictions Division in the Department of Family and Community Medicine, University of Toronto. He is cross appointed in the departments of Psychiatry and the School of Public Health. As a Senior Scientist at CAMH, his research focuses on innovative methods to understand and treat addictive behaviours and their comorbidities. To support these research initiatives, Dr. Selby has received grants totaling over 100 million dollars from the Canadian Institutes of Health Research, the National Institutes of Health, the Ministry of Health, as well as others. Dr. Selby has held more than 145 grants as Principal or Co-Principal Investigator. He has more than 150 peer-reviewed publications, including 74 as first or senior author. He is also an expert presenter and educator in addiction and mental health especially in primary care and community settings.

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