CNMMA
CANADIAN NATIONAL MEDICAL MARIJUANA ASSOCIATION

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Second submission to the Task Force on Cannabis Legalization and Regulation

Since our first submission, we have been pleased by the release of a comprehensive report by the Federal taskforce on Cannabis Legalization and Regulation detailing over 80 recommendations surrounding the legalization of cannabis in Canada. It is clear that Canada is on the right track to finally bringing the legal status of cannabis and cannabis products into line with the reality of consumer demand and use, both for medical and non medical purposes.

In our supplemental submission, we have set out hoping to identify how well the final report has met the suggestions we initially proposed, and more broadly, how well the report responds to the needs of both consumers and industry as we see them. What follows is an analysis framed by the previous consultation process, assessing the final report in tandem with our response to the consultation questions. Some aspects of the report have raised new questions, particularly about the rights of medical marijuana patients.

The quality of the final report shows an exceptional level of consultation and consideration of all relevant issues. We hope that our supplemental submission serves to dually highlight how the task force has gotten it right, and where increased clarity may be required. Given numerous open-ended recommendations, we hope that the following suggestions can help further inform the path that government takes in acting on the task force recommendations.

Minimum age

The Task Force has made the recommendation that the federal minimum age be set at 18 and that provinces be allowed to set their own. Our previous recommendation sought 21 as the recommended minimum, to strike the necessary balance between protecting youth (based especially on the growing consensus that the impacts of marijuana use on developing brains are still not fully known) and reducing the demand for black-market products. The Task Force report acknowledges these concerns by the healthcare community, as well as concerns by law enforcement agencies over the possibility of cross-border shipping, both interprovincially and between the United States (which so far has a minimum age tied to that of alcohol at 21 in states that have allowed it) and Canada.

We are satisfied by the evidence cited that 18 is a reasonable minimum to set federally, though we still encourage provincial governments, as they develop the distribution frameworks, to

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consider on a case-by-case basis whether their current minimum ages for alcohol purchase would serve to reduce both harm to young people and the impacts of restrictions that drive willing consumers out of the regulated market and into the illicit one.

On the medical use side, we strongly encourage policymakers to consider the exceptional cases where medical marijuana successfully treats conditions like epilepsy in children and youth. Minimum age is crucial for protecting youth, but it should not be used to bar doctors from administering medical cannabis products as treatments in rare cases when conventional treatments have failed. It should be reiterated that such treatments typically have an extraordinary low or near-absent THC level, and they are chosen for other compounds in marijuana proven to deliver measurable medical benefits, such as regulating seizures, in the case of children suffering from epilepsy, or providing pain/discomfort relief to juveniles undergoing treatment for conditions like cancer. These cases are not typical, but a federal minimum age set with the intent to keep non medical marijuana out of the hands of young people must consider the legitimate circumstances in which responsible medical access, carefully managed by both a doctor and parent/guardian, should be protected. Clarity surrounding these cases is needed to ensure that parent's acting in their child's best interests do not risk legal consequences or loss of custody.

Taxation and pricing

The task force's recommendations are broadly aligned with our own, except on two points.

Firstly, we disagree that taxing and pricing medical marijuana like non medical marijuana protects the interests of patients who depend on cannabis for treating and managing a wide range of medical illnesses. In developing a taxation framework, the access of low-income patients must be prioritized. We agree that taxation is an important tool to recoup administrative costs and generate funding for programs necessary when non medical cannabis is legalized, but medical users must not be forced to bear a disproportionate share of cost.

While non medical use is a choice, medical users don't always have another option, and in many cases they have found cannabis to be a last-resort medicine. In situations where patients require a much higher daily dosage, especially in chronic and severe pain relief/management, we are concerned that they would be unduly penalized. Uncertain insurance coverage must be another consideration; medical marijuana patients unable to be reimbursed for medical use would be forced to deal with the expenses themselves, putting them into the difficult situation of having to

choose between treatment and other life essentials. It is crucial that a taxation regime for cannabis consider the unique needs of medical patients.

Furthermore, until patients are able to claim their medical marijuana expenses on their tax returns, as is done with all other medicines, we suggest that revenue generation be a low priority. Establishing a dedicated medical tax credit, if both non medical and medical marijuana products are taxed identically, may serve as a tool to protect the needs of all medical users of all financial means.

A minimum price, such as that which is applied to tobacco and alcohol, serves to deter overconsumption. It is a useful mechanism when the goal is to prevent non medical use from turning into abuse. However, neither alcohol nor tobacco are used for medical reasons. Moderating the use of cannabis for legitimate medical illnesses is best done by qualified medical professionals. The market price of medical marijuana must reflect the principle that medical use is different from non medical use. A price substantially at odds with the cost of production (including licensing and other regulatory costs) risks restricting reasonable access to the most vulnerable. It is in the interests of quality oversight and data collection about medical use that medical marijuana patients choose to acquire their medicine legally. An onerous minimum price would only serve to increase demand outside of the regulated stream.

Limits of allowable THC potency

We agree that high-potency cannabis may carry risks that are not yet understood. Non medical users, especially those whose brains are still developing, should be discouraged or outright prevented from buying cannabis with unprecedented THC levels (based on the observed massive increase in potency over the last few decades).

Again, in consideration of the unique needs of marijuana patients, we urge the government to implement the recommendations surrounding THC potency to non medicalnon medical use one way, and to implement them on medical use another way. We know that cannabis patients often require higher potency products. Dosage is ultimately best decided by the prescribing medical practitioner, in consideration of the patient's individual needs and the leading research and practices available.

If the two pricing systems are not kept separate from the beginning, it may become difficult, as more data emerges about usage trends caused by legalization, to apply a higher tax to high-potency non medical marijuana and marijuana products, for example, and retain medical prices

at a lower level, or vice versa. Both systems require flexibility and independence from each other, as conclusions drawn about non medical use can't be used to make conclusions about medical use, and vice-versa.

A careful balance must be struck between risk mitigation, particularly by disincentivizing the use of potentially risky high-potency, high THC products, and ensuring that government regulations are not so restrictive that they prevent the legal market from serving as a desirable alternative to illegal sources.

Restrictions on marijuana products

We support the measures proposed, especially those concerning adaptability to new types of products. Both in the non medical and medical marijuana spaces, producers and consumers are constantly developing different types of product. So long as the guiding principles about keeping marijuana out of the hands of young people and ensuring consistent, reliable, and predictable quality and dosage are maintained, we encourage the developing legislative framework to make sufficient room for innovation. Speaking for medical marijuana users, the ability to choose how a medicine is delivered is vital to fostering an environment where marijuana patients' choices are respected and their choice of medicine is not stigmatized.

Limitations on quantities for personal use

The recommendations on home cultivation predominately fall in line with the CNMMA's previous submission to the task force. The task force report recommends a maximum of four plants at a maximum height of 100cm. We would suggest that the rationale for height restrictions be carefully assessed, so that rather than an arbitrary limit being set, there is a clear understanding on how height affects the amount of harvestable product, potency, and cultivation methods. The breed of the plant may indeed have a greater impact on these factors than height.

Height restrictions may require a different approach for those who wish to grow outdoors, with the caveat that visibility and security measures are in place. If personal cultivation is allowed, it may be in the interests of environmental sustainability and reduced electrical use that outdoor growth is a viable option.

Limitation on where marijuana can be sold

We are satisfied that the task force recommendations take fully into account the pros and cons of both retail and mail-delivery distribution models. On the medical front, we reiterate the potential value of utilizing the existing pharmacy infrastructure nationwide, for those pharmacies that are

equipped and willing to enter this market. We understand that some submissions to the task force indicated a lack of necessary training and knowledge by pharmacists. On this point, we must stress again, as done in our last submission, that professional training must be provided at post-secondary institutions with respects to all steps in the seed-to-sale system. Existing programs for medical and health care professionals, including pharmacists and pharmacologists, would greatly benefit from government investments for funding new research and training development.

Even if pharmacy distribution is not widespread, licensing some pharmacies to work with producers would be superior to an alternative in which consumers have limited, or no access, to someone with professional knowledge on drug interactions and risk factors.

2.1 Production model

As in our previous suggestion, we support licensing for all producers for both the non medical and medical markets. The task force report refers to a system of supply management with the intent of controlling price. We are concerned that a licensing model based on limiting supply would reduce market diversity and draw the focus away from rewarding producers that innovate and consistently produce high-quality products.

There are better ways of preventing low prices from over-supply – namely, a minimum price on non medical cannabis and non medical cannabis products. If producers are able to produce both for the medical and the non medical markets, it is at the point of distribution that minimum prices and taxes should be enforced. The differing needs of medical and non medical consumers must be considered – those relying on access to marijuana as a medicine should not be affected by artificial supply caps. More crucially, both non medical and medical products must be held to the same stringent production standards. Current licensed medical cannabis producers are best equipped to lead the industry in this respect.

A market of producers and distributors concerned with fully meeting and even exceeding industry standards requires an environment of cooperation between regulators and industry, as well as regulatory certainty. A licensing model that is clear and transparent on costs and fees is integral in this regard.

2.2 Good production practices

Encouraging excellent industry standards begins with proper education and training. Post-secondary institutions in British Columbia have begun offering courses in industrial cultivation. The task force report makes no mention of this vital factor in the establishment of clear quality

expectations and standards. Ideally, a curriculum would be developed in conjunction with licensing, ensuring that producers with superior expertise and evidence-based training are given priority status to receive a license.

Similarly, we concur with the recommendation that staff in any retail storefronts are professionally trained. If properly implemented, good training has the potential to mitigate drug interactions and overdoses by providers educating any potential consumers about pertinent risk factors.

2.3 Product packaging and labelling

We are pleased with this series of recommendations. They address our concerns fully.

n/a 3.1 Phased-approach to distribution

n/a 3.2 Storefronts

n/a 3.3 Local choice

We continue to hold the opinion that a combination of those three approaches over time is best, beginning with a phased-approach that utilizes existing, well-tested delivery methods such as mail-delivery.

Considering the national implications of marijuana legalization, we stand by the suggestion that basic standards for distribution in the early stages be set nationally, even if the intent is to transition much of the regulation on distribution to the provinces. For provinces and municipalities that do not have prior experience, or have limited experience, with regulating mail distribution, storefronts, and other distribution methods, the federal government must provide guidance by setting an example. Beginning the process of legalization by depending on the proven efficacy of a mail-order system would ensure that unprepared municipalities are not suddenly expected to develop a framework to meet market demand.

4.1 Strengthened laws and enforcement response

We fully support the task force on making recommendations that demonstrate an evolving approach to the criminal status of individual possession and use.

We are convinced that the recommendations make sufficient distinction between illicit production/trafficking and personal use, which in many jurisdictions has seen unequal enforcement. We would suggest further that distinctions between medical and non medical use be made when assessing the criminality of certain behaviors.

4.2 Enforcement tools for marijuana-impaired driving

The comprehensive series of recommendations on this issue are satisfactory. We are pleased that they specifically make reference to graduated sanctions for impaired driving. We would again suggest that if all laws surrounding marijuana use are addressed via a dedicated legislative act, including those for impaired driving, that medical users be held to the same expectation of responsible use, but that their use of low-THC products be considered fairly.

4.3 Restriction of consumption to the home or a limited number of well-regulated publicly-accessible sites

The task force report recommends that cannabis smoke be treated the same as tobacco smoke, and therefore banned from public spaces. The question remains of how medical access should be protected for those living in condos and apartment buildings with restrictions, for those who are homeless or live in a collective dwelling (including shelters, halfway houses, nursing homes, and long-term care facilities) or for those in urban areas.

Uncertainty around current restrictions for medical users is commonplace, as seen in a case where a medical marijuana user got into trouble for smoking on a BC Ferry in an area where tobacco smoking was allowed. Even though municipalities will ultimately control much of the rules in this realm, it is critical that the federal government set reasonable examples to reinforce the rights of medical marijuana patients and to ensure that municipalities and organizations cannot be overzealous in their regulation at the expense of patient rights.

Respectfully,

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