

# **Submission to the Task Force on Marijuana Legalization and Regulation**



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## Introduction

MADD Canada welcomes the opportunity to comment on the federal government's paper entitled: *Toward the Legalization, Regulation and Restriction of Access to Marijuana* (Discussion Paper).<sup>1</sup> We have taken the liberty to include in our comments a summary of the research upon which they are based. The remainder of the introduction addresses several general matters that are relevant to the paper as a whole.

In responding to the questions, we are assuming that the decision has been made to legalize the possession of cannabis by adults and to create a legal source of supply for this recreational market. MADD Canada has not taken a position on the legalization of recreational cannabis use. Nevertheless, it is important to qualify our responses in this way, because we do not agree with the government's view that creating a lawful recreational cannabis market for adults will minimize the harms posed by cannabis, particularly regarding youth.

We share the concerns expressed more than four decades ago in the majority report of the Royal Commission of Inquiry into the Non-Medical Use of Drugs (Le Dain Commission).<sup>2</sup> After stating that the focus of social concern should be adolescent cannabis use, the majority stated:

A policy of making cannabis available to adults would have the effect of making it more available to minors. This is the lesson of our experience with alcohol. It would also make cannabis appear to be relatively harmless. Further, there is no reason to believe that we could effectively control potency and encourage moderate use by a system of administrative regulation or licensing.<sup>3</sup>

Nevertheless, some legalization approaches will better protect the public interest than others.

For the most part, the Discussion Paper provides an excellent summary of the background issues and appropriately acknowledges the problems with the current approach to the cannabis prohibition. However, it would have been helpful to have more information on the illicit cannabis market and the related enforcement statistics, particularly in regard to youth. For example, including some of the following information would have provided the reader with a broader understanding of the current situation.

Based on the 2012 Canadian Community Health Survey – Mental Health, it was estimated

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<sup>1</sup> Task Force on Marijuana Legalization and Regulation, *Toward the Legalization, Regulation and Restriction of Access to Marijuana* (Ottawa: Government of Canada, 2016) online: < <http://healthy.canadians.gc.ca/health-system-systeme-sante/consultations/legalization-marijuana-legalisation/alt/legalization-marijuana-legalisation-eng.pdf>>.

<sup>2</sup> G. Le Dain, H. Lehmann & J. Stein, *Cannabis: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs* (Ottawa: Information Canada, 1972), at 265-303 [Le Dain Commission].

<sup>3</sup> *Ibid.*, at 301.

that 3,429,700 Canadians, 15 years of age or older, used cannabis at least once in the past year.<sup>4</sup> The rate of past year use among 15-24 year olds was three times that of older Canadians. Moreover, among 15-17 year olds who reported past year cannabis use, 31.8% were weekly or daily users. Among 20-24 year olds, the comparable percentage of weekly or daily cannabis users was 39%.<sup>5</sup> These figures do not include those under the age of 15, or necessarily reflect the rates of cannabis use among transients and other groups who would not be captured by a household survey. Of concern as well is the age at which youth begin using cannabis. For example, a 2012-13 study of grade 7-12 students found that, among past year cannabis users, the average age of initiation was 14.<sup>6</sup> Thus, young people make up a major segment of the current illicit cannabis market, particularly in regard to weekly and daily users.

Cannabis offences constituted 67% (54% possession and 13% other) of the 109,000 police-reported drug offences in 2013. However, 41% of the cannabis-related offences were cleared by issuing a warning or by some other exercise of departmental discretion. Moreover, even when cannabis charges were laid, they were dropped or withdrawn in 55% of adult court cases.<sup>7</sup> Despite the potentially severe penalty provisions in the *Controlled Drugs and Substances Act (CDSA)*,<sup>8</sup> very few cannabis possession offenders are sentenced to imprisonment.<sup>9</sup>

Nevertheless, 18-24 year olds had the highest charge rate for drug offences in 2013, approximately 75% of which involved cannabis. Those 12-17 years of age had the second highest charge rate for drugs, 90% of which were for cannabis.<sup>10</sup> Although police, Crown and

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<sup>4</sup> M. Rotermann & K. Langlois, "Prevalence and correlates of marijuana use in Canada, 2012" (2015) 26(4) *Health Reports* 10, at 11 [Rotermann].

<sup>5</sup> *Ibid.*, at 12.

<sup>6</sup> Canadian Centre on Substance Abuse, *Cannabis (Canadian Drug Summary)* (Ottawa: Canadian Centre on Substance Abuse, 2016), at 3, online: < <http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Summary-Cannabis-2016-en.pdf> > [*Cannabis (Canadian Drug Summary)*].

<sup>7</sup> A. Cotter, J. Greenland & M. Karam, *Drug-related offences in Canada, 2013* (Ottawa: Statistics Canada, 2015), at 3 [Cotter]. In contrast to the cannabis offences, only 17% of all other police-reported drug offences were cleared by discretion, and only 38% of the charges in these other drug cases were stayed or withdrawn.

<sup>8</sup> S.C. 1996, c.19, s. 4(4) and (5).

<sup>9</sup> While sentencing data for drug possession are available, they are not broken down by drug category. Nevertheless, in 2013/14, only 11% of total adult drug possession convictions resulted in a custodial sentence. The relevant percentage for 18-24 year olds was only 7.1%. Statistics Canada, *CANSIM Table 252-0056: Adult Criminal Courts, Guilty Cases by Type of Sentence, Annual (Number)* (Ottawa: Statistics Canada, 2015), online: <<http://www5.statcan.gc.ca/cansim/a26>>.

In terms of young offenders, only 1.1% of total drug convictions resulted in a custodial sentence. Statistics Canada, *CANSIM Table 252-0067: Youth Courts, Guilty Cases by Type of Sentence, Annual (Number)* (Ottawa: Statistics Canada, 2015), online: <<http://www5.statcan.gc.ca/cansim/a26>>.

<sup>10</sup> Cotter, *supra* note 7, at 16, Chart 7.

judicial discretion has significantly reduced the adverse legal consequences of the cannabis offences,<sup>11</sup> young people make up a disproportionate share of those potentially subject to federal criminal sanctions.

Of particular concern for MADD Canada is that motor vehicle crashes constitute the leading cause of death among 15-24 year old Canadians.<sup>12</sup> Moreover, impairment-related crashes take a disproportionate toll among young people. For example, in 2010, 16-25 year olds made up 13.6% of the population<sup>13</sup> but accounted for almost 33.4% of the alcohol-related traffic deaths.<sup>14</sup> Similarly, the percentage of 16-19 year old fatally-injured drivers who tested positive for drugs rose from approximately 23% in 2000 to over 40% in 2012.<sup>15</sup> In terms of public health, youth crash deaths represent a major preventable cause of years of life lost, as these victims die 50-60 years prematurely.

The Discussion Paper appropriately recognizes the complexity of attempting to legalize and regulate the adult recreational cannabis market in the public interest. It also sets out the objectives of any such framework, but without clearly indicating that achieving some of these objectives will invariably come at the expense of others. Regardless of the legalization model adopted, very difficult decisions will have to be made.

For example, almost all of the legalization proposals include a 19 or 21-year-old minimum age of purchase and possession, leaving a significant percentage of Canadian cannabis users dependent on the illicit trade or on cannabis illegally diverted from the medical or lawful recreational markets. Moreover, those under the minimum age, who already have among the highest per capita rate of being charged with a cannabis offence, would remain subject to potential criminal sanctions. For example, a minimum age of purchase of 21 would leave the approximately 715,000 users aged 15-20 years old dependent on the illicit market and vulnerable

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<sup>11</sup> Other research indicates that a very small percentage of police-reported cannabis possession offences result in an individual being charged, tried, convicted, and imprisoned. For a summary of the Canadian data, see H. Kalant, “A critique of cannabis legalization proposals in Canada” (2016) 34 *International Journal of Drug Policy* 5, at 6 [Kalant].

<sup>12</sup> Public Health Agency of Canada, *Injury in Review* (Ottawa: Public Health Agency of Canada, 2012), at 10.

<sup>13</sup> Statistics Canada, *CANSIM Table 051-0001: Estimates of Population, by Age Group and Sex for July 1, Canada, Provinces and Territories Annual (Persons Unless Otherwise Noted)* (Ottawa: Statistics Canada, 2012), online: <<http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=0510001&paSer=&pattern=&stByVal=1&p1=1&p2=37&tabMode=dataTable&csid>>.

<sup>14</sup> Traffic Injury Research Foundation, *Alcohol-Crash Problem in Canada: 2010* (Ottawa: Traffic Injury Research Foundation, 2013), at 15.

<sup>15</sup> Traffic Injury Research Foundation, *Trends Among Fatally Injured Teen Drivers, 2000-2012* (Ottawa: Traffic Injury Research Foundation, 2015), at 4.

to criminal sanction.<sup>16</sup> Although not addressed in the Discussion Paper, we have suggested means of mitigating the adverse legal consequences that would otherwise apply to underage users and others convicted of cannabis possession under the proposed law.

Greater consideration should also have been given to the dynamic nature of the cannabis market that will be created. The proposed recreational distribution system will have to compete with the well-entrenched illicit trade, currently supplying about 3.5 million Canadians,<sup>17</sup> and the rapidly growing lawful medical cannabis market, which is expected to comprise well over 400,000 users by 2020.<sup>18</sup> For example, many cannabis users will continue to resort to the illicit trade if the lawful recreational market is uncompetitive in terms of price, potency, convenience, product selection, and other variables. However, giving priority to these market considerations would conflict with the research on the health and safety benefits of maintaining high prices and limiting the availability of potent cannabis products. As will be discussed, MADD Canada advocates for a system which promotes public health and safety, recognizing that it will have a more limited impact on the illicit trade than systems which attempt to meet “consumer demand.”

The Discussion Paper briefly mentions the need for all levels of government to cooperate in developing a workable legalization model. While we agree that inter-government cooperation is important, the Discussion Paper does not address critical issues relating to the limits of the federal government’s constitutional authority. For example, if the federal government completely repealed the cannabis possession offence for adults and the related distribution offences, it would likely lose constitutional authority over the situations in which cannabis could be lawfully possessed and sold, and the price, potency and range of lawful cannabis products. The provinces could simply replace the repealed federal offences with provincial offences, or establish a patchwork of regulated, licensed and/or taxed cannabis marketing systems.<sup>19</sup>

It is questionable whether the federal government has constitutional authority to replace the current criminal prohibitions with comprehensive regulatory legislation, controlling all aspects of lawful production, distribution, retail sales, and marketing within the provinces.<sup>20</sup> The legislation

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<sup>16</sup> Rotermann, *supra* note 4, at 11. The authors provide an estimate of past year cannabis users for the 15-17 year old cohort and for the 18-24 year old cohort. For the purposes of our calculation, we have assumed that 18-20 year olds accounted for 3/7ths of the 18-24 year old cohort.

<sup>17</sup> *Ibid.*

<sup>18</sup> L. Bastien & M. Hager, “Canada’s medical pot companies aim to grow export business” *The Globe and Mail* (22 July 2016), online: < <http://www.theglobeandmail.com/news/toronto/canadas-medical-pot-companies-aim-to-grow-export-business/article31088427/>> [Bastien].

<sup>19</sup> For a discussion of the federal government’s constitutional authority over drug law and policy, see Le Dain Commission, *supra* note 2, at 213-29.

<sup>20</sup> As the Supreme Court of Canada stated in *R. v. Malmo-Levine*, [2003] 3 S.C.R. 57, at para. 721: “If [...] Parliament removes marihuana entirely from the criminal law framework, Parliament’s

would most likely be challenged as being colourable criminal law – that is, invalid legislation which bears the trappings of criminal law, but which in fact deals with intra-provincial trade, a matter within the provinces’ exclusive legislative authority.<sup>21</sup> Federal attempts to establish broad regulatory control of retail markets and various trades in the provinces have generally failed.<sup>22</sup>

The fate of a more modest federal regulatory scheme governing limited aspects of the lawful adult market would be difficult to predict. If such provisions were enacted as an exception to a broad criminal cannabis prohibition, they may be viewed as falling within federal criminal law authority. The issue is contentious and would likely turn on the exact scope of the regulatory exceptions.

Assuming that the inevitable negotiating problems were overcome, the federal and provincial governments could agree to adopt a single legislative approach to cannabis. The provinces could agree not to enact a conflicting cannabis distribution system, if the federal cannabis prohibitions permitted them to licence, regulate and tax recreational cannabis use. Similarly, the federal government could partially or totally repeal its criminal cannabis prohibitions provided that the provincial regulatory systems met certain criteria. The only limit on these kinds of arrangements is that the level of government enacting the legislation must have constitutional power to do so. Given the differences in the provinces’ approach to enforcing the current federal cannabis law, a consensus may be difficult to reach. In any event, these constitutional issues need to be thoroughly analyzed in developing federal cannabis policy.<sup>23</sup>

MADD Canada believes that, regardless of how it is accomplished, there should be a single, federally-mandated legalization regime. It would be contrary to the public interest to have 13 different recreational cannabis systems, each of which may be subject to different rules on production, distribution, price, potency, availability, access, and marketing. The prospect of having 13 jurisdictions pressured to enact only limited regulatory controls in an effort to compete for market share and tax revenue is troubling. Invariably, cannabis will flow across provincial and territorial borders, and when it does, it should be subject to a uniform set of rules.

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continuing legislative authority to deal with marihuana use on a purely regulatory basis might well be questioned.”

<sup>21</sup> *Constitution Act, 1867* (UK), 30 & 31 Vict, c. 3, s. 92(13), reprinted in R.S.C. 1985, Appendix II, No. 5.

<sup>22</sup> See generally, Le Dain Commission, *supra* note 2, at 213-19; and P. Hogg, *Constitutional Law of Canada*, 5th ed., vol. 1 (Toronto: Carswell, 2007) (loose-leaf 2015 supplement), ch. 18, at 27-34.

<sup>23</sup> These issues were discussed at length in the Le Dain Commission report on cannabis. Le Dain Commission, *ibid.*, at 213-29.

## 1. Minimizing Harms of Use: Questions

- (a) *Do you believe that these measures are appropriate to achieve the overarching objectives to minimize harms, and in particular to protect children and youth? Are there other actions which the Government should consider enacting alongside these measures?*

A legalization model incorporating the seven measures listed on pages 13 and 14 of the Discussion Paper could reduce some of the current costs of enforcement and prosecution, allow the government to control the purity, potency and price of cannabis sold in the lawful market, and give adult cannabis users the opportunity to end their reliance on the illicit trade. However, the impact of the legalization option will vary dramatically, depending on its specific features.

MADD Canada would favour a legalization model that expressly prioritizes public health and safety. This should include, among other things: controls on the price, potency and range of cannabis products; a strictly enforced age of purchase; a ban on all cannabis advertising, promotions and marketing; and criminal prohibitions on public consumption and unauthorized production, distribution, sales, and possession.

As indicated, it is important to expressly acknowledge that, all things being equal, this type of legalization option would have less impact on the illegal trade than legalization options that catered to consumer demand. Consequently, a legalization model prioritizing health and safety would be hard-pressed to compete with the illicit trade unless it was accompanied by a sustained crackdown on the black market, including the illegal medical cannabis shops. The public health and safety benefits that accrue from having a well-regulated legal market will be completely undermined if the illegal medical marijuana shops and others are allowed to operate in open defiance of the CDSA.

Working in conjunction with the regulatory colleges, the provincial and territorial governments need to ensure that physicians and nurse practitioners who issue medical authorizations comply with both the law and accepted medical practice. The aggressive promotion of cannabis for a broad range of medical conditions by corporations that advertise the easy availability of medical authorizations is troubling. The website of one company advertises a roster of “marijuana friendly doctor[s],” who “are happy to provide professional assessments of your illness and explain how marijuana will work for you.” The website indicates that: medical assessments can be done in person or by Telemedicine; registration requires only 20-30 minutes; 95% of applicants are processed within 3 days; and no medical supporting documents are required in many cases.<sup>24</sup> Leaving aside the broad claims about the unique medicinal benefits of

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<sup>24</sup> Medical Marijuana Services, “Why you will love this program” (2016), online: <<https://medicalmarijuanaservices.ca/>>. The website also explains, among other things, “How To Make Highly Potent

cannabis, it is disconcerting to see cannabis publicly promoted to the public as a risk free cure-all.

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

Given the concerns expressed by the medical community<sup>25</sup> and researchers,<sup>26</sup> limiting lawful cannabis purchase and possession to those 25 years of age and older would be justifiable on public health and safety grounds. Consistent with the findings of other researchers,<sup>27</sup> the author of a 2014 review stated:

Research in the past 20 years has shown that driving while cannabis-impaired approximately doubles car crash risk and that around one in 10 regular cannabis users develop dependence. Regular cannabis use in adolescence approximately doubles the risk of early school-leaving and of cognitive impairment and psychoses in adulthood. Regular cannabis use in adolescence is also associated strongly with the use of other illicit drugs. These associations persist after

Cannabis Oil At Home [...]” and “How To Make Cream of Cannabis Soup This Winter For Mental And Physical Vitality.”

<sup>25</sup> For example, based on the “potentially severe nature” of the risks of adolescent cannabis use, the College of Physicians and Surgeons of Ontario (CPSO) stated that “physicians must not prescribe dried marijuana to patients under the age of 25 unless all other conventional therapeutic therapies have been attempted and have failed to alleviate the patient’s symptoms.” CPSO, *Policy Statement #1-15: Marijuana for Medical Purpose* (Toronto: CPSO, 2015), at 3.

In a recent Canadian Medical Association poll, 46% of the almost 800 physicians who responded stated that the minimum purchase age for recreational cannabis should be at least 21 (20.3% endorsed a minimum age of 25 and 25.4 endorsed an age of 21). P. Fayerman, “Doctors to give Trudeau an earful for his marijuana legalization plans,” *The Vancouver Sun* (25 August 2016), online: <<http://vancouversun.com/news/national/doctors-weigh-in-on-pm-trudeaus-plans-for-marijuana-legalization>>.

<sup>26</sup> See for example, A. Porath-Waller, *Clearing the Smoke on Cannabis: Chronic Use and Cognitive Functioning and Mental Health* (Ottawa: Canadian Centre on Substance Abuse, 2009) [Porath-Waller]; W. Hall, “What has research over the past two decades revealed about the adverse health effects of recreational cannabis use?” (2014) 110 *Addiction* 19 [Hall]; E. Silins, “Young adult sequelae of adolescent cannabis use: an integrative analysis,” (2014) 1(4) *The Lancet Psychiatry* 286; and N. Volkow *et al.*, “Adverse Health Effects of Marijuana Use” (2014) 370(23) *New England Journal of Medicine* 2219 [Volkow].

<sup>27</sup> See for example, Porath-Waller, *ibid.*; Volkow, *ibid.*; Kalant, *supra* note 11; and *Cannabis: Canadian Drug Summary*, *supra* note 6. In this last study, the authors stated, at 1-2, that: “Chronic cannabis use is associated with deficits in memory, attention, psychomotor speed and executive functioning, particularly among those who started using cannabis during early adolescence. Chronic use of this drug can also increase the risk of psychosis, depression and anxiety, breathing problems and respiratory conditions, and possibly lung cancer. Use of cannabis during pregnancy — particularly heavy use — can affect children’s cognitive functioning, behaviour, future substance use behaviour and mental health.”

controlling for plausible confounding variables in longitudinal studies.<sup>28</sup>

However, the proposal to impose a purchase and possession minimum of 25 years of age is unlikely to garner sufficient public and political support. For the reasons set out below, MADD Canada would strongly advocate adopting a minimum age of lawful purchase and possession of at least 21. The research on the alcohol and tobacco minimum purchase age legislation is instructive in this regard.

The American state laws creating a minimum drinking age of 21 have significantly reduced alcohol consumption and related crash deaths among young people, despite the legislation's less than rigorous enforcement.<sup>29</sup> For example, the National Highway Traffic Safety Administration (NHTSA) has estimated that these minimum drinking age laws saved more than 30,300 lives from 1975 to 2014.<sup>30</sup> Similarly, it is reasonable to assume that a minimum age of 21 for cannabis purchase and possession would reduce cannabis-related crash deaths, relative to a minimum age of 18 or 19.

In 2015, the American National Academy of Sciences published a comprehensive study of the potential impact of raising the minimum age of lawful access to tobacco from 18 to 21 years of age.<sup>31</sup> Among other things, the authors concluded that: this policy would prevent or delay initiation of smoking by adolescents and young adults; the proportionately largest reduction in initiation would be among 15 to 17-year olds; a minimum age of 21 would have substantially greater benefits than a minimum age of 19; and that implementing the policy in 2015 would result in a 10% reduction in lifetime premature deaths, lung cancer deaths and years of life lost among those born between 2000 and 2019.<sup>32</sup>

Based on the research, MADD Canada has long advocated that all new drivers be required to have a .00% blood-alcohol concentration<sup>33</sup> and be negative for any non-medical drug if they

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<sup>28</sup> Hall, *supra* note 26., at 19.

<sup>29</sup> See for example, J. Fell *et al.*, "The Impact of Underage Drinking Laws on Alcohol-Related Fatal Crashes of Young Drivers" (2009) 33(7) *Alcoholism: Clinical and Experimental Research* 1208; and A. McCartt, L. Hellinga & B. Kirley, "The effects of minimum legal drinking age 21 laws on alcohol-related driving in the United States" (2010) 41 *Journal of Safety Research* 173. Conversely, research indicates that lowering the drinking age increases alcohol-involved crashes among young people. K. Kypri *et al.*, "Minimum Purchasing Age for Alcohol and Traffic Crash Injuries Among 15- to 19-Year-Olds in New Zealand" (2006) 96(1) *American Journal of Public Health* 126.

<sup>30</sup> NHTSA, *Traffic Safety Facts, 2014 Data, Young Drivers* (Washington, DC: NHTSA, 2016), at 5.

<sup>31</sup> R. Bonnie *et al.*, *Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products* (Washington, DC: The National Academies Press, 2015).

<sup>32</sup> *Ibid.*, at 4, 5 and 9.

<sup>33</sup> See R. Solomon *et al.*, *Rating the Provinces: The 2003 Report Card - A Comprehensive Review of Provincial and Territorial Impaired Driving Law* (Mississauga, Ontario: MADD Canada, 2003), at 10;

are under the age of 21 or have less than 5 years' driving experience. Adopting a minimum cannabis purchase and possession age of 21 would be consistent with this proven impaired driving countermeasure.<sup>34</sup>

## 2. Establishing a Safe and Responsible Production System: Questions

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

MADD Canada believes that the system of licensing the 34 commercial producers for the lawful medical cannabis market provides an appropriate, albeit very small-scale, model for the lawful recreational cannabis market. Given that the current medical cannabis market is dwarfed by the potential lawful recreational market, the federal government must ensure that it has the staff and resources necessary to licence and regulate the far greater number of commercial producers that will be needed. The government will also require considerable lead time to process the increased flood of applications that it will receive.

*(b) To what extent, if any, should home cultivation be allowed in a legalized system? What, if any, government oversight should be put in place?*

The Discussion Paper aptly summarizes the daunting challenges of regulating home cultivation in the medical cannabis market and acknowledges that it is “virtually impossible” to effectively oversee this regime. Permitting home cultivation for recreational purposes would multiply these problems several hundredfold. It would be impossible for the police to enforce any cultivation limit and there would be no means of minimizing underage access. Both small and large-scale commercial cannabis production would proliferate in the guise of lawful home cultivation. The government would also lose the ability to control the purity, potency and range of cannabis products in the recreational market. Home cultivation, both lawful and unlawful, would undermine the viability of any government-regulated recreational cannabis system. It is for these reasons that MADD Canada is strongly opposed to permitting home cultivation.

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and R. Solomon & E. Chamberlain, “Zero BAC Limits for Drivers Under 21: Lessons from Canada” (2008), 14 *Injury Prevention* 123.

<sup>34</sup> See for example, J. Lacey, R. Jones & C. Wiliszowski, *Zero Tolerance for Youth: Four States' Experience* (Washington, DC: NHTSA, 2000); R. Voas, A. Tippetts & J. Fell, “Assessing the Effectiveness of Minimum Legal Drinking Age and Zero Tolerance Laws in the United States” (2003) 35 *Accident Analysis and Prevention* 579; and L. Liang & J. Huang, “Go Out or Stay In? The Effects of Zero Tolerance Laws on Alcohol Use and Drinking and Driving Patterns Among College Students” (2008) 17 *Health Economics* 1261.

(c) *Should a system of licensing or other fees be introduced?*

MADD Canada would support charging producers a licensing fee that is sufficient to cover the costs of processing applications and overseeing production.

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

The *Marihuana for Medical Purposes Regulations (MMPRs)*<sup>35</sup> and the accompanying *Regulatory Impact Analysis Statement*, which together run to almost 130 pages in length, contain extremely detailed provisions governing licensed producers. This legislation relates to, among other things: Health Canada inspections;<sup>36</sup> personal security clearances;<sup>37</sup> the physical security of the premises;<sup>38</sup> “good production practices”;<sup>39</sup> labelling, shipping and child-proof packaging;<sup>40</sup> and record keeping.<sup>41</sup> These regulations provide an appropriate framework for the production of cannabis for the recreational market.

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

If the federal government is to have any realistic hope of meeting initial demand, it will have to rely on the existing 34 licensed producers and support their efforts to expand production. Thereafter, the current licensed producers should have to compete with other qualified applicants. The number of licensed producers will need to be carefully assessed. While there are risks in licensing too few producers, there are also risks in licensing too many. Having a large number of commercial producers having to compete for market share on the basis of low prices and high potency cannabis products is not in the public interest.

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<sup>35</sup> SOR/2013-119.

<sup>36</sup> *Ibid.*, s. 9.

<sup>37</sup> *Ibid.*, ss. 89-100.

<sup>38</sup> *Ibid.*, ss. 41-51.

<sup>39</sup> *Ibid.*, ss. 52-63. Among other things, “good production practices” include provisions relating to contaminants, pest control, sanitation, quality assurance measures, recall reporting, and the reporting of all adverse reactions.

<sup>40</sup> *Ibid.*, ss. 64-73. In terms of labelling, the producers have to specify the weight in grams of the dried cannabis, as well as the percentages of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).

<sup>41</sup> *Ibid.*, ss. 134-50.

### 3. Designing an Appropriate a Distribution System: Questions

(a) Which distribution model makes the most sense and why?

MADD Canada believes that the phased-in approach to distribution set out in the Discussion Paper is appropriate. If the decision is made to permit retail outlets, MADD Canada would favour a single, federally-mandated government-controlled system that would operate in a manner akin to the current provincial government liquor stores.<sup>42</sup> Research indicates that government monopoly control over retail alcohol sales generates fewer problems than private sector distribution systems.<sup>43</sup> However, MADD Canada would be opposed to permitting cannabis to be sold in the same retail outlets as alcohol.

This distribution model or variants of it are far preferable to private sector retail or store front outlets. Government-controlled outlets are far more likely to demand proof of age, refuse sales to underage or apparently high or intoxicated customers, sell only cannabis products supplied by licensed producers, and comply with the other federal regulatory limits imposed on retail sales. Even if one ignores the fact that the existing illegal medical cannabis shops are blatantly violating the *CDSA*, the reported practices of many of these private sector operations are disconcerting. Some make no pretext of limiting sales to those with a medical need for the drug, and others sell contaminated or improperly labelled cannabis. It is unrealistic to assume that the police would have anywhere close to the resources to regulate hundreds or thousands of independent private sector retail outlets.

However, it is essential that the federal government enact effective drug-impaired driving legislation, including workable police enforcement powers well before legalizing adult recreational cannabis use. MADD Canada would be vehemently opposed to any legalization initiative until effective means are in place to address the increased rates of driving after cannabis use that would otherwise occur.

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<sup>42</sup> As indicated, creating a retail cannabis distribution system in the provinces that operates under a federal regulatory scheme raises potential constitutional issues. In addition to carefully drafting the legislation, the federal government may well need to reach an agreement with the provinces. Regardless of how it is accomplished, having a single federally-mandated system for recreational cannabis use is in the public interest.

<sup>43</sup> See for example, R. Mann *et al.*, *Alcohol Distribution, Alcohol Retailing and Social Responsibility: A Report Submitted to the Beverage Alcohol System Review Panel* (Toronto: Centre for Addiction and Mental Health, 2005), at 10-12; T. Babor *et al.*, *Alcohol No Ordinary Commodity: Research and Public Policy*, 2d ed. (New York: Oxford University Press, 2010), at 136-38 [Babor]; S. Popova *et al.*, “Cost of privatization versus government alcohol retailing systems: Canadian example” (2012) 31 *Drug and Alcohol Review* 4; and R. Hahn *et al.*, “Effects of Alcohol Retail Privatization on Excessive Alcohol Consumption and Related Harms: A Community Guide Systematic Review” (2012) 42(4) *American Journal of Preventive Medicine* 418.

*(b) To what extent is variation across provinces and territories in terms of distribution models acceptable?*

All things being equal, it is preferable to have a single framework for retail cannabis distribution across Canada, rather than having a patchwork of 13 different systems. The public and the media are already confused about the legal status of cannabis, and the creation of 13 different distribution systems would only exacerbate this problem. This eventuality would also undermine any federal attempts to increase public understanding of the cannabis laws.

Moreover, if differing distribution systems were created, conduct that was lawful under the *CDSA* in one province because it was in accordance with that jurisdiction's distribution scheme could result in criminal liability under the *CDSA* in provinces that had a different system. In our view, it is inappropriate, and arguably unconstitutional, that individuals engaging in exactly the same conduct should be subject to fundamentally different federal criminal law consequences.

*(c) Are there other models worthy of consideration?*

See above.

#### **4. Enforcing Public Safety and Protection: Questions**

*(a) How should governments approach designing laws that will reduce, eliminate and punish those who operate outside the boundaries of the new legal system for marijuana?*

Traffic safety research has established that the perceived and actual rates of apprehension are the most important variables in deterring impaired driving.<sup>44</sup> It is worth noting in this regard that Saskatchewan, which had by far the highest per capita charge rate for cannabis possession among the provinces in 2014,<sup>45</sup> had the lowest reported rate of past year cannabis use in 2012.<sup>46</sup> While other factors were involved, the level of enforcement appears to be an important variable.

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<sup>44</sup> See for example, R. Homel, "Drivers Who Drink and Rational Choice: Random Breath Testing and the Process of Deterrence" in R. Clarke & M. Felson, eds., *Routine Activity and Rational Choice: Advances in Criminological Theory* vol. 5 (New Brunswick, NJ: Transaction, 1993), at 59; R. Tay, "General and Specific Deterrent Effects of Traffic Enforcement: Do We Have to Catch Offenders to Reduce Crashes?" (2005) 39(2) *Journal of Transport Economics and Policy* 209; B. Watson & J. Freeman, "Perceptions and Experiences of Random Breath Testing in Queensland and the Self-Reported Deterrent Impact on Drunk Driving" (2007) 8(1) *Traffic Injury Prevention* 11; K. Beck, J. Fell & A. Yan, "A Comparison of Drivers with High Versus Low Perceived Risk of Being Caught and Arrested for Driving Under the Influence of Alcohol" (2009) 10(4) *Traffic Injury Prevention* 312.

<sup>45</sup> Statistics Canada, *CANSIM Table 252-0051, Incident-based crime statistics, by detailed violations, annual (number)* (Ottawa: Statistics Canada, 2016), online: < <http://www5.statcan.gc.ca/cansim/a26>>.

If the federal government is committed to reducing, eliminating and punishing those operating outside of the new cannabis regime, it will have to dramatically increase the related apprehension and charge rates. It is essential to shut down the illegal medical cannabis shops and other enterprises that openly operate in violation of the *CDSA* or any new distribution system. While the cooperation of the municipal and provincial governments will be needed, it may be difficult to obtain. The preceding health and safety considerations may not be given priority if the provinces and municipalities are given unfettered authority to regulate recreational cannabis use. If the past is any indication, the prevailing public attitude towards cannabis availability, the willingness to enforce the *CDSA* and revenue considerations may well dictate the provinces' and municipalities' responses.

For example, the Vancouver City Council announced on June 24, 2015 that, rather than closing down the almost 100 illegal medical cannabis shops, it was going to charge them a \$30,000 licensing fee. The Council then publicly defended its decision to profit from conduct that constituted, among other things, the federal indictable offence of trafficking.<sup>47</sup> These shops have proliferated in Toronto, Montreal and other cities,<sup>48</sup> some of which have also considered licensing them. In fairness, it should be noted that action has recently been taken in both Vancouver<sup>49</sup> and Toronto<sup>50</sup> to close down some of these shops. Nevertheless, municipal governments have no authority to exempt individuals (whether municipally-licensed or not) from federal criminal law, let alone profit from the crime. Of equal concern is that a relatively small-scale cannabis dealer in Saskatchewan, for example, may well end up in prison, while an individual openly running a string of municipally-licensed illegal cannabis shops in Vancouver would not even be charged.

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In 2014, the charge rate for cannabis possession in Saskatchewan was almost six times that of Prince Edward Island, the province with the lowest charge rate (131.94 versus 23.48 per 100,000).

<sup>46</sup> Rotermann, *supra* note 4. Saskatchewan's per capita rate of past year cannabis use was 9.9% in 2012, which compared to 12.2% for Canada as a whole.

<sup>47</sup> L. Johnson, "Marijuana dispensary regulations approved in Vancouver," CBC News (24 June 2015), online: <<http://www.cbc.ca/news/canada/british-columbia/marijuana-dispensary-regulations-approved-in-vancouver-1.3126111>>.

<sup>48</sup> It was reported in January, 2016 that Toronto had 40 illegal dispensaries and that the number was expected to grow to over 100 by the spring. M. Hager, "Canada's pot industry calling on Ottawa to stop rise of illegal stores," *The Globe and Mail* (14 January 2016), online: <[http://www.the\\_globeandmail.com/news/british-columbia/canadas-pot-industry-calling-on-ottawa-to-stop-rise-of-illegal-stores/article28207667/](http://www.the_globeandmail.com/news/british-columbia/canadas-pot-industry-calling-on-ottawa-to-stop-rise-of-illegal-stores/article28207667/)>.

<sup>49</sup> As of May 31, 2016, Vancouver had licensed only 11 of the 176 applicants and filed injunctions to close 17 of the 55 unlicensed stores that ignored orders to close. K. Mangione, "Vancouver files injunctions to force closure of 17 pot dispensaries," CTV Vancouver (31 May 2016), online: <<http://bc.ctvnews.ca/vancouver-files-injunctions-to-force-closure-of-17-pot-dispensaries-1.2925771>>.

<sup>50</sup> The Toronto police have recently raided 43 of the approximately 100 shops that had opened in the last year. J. Gray, "Toronto police bust three more illegal marijuana dispensaries," *The Globe and Mail* (9 August 2016), online: <<http://www.theglobeandmail.com/news/toronto/toronto-police-bust-three-more-illegal-marijuana-dispensaries/article31338615/>>.

Research also establishes that the speed with which a sanction is imposed is an important variable in deterring criminal behavior. Moreover, the research indicates that the severity of the potential penalty is a less significant variable.<sup>51</sup> Our experience in the impaired driving field indicates that the more difficult, time consuming and frustrating it is to enforce a law, the more reluctant the police and prosecutors will be to lay charges and proceed to trial.<sup>52</sup>

Some of the aforementioned concerns can be addressed by amending the *CDSA* to include comprehensive mitigation measures that maintain the criminal status of unauthorized cannabis possession, but streamline the arrest, charge and trial process. Mitigation measures can also be used to significantly reduce the adverse consequences that a conviction would otherwise have on cannabis possession offenders. The mitigation alternatives could range from modest proposals that merely lower maximum penalties to more elaborate schemes that encompass fine-only sentencing options, simplified criminal procedures and the automatic elimination of criminal records after a specified waiting period. Since, as indicated, very few cannabis possession offenders are currently sentenced to imprisonment,<sup>53</sup> a fine-only mitigation approach would have a negligible impact.

A comprehensive mitigation scheme could include: banning the fingerprinting and photographing of cannabis offenders; replacing the current trial procedures with a ticketing system that does not require a court appearance; and enacting legislation that automatically deems cannabis possession offenders who have no subsequent criminal convictions within two years to have no criminal record. Moreover, the cannabis production and trafficking offences could be redefined to ensure that conduct that is equivalent to personal use is subject to the same sanctions as “simple” possession. For example, sharing a joint with a friend and similar acts could be excluded from the definition of trafficking, which is currently a very broadly defined indictable offence that carries a potentially lengthy prison sentence.<sup>54</sup>

One potential mitigation option relies on an existing piece of federal legislation. In 1992, Parliament enacted the *Contraventions Act*,<sup>55</sup> which allows ticketing for minor federal regulatory

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<sup>51</sup> See *supra* note 44.

<sup>52</sup> For a discussion of the impact of these factors on impaired driving charge rates, see R. Solomon *et al.*, “The Case for Comprehensive Random Breath Testing Programs in Canada: A Review of the Evidence and Challenges” (2011) 49(1) *Alberta Law Review* 37, at 45-48 [Solomon, 2011].

<sup>53</sup> See *supra* note 9. The 2013/14 incarceration rates for drug possession set out in note 9 are considerably lower than the rates reported a few years ago. From 2008/09 to 2011/12, 9% of young offenders convicted of cannabis possession and 16% of adult offenders convicted of this offence received custodial sentences. Cotter, *supra* note 7, at 21 and 22.

<sup>54</sup> The *CDSA* defines trafficking to include, among other things: selling, administering, giving, transferring, transporting, sending, or delivering a drug, or offering to do any of these things. This definition applies regardless of the quantity of drugs involved. *CDSA*, *supra* note 8, s. 2(1) “traffic.”

<sup>55</sup> S.C. 1992, c. 47.

offences that the government has designated as “contraventions.” It has been suggested that cannabis possession be designated as a contravention.<sup>56</sup> This would have given the police discretion to treat cannabis possession as a contravention and issue a ticket, or treat the conduct as a federal criminal offence and proceed by summary conviction. The Act is extremely complex and has generated legal challenges. Moreover, major parts have still not been brought into force. The Act requires provincial buy-in, which has been slow to materialize, and Alberta and Saskatchewan have not yet agreed to use the *Contraventions Act*. In any event, the federal government has not designated cannabis possession as a contravention.

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

We have elsewhere discussed in detail our concerns with drug-impaired driving and the ineffectiveness of the current *Criminal Code* enforcement provisions.<sup>57</sup> Nevertheless, because of MADD Canada’s focus on drug-impaired driving, we have provided some background information below before answering the question.

Canadian survey data, roadside screening studies and post-mortem reports indicate that driving after drug use has become a major traffic safety issue. Provincial, regional and national surveys indicate that rates of driving after cannabis use among young people now exceed rates of driving after drinking.<sup>58</sup> Recent national survey data indicated that 18-19 year olds had the

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<sup>56</sup> Canadian Association of Chiefs of Police, Media Release, “Canadian Association of Chiefs of Police (CACP) Propose ‘Ticketing Option’ For Simple Possession of Cannabis” (20 August 2013), online: <<http://www.oacp.on.ca/Userfiles/Files/NewAndEvents/Final%20-%20CACP%20Media%20Release%20-%20Cannibus%20Possesion.pdf>>.

<sup>57</sup> See R. Solomon, E. Chamberlain & A. Kus, “Drug-Impaired Driving in Canada: Moving Beyond American Enforcement Models” (2013) 60(2) *Criminal Law Quarterly*, 238 [Solomon, 2013]; R. Solomon & E. Chamberlain, “Canada’s New Drug-Impaired Driving Law: The Need to Consider Other Approaches” (2014) 15 *Traffic Injury Prevention*, 685; R. Solomon, A. Berger & M. Clarizio, *Drug-Impaired Driving Charges by Jurisdiction: Canada, 2008-2014* (Oakville: MADD Canada, 2015) [Solomon, 2015]; and R. Solomon & M. Clarizio, *Cannabis and other drugs among fatally injured drivers of highway vehicles: Canada, 2012* (Oakville: MADD Canada, 2016) [Solomon, 2016].

<sup>58</sup> For example, in the national *Canadian Addiction Survey (CAS)*, 39.8% of those aged 15-24 reported driving under the influence of cannabis during the past 12 months, compared to 20.9% who reported driving under the influence of alcohol. In addition, the mean number of times that respondents admitted to driving “under the influence of cannabis” in the past year was 10, compared to 1.6 for alcohol. *Canadian Addiction Survey (CAS): Substance Use by Canadian Youth* (Ottawa: Health Canada, 2007), at 95. Note that the percentages relate to 15-24 year olds who reported driving in the past 12 months, and also reported using cannabis or reported drinking in the past 12 months. See also M. Asbridge, C. Poulin & A. Donato, “Motor vehicle collision risk and driving under the influence of

highest reported rate of driving after using cannabis, followed by 15-17 year olds. While 6% to 8% of youth reported driving after cannabis use, 15.8% reported being a passenger of a driver who recently used cannabis.<sup>59</sup> Several authors have attributed these high rates of driving after cannabis use to a lack of awareness about its risks and a lack of fear of being charged and convicted for such behaviour.<sup>60</sup>

Recent roadside screening studies indicate that the percentage of drivers positive for drugs exceeds the percentage positive for alcohol, particularly among young drivers.<sup>61</sup> A 2012 British Columbia study reported that, while 5.4% of randomly-screened drivers were positive alcohol, 7.4% were positive for drugs.<sup>62</sup> In a 2014 Ontario roadside survey, only 4% of drivers were positive for alcohol, whereas 10.2% were positive for at least one drug other than alcohol.<sup>63</sup> Cannabis is generally the most commonly-found drug, with about half the drug-positive drivers testing positive for the drug.<sup>64</sup> Further, it is not uncommon for drivers to test positive for both alcohol and cannabis, or for cannabis and one or more drugs other than alcohol.

The fact that a driver tests positive for cannabis does not necessarily mean that his or her ability to drive is impaired. However, a 2010 British Columbia roadside screening study reported

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cannabis: Evidence from adolescents in Atlantic Canada” (2005) 37 *Accident Analysis and Prevention* 1025, at 1029 [Asbridge, 2005].

<sup>59</sup> D. Beirness & A. Porath-Waller, *Clearing the smoke on Cannabis: Cannabis use and driving – An Update* (Ottawa: Canadian Centre on Substance Abuse, 2015), at 2 and 3 [Beirness, 2015].

<sup>60</sup> Asbridge, 2005, *supra* note 58, at 1031; C. Poulin & A. Donato, “Motor vehicle collision risk and driving under the influence of cannabis: Evidence from adolescents in Atlantic Canada” (2005) 37 *Accident Analysis and Prevention* 1025, at 1031; D. Patton *et al.*, *Substance Use Among Manitoba High School Students* (Winnipeg: Addiction Research Foundation of Manitoba, 2001), at 2 and 50; and B. Fischer *et al.*, “Toking and Driving: Characteristics of Canadian university students who drive after cannabis use – an exploratory pilot study” (2006) 13(2) *Drugs: Education, Prevention and Policy* 179, at 183-85.

<sup>61</sup> See, E. Beasley & D. Beirness, *Alcohol and Drug Use among Drivers Following the Introduction of Immediate Roadside Prohibitions in British Columbia: Findings from the 2012 Roadside Survey* (Victoria: Office of the Superintendent of Motor Vehicles, 2014) [Beasley, 2014]; and D. Beirness, E. Beasley & K. McClafferty, *Alcohol and Drug Use Among Drivers in Ontario: Findings from the 2014 Roadside Survey* (Toronto: Ontario Ministry of Transportation, 2015) [Beirness *et al.*]. See also M. Brault *et al.*, “The Contribution of Alcohol and Other Drugs Among Fatally Injured Drivers in Québec: Final Results,” in P. Williams & A. Clayton, eds. *Proceedings of the 17th International Conference on Alcohol, Drugs and Traffic Safety*, Glasgow, 8-13 August 2004, CD-ROM (Glasgow: The International Council on Alcohol, Drugs and Traffic Safety (ICADTS), 2004).

<sup>62</sup> Beasley, 2014, *ibid.*, at 4.

<sup>63</sup> Beirness *et al.*, *supra* note 61, at 1.

<sup>64</sup> For example, Beasley, 2014 *supra* note 61, at 23 reported that cannabis accounted for 43.6% of the drugs found; and Beirness *et al.*, *ibid.*, at 27 reported that cannabis was found in 69.1% of drug-positive drivers.

that the majority of cannabis-positive drivers had THC levels over 40ng/ml. The authors stated that these readings are indicative of use just prior to or while driving and concluded that the vast majority of cannabis-positive drivers had THC levels that impaired “their ability to operate a motor vehicle safely.”<sup>65</sup>

The Canadian toxicology studies on fatally-injured drivers reinforce the previously described patterns of driving after drug use. As the following chart illustrates, while the presence of alcohol has been declining among fatally-injured drivers, the presence of drugs (particularly cannabis) has been increasing.

**Alcohol and Drugs Among Fatally-Injured Drivers  
of Highway Vehicles in Canada, 1990-2012<sup>66</sup>**

|      | % of Fatally-Injured Drivers Testing Positive For |         |
|------|---|---------|
|      | Alcohol   | Drugs   |
| 1990 | 45%   | No Data |
| 1992 | 47%   | No Data |
| 1994 | 44%   | No Data |
| 1996 | 40%   | No Data |
| 1998 | 38%   | No Data |
| 2000 | 35%   | 35%     |
| 2002 | 34%   | 42%     |
| 2004 | 34%   | 36%     |
| 2006 | 37%   | 34%     |
| 2008 | 38%   | 38%     |
| 2010 | 38%   | 37%     |
| 2012 | 33%   | 40%     |

The presence of cannabis among fatally-injured drivers has been increasing. In 2012, cannabis was the most commonly-found drug among fatally-injured drivers in Canada as a whole

<sup>65</sup> D. Beirness & E. Beasley, *Alcohol and Drug Use Among Drivers: British Columbia Roadside Survey 2010* (Ottawa: Canadian Centre on Substance Abuse, 2011), at 12 and 13.

<sup>66</sup> Solomon, 2016, *supra* note 57, at 1.

Of concern as well is that alcohol and/or drugs are present in a majority of fatally-injured drivers. A 2011 study found that 54.6% of Canadian drivers fatally injured from 2000 to 2007 were positive for alcohol and/or drugs. E. Beasley, D. Beirness & A. Waller, *A Comparison of Drug- and Alcohol-involved Motor Vehicle Driver Fatalities* (Ottawa: Canadian Centre on Substance Abuse, 2011), at 1. Similarly, 58.8% of drivers fatally injured in 2012 were positive for alcohol and/or drugs. R. Solomon & M. Clarizio, *Alcohol and/or drugs Among Crash Victims Dying Within 30 Days and 12 Months, by Jurisdiction: Canada, 2012* (Oakville: MADD Canada, 2016), at 6.

and in every province except Manitoba, Prince Edward Island and Saskatchewan. Almost half (47%) of Canadian drug-positive, fatally-injured drivers were positive for cannabis.<sup>67</sup>

Estimates vary on the relative risk of a crash associated with cannabis use. A 2012 meta-analysis reported that acute cannabis consumption doubled the risk of a fatal or serious injury crash.<sup>68</sup> A second 2012 meta-analysis reported that cannabis consumption more than doubled the risk of a crash, and that the crash risk increased with the amount consumed and the frequency of use.<sup>69</sup> These studies are generally consistent with previous studies on the relative risk of crash.<sup>70</sup> A recent study comparing British Columbia roadside survey results with post-mortem data reported that cannabis use alone increased the risk of a fatal crash fivefold and that cannabis use, if combined with alcohol, increased the risk fortyfold.<sup>71</sup>

The most recent estimates of the number of crash deaths attributable to cannabis are equally concerning. One study estimated that, in 2012, there were 75 cannabis-attributed crash deaths in Canada, while another study put the figure at 94 deaths.<sup>72</sup> The authors of a third study estimated that there were between 89 and 267 cannabis-related crash deaths in 2010.<sup>73</sup> Rates of driving after cannabis use and related crash deaths and injuries may have increased in the last several years, given the sharp rise in the number of lawful medical marijuana users and the proliferation of illegal medical cannabis shops.

Preliminary results from Colorado and Washington State indicate that commercializing lawful medical cannabis use and legalizing adult recreational use increased cannabis-related

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<sup>67</sup> Solomon, 2016 *supra* note 57, at 2.

<sup>68</sup> M. Asbridge, J. Hayden & J. Cartwright, “Acute cannabis consumption and motor vehicle collision risk: A systematic review of observational studies and meta-analysis” (2012) 344 *British Medical Journal* e536.

<sup>69</sup> M. Li *et al.*, “Marijuana Use and Motor Vehicle Crashes” (2012) 34 *Epidemiologic Reviews* 65, at 69.

<sup>70</sup> J Ramaekers *et al.*, “Dose related risk of motor vehicle crashes after cannabis use” (2004) 73 *Drug Alcohol Dependence* 109; S. Blows *et al.*, “Marijuana use and car crash injury” (2005) 100 *Addiction*, 605; M. Bedard, S. Dubois & B. Weaver, “The impact of cannabis on driving” (2007) 98 *CJPH* 6; and R. Sewell, J. Poling & M. Sofuoglu, “The Effect of Cannabis Compared with Alcohol on Driving” (2009) 18 *The American Journal on Addictions* 185.

<sup>71</sup> D. Beirness & E. Beasley & P. Boase, “A comparison of drug use by fatally-injured drivers and drivers at risk,” in *Proceedings of the 20th International Conference on Alcohol, Drugs and Traffic Safety T2013* (Brisbane: The International Council on Alcohol, Drugs and Traffic Safety, 2013), at 4.

<sup>72</sup> A. Wettlaufer *et al.*, *The Impact of Cannabis on Road Safety in the Canadian Provinces: Estimates of Collisions, Casualties and Costs in 2012* (Ottawa: Canadian Centre on Substance Abuse, 2016), at 13; and S. Imtiaz *et al.*, “The burden of disease attributable to cannabis use in Canada in 2012” (2016) 111(4) *Addiction* 653, at 656.

<sup>73</sup> B. Fischer *et al.*, “Crude estimates of cannabis-attributed mortality and morbidity in Canada – implications for public health focused intervention priorities” (2015) 10 *Journal of Public Health* 1, at 2.

diving problems. A study of the widespread commercializing of lawful medical marijuana use in Colorado concluded: that the percentage of marijuana-positive drivers in fatal crashes, which had been decreasing, increased in the post-commercialization period; and that this increase during the post-commercialization period in Colorado was higher than that in 34 non-medical marijuana states (NMMS).<sup>74</sup> Another study found that fatalities involving THC-positive drivers increased 44% in 2014, the year after Colorado legalized recreational cannabis use.<sup>75</sup> Similarly, a Washington State study reported that the number and percentage THC-positive drivers in fatal crashes approximately doubled in the year after recreational cannabis use was legalized.<sup>76</sup> Granted, the fact that a driver is positive for cannabis does not mean that his or her driving ability was impaired, or that he or she was at fault in the fatal crash. Nevertheless, the results of these early studies are alarming.

Although drug-impaired driving was first prohibited in 1925,<sup>77</sup> the police were not given any specific authority to gather related evidence until 2008. There are no data on the number of drug-impaired driving charges prior to 2008, because they were not separately recorded. Nevertheless, it appears that very few charges were laid even after the sharp rise in recreational drug use in the mid-1960s. Prior to the 2008 amendments, prosecuting drug-impaired driving cases was exceedingly onerous and the outcome was uncertain.<sup>78</sup>

In 2008, the *Criminal Code* was amended to authorize the police to demand “physical coordination tests” (*i.e.* the Standard Field Sobriety Test or SFST) and drug “evaluations” (*i.e.* the Drug Recognition Evaluation or DRE) in specified circumstances.<sup>79</sup> The SFST and DRE

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<sup>74</sup> S. Salomonsen-Sautel *et al.*, “Trends in fatal motor vehicle crashes before and after marijuana commercialization in Colorado” (2014) 140 *Drug and Alcohol Dependence* 137, at 140. The authors also reported that there were no significant changes in the percentage of alcohol-impaired drivers in fatal crashes in either Colorado or the NMMS.

<sup>75</sup> J. Reed, *Marijuana Legalization in Colorado: Early Findings* (Denver: Colorado Department of Public Safety, 2016), at 6. In fairness, the author stated that the traffic safety data were limited.

<sup>76</sup> B. Tefft, L. Arnold & J. Grabowski, *Prevalence of Marijuana Involvement in Fatal Crashes: Washington, 2010-2014* (Washington, DC: AAA Foundation for Traffic Safety, 2016), at 1.

<sup>77</sup> *An Act to Amend the Criminal Code*, S.C. 1925, c. 38, s. 5. The 1925 provision prohibited driving under the influence of “narcotics.” In 1951, it was broadened to include driving while under the influence of any drug. *An Act to Amend the Criminal Code*, S.C. 1951, c. 47, s. 14(1) and (2).

<sup>78</sup> Even when an accused was obviously impaired and there was evidence of recent drug use, it was still necessary in most cases to introduce expert evidence linking the accused’s drug use and the effects of that drug to the impairment of his or her ability to drive. See *R. v. Hollahan*, [1970] 1 C.C.C. 373 (N.S. Co. Ct.), at paras.16-17; *R. v. Kurgan* (1987), 2 M.V.R. (2d) 79 (Ont. Dist. Ct.), at paras. 10-14; and *R. v. Beaulne* (1993), 46 M.V.R. (2d) 135 (Ont. Prov. Div.), at para.9. As one judge remarked, “the preferred practise [is] for the Crown to call expert medical or scientific evidence regarding the effects of drugs [...] the court cannot take judicial notice of the effects of various drugs.” *R. v. Rosskopf* (1995), 11 M.V.R. (3d) 62, at para.18.

<sup>79</sup> *Criminal Code*, R.S.C. 1985, c. C-46, s. 254(2)(a). The elements of the SFST and DRE are set out in

process is exceedingly technical, takes about two hours and the DRE itself requires the evaluating officer to collect more than 100 separate pieces of information. A DRE can only be conducted by an “evaluating” officer. In order to qualify for this designation, an officer must be accredited and certified by the International Association of Chiefs of Police. Training costs per evaluating officer are high (\$17,000), as are the costs of maintaining certification. Among other things, evaluating officers are required to maintain a “rolling” log of all evaluations they have conducted, as well as a current resume.<sup>80</sup>

Defence counsel have routinely challenged the basis of an officer’s demand for a SFST, and the accuracy of the SFST and DRE process in determining whether an individual’s ability to drive was impaired by a drug. The Canadian courts remain skeptical about the link between the mere presence of drugs in a driver’s system and the actual impairment of driving ability.<sup>81</sup> Some courts have rejected the DRE evidence out of hand.<sup>82</sup> Other courts have required the Crown to prove that the evaluating officer is an expert before he or she will be considered qualified to provide an opinion as to whether the accused’s ability to drive was impaired by a drug.<sup>83</sup> The courts have also demanded detailed expert evidence on the 12 steps of the DRE, the evaluating officer’s qualifications, and the relationship between the drug in issue and the accused’s ability to drive.

Even if all of the evaluating officer’s testimony is accepted, the court may simply not be convinced beyond a reasonable doubt that the accused’s driving ability was impaired by a drug when arrested. For example, in *R. v. Perillat*,<sup>84</sup> the accused was stopped at a roadside checkpoint. The investigating officer, who was also a certified DRE evaluator, smelled “an overwhelming odour” of marijuana emanating from the accused’s vehicle. The accused admitted to smoking marijuana two and a half hours earlier, and showed the officer the “roach” on her centre console. After the accused failed the SFST and the DRE, and tested positive for the presence of cannabis, she was charged with impaired driving. In acquitting the accused, the judge stated:

But at its best, Constable Schaefer’s evidence convinces me that the accused had used marijuana at some point prior to her being stopped at the police check stop that evening and that she still had some of it in her system at the time he did his Drug Recognition Evaluation on her at the police station. What his evidence does not

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*Evaluation of Impaired Operation (Drugs and Alcohol) Regulations, SOR/2008-196.*

<sup>80</sup> For detailed discussion of the SFST and DRE process, see Solomon, 2013 *supra* note 57, at 247-56.

<sup>81</sup> *R. v. Perillat*, 2012 SKPC 135 [*Perillat*]; and *R. v. Jansen*, 2010 ONCJ 74.

<sup>82</sup> *R. v. Wood*, [2007] 11 W.W.R. 330 (Alta. Q.B.).

<sup>83</sup> *R. v. Wakewich*, 2010 ONCJ 86. It should be noted that the Ontario Court of Appeal unanimously held that evaluating officers were experts and that their evidence was admissible to establish that an accused was impaired by a drug. *R. v. Bingley*, 2015 ONCA 439. However, the Supreme Court of Canada has given leave to appeal in this case. *R. v. Bingley*, 2016 CarswellOnt 1276.

<sup>84</sup> *Perillat*, *supra* note 81.

convince me of is that at the time she was driving, her ability to operate a motor vehicle was impaired by marijuana?

[...]

Constable Schafer's evidence does not explain the accused's test results and how they relate to the accused's ability to drive a motor vehicle or how they relate back to the time of driving. Without testimony on these points, I am left with many questions. For example, what signs of impairment would one expect to see in someone who has been using marijuana? How long after using marijuana would you expect to see these signs and how long would they last? Can the results of Drug Recognition Evaluation tests taken over one and one-half hours after the time of driving be reliably related back to the time the accused pulled into the check stop? Was the accused's performance in some of the tests just as consistent with someone who has poor balance or poor co-ordination as it was with someone who had used marijuana?<sup>85</sup>

The cases to date do not bode well for relying on the SFST and DRE process in drug-impaired driving enforcement, and this is borne out by the charge statistics. While rates of drug-impaired driving and alcohol-impaired driving are roughly comparable, drug-impaired driving charges constituted only 2.6% (1,355) of the total impaired driving charges (51,637) in 2014.<sup>86</sup> Unfortunately, there are no data on drug-impaired driving convictions. Even if all 1,355 drug-impaired driving charges in 2014 involved cannabis, survey data indicate that an individual could drive after using cannabis once a day for over 21 years before being charged with, let alone convicted of, a drug-impaired driving offence.<sup>87</sup> Thus, it is hardly surprising that young people believe that they can drive after smoking cannabis with little fear of being charged and convicted of drug-impaired driving.

Drug-impaired driving poses a major traffic safety risk, particularly for young drivers and their passengers. The 2008 enactment of SFST and DRE legislation has proven to be inadequate on several grounds: the cost of training evaluating officers is high; the processing of drug-impaired driving suspects is complex, technically exacting and time-consuming; and there will likely continue to be serious legal challenges to the SFST and DRE process. Perhaps most importantly, the 2008 legislation has likely had no appreciable deterrent impact on drug-impaired driving<sup>88</sup> – a factor that helps to explain the normalization of driving after cannabis use among Canadian youth. These types of concerns have led several leading American traffic safety experts

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<sup>85</sup> *Perillat*, *supra* note 81, at paras. 24 and 26.

<sup>86</sup> Solomon, 2015 *supra* note 57, at 3.

<sup>87</sup> This calculation is based on a 2012 survey indicating that 10.4 million trips were made by drivers who had recently consumed cannabis. Beirness, 2015, *supra* note 59, at 2. A 2008 survey, which estimated that drivers made 15.6 million trips per year after using cannabis, would yield a far lower charge rate per cannabis-related driving trip. Canadian Centre on Substance Abuse, "Drugs and Driving" (12 December 2011), online: <<http://www.ccsa.ca/Eng/Priorities/ImpairedDriving/Pages/default.aspx>>.

<sup>88</sup> See generally, *supra* note 44.

to call for less reliance on SFST and DRE, and the enactment of *per se* drug limits for driving.<sup>89</sup>

It is not enough to create an offence for driving with a specified amount of a drug in one's body. As with alcohol-impaired driving, police need to be given the authority and the means to conduct toxicological drug tests on drivers. Given the other demands on criminal justice resources, enforcement powers that are time-consuming, costly, complex, and generate frequent legal challenges will likely be limited to cases involving obvious drug impairment or crashes. Consequently, it is necessary to enact enforcement powers that are relatively straightforward and cost-effective, while still constitutionally valid.

Several European countries and the Australian states have enacted drug-impaired driving laws based on *per se* limits and mandatory roadside oral fluid (saliva) testing for specified drugs. In these jurisdictions, police typically have authority to stop any driver and demand that he or she provide a saliva sample. Drivers who test positive will be required to undergo additional evidentiary testing. Drivers are only charged if the second evidentiary test establishes the presence of a drug in excess of the *per se* limit. Like random breath testing, which also exists in these jurisdictions, random drug screening allows the police to screen a large number of drivers in a relatively short period of time. For drivers who test negative, there is only a modest delay and slight inconvenience.<sup>90</sup>

As in the case of mandatory breath screening, a comprehensive mandatory drug screening program will dramatically increase both the perceived and actual rates of apprehension. The mandatory breath screening research indicates that the deterrent impact of the drug-impaired driving law will increase as the number of drivers tested increases.<sup>91</sup>

The federal government should move from its exclusive reliance on SFST and DRE, and work toward enacting a system of roadside saliva testing for the most commonly-used drugs. In our view, the European and Australian approach provides, with appropriate modifications, a useful model for developing a far more effective system of drug-impaired driving enforcement in Canada. Like most changes in enforcement practices, the introduction of mandatory oral fluid

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<sup>89</sup> R. Dupont *et al.*, "The Need for Drugged Driving *Per Se* Laws: A Commentary" (2012) 13 *Traffic Injury Prevention* 31.

<sup>90</sup> For a discussion of the alternatives to the SFST and DRE process, see R. Solomon, 2013 *supra* note 57, at 260-70.

<sup>91</sup> R. Homel, "Random Breath Testing and Random Stopping Programs in Australia," in R. Wilson & R. Mann, eds., *Drinking and Driving: Advances in Research and Prevention* (New York: Guilford Press, 1990) 159, at 162; J. Henstridge, R. Homel & P. Mackay, *The Long-Term Effects of Random Breath Testing in Four Australian States: A Time Series Analysis* (Canberra: Federal Office of Road Safety, 1997), at 50 and 115; and J. Ferris *et al.*, "Random breath testing in Queensland and Western Australia: Examination of how the random breath testing rate influences traffic crash rates" (2013) 60 *Accident Analysis and Prevention* 181.

testing will be challenged under the *Canadian Charter of Rights and Freedoms*. As we have discussed elsewhere in detail,<sup>92</sup> the random roadside screening of drivers for alcohol and drugs, like random airport, customs and court screening procedures, is consistent with *Charter* values. Our conclusion in this regard has been endorsed by Dr. Peter Hogg, Canada's pre-eminent constitutional law scholar.<sup>93</sup>

Once a sufficient scientific consensus has emerged, the federal government should enact *per se* drug-impaired driving limits that are akin to a .05% BAC limit for drinking and driving. We acknowledge that the proposed cannabis impairment level would be lower than the *Criminal Code* impairment level for alcohol (*i.e.* a BAC > .08%). This approach is justifiable given that the current criminal BAC limit is: inconsistent with international and domestic traffic safety research; and out of step with the BAC limits in the vast majority of comparable developing and developed nations (*i.e.* a BAC ≤ .05%).<sup>94</sup> MADD Canada strongly advocates setting the THC limit for the proposed *per se* drug-impaired driving offence at a level that does not replicate the preventable crash deaths and injuries associated with the current criminal BAC limit for driving.

The accuracy of the oral fluid tests to determine THC levels will likely continue to improve and become more affordable. The government will also need to keep abreast of the international research on, among other things, the impairing impact of various drugs, the relative crash risk that they pose, and the development of any widely-accepted *per se* limits. Nevertheless, the rapid growth in international drug-impaired driving research should not be used as an excuse for delaying measures that have proven effective in other jurisdictions.

All things being equal, legalizing cannabis possession by adults and creating a legal source of supply will likely significantly increase cannabis-related problems, including drug-impaired driving.<sup>95</sup> Unless the federal government enacts *per se* cannabis limits for driving and authorizes

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<sup>92</sup> With regard to random breath testing and random oral fluid testing, see respectively Solomon, 2011 *supra* note 52, at 60-77; and Solomon, 2013 *supra* note 57, at 270-75.

<sup>93</sup> Memorandum from P. Hogg, Blake, Cassels and Graydon LLP (4 August 2011) to W. Kauffeldt, Chair, Board of Directors, MADD Canada.

<sup>94</sup> For a discussion of the research see, R. Solomon & E. Chamberlain, "The Case for a 0.05% Criminal Law Blood Alcohol Concentration Limit for Driving" (September, 2002), 8 *Supp. III Injury Prevention* iii1; and R. Solomon & E. Chamberlain, "Federal Impaired Driving Policy: Moving Beyond Half Measures" (2014), 40(1) *Canadian Public Policy* 15, at 17-19 [Half Measures].

<sup>95</sup> See pages 9 and 10 of our submission which briefly discuss the impact that broadening lawful access to cannabis had on cannabis-related fatal crashes in Colorado and Washington State. These preliminary findings are wholly consistent with the research on alcohol availability and the level of related harms, including impaired driving. See for example, J. Grube & K. Stewart, "Preventing Impaired Driving Using Alcohol Policy" (2004) 5 *Traffic Injury Prevention* 199; R. Room, T. Babor & J. Rehm, "Alcohol and public health" (2005) 365 *The Lancet* 519, at 526; S. Casswell & T. Thamarangsi, "Reducing harm from alcohol: call to action" (2009) 373 *The Lancet* 2247; and Babor, *supra* note 43, at 103-146.

mandatory roadside oral fluid testing, driving under the influence of cannabis will increase, along with related crash deaths and injuries. MADD Canada believes that it is imperative for this legislation to be enacted well before legalizing recreational cannabis use.

*(c) Should consumption of marijuana be allowed in any publicly-accessible spaces outside the home? Under what conditions and circumstances?*

MADD Canada is opposed to permitting cannabis consumption in publicly-accessible spaces outside the home for several reasons. First, permitting public consumption would normalize cannabis use and reinforce the already too prevalent belief that cannabis is a benign drug. Young people may not be well-informed, but they are perceptive enough to rightly question why the federal government would not only legalize recreational cannabis use but also allow public consumption if the drug was harmful.

Second, permitting public cannabis use would effectively sabotage any government effort to increase public awareness of the risks of cannabis use. Research indicates that, even in the best of circumstances, education and awareness programs have a limited impact on behaviour.<sup>96</sup> As one team of researchers concluded in regard to alcohol awareness and education initiatives:

In recent years, the number of informational and educational programmes has grown exponentially. [...] Many of these educational campaigns have not been evaluated. Where evaluations have been conducted, they often do not meet the criteria of ‘methodological soundness.’ [...] Compared with other interventions and strategies, educational programmes are expensive and appear to have little long-term effect on alcohol consumption levels and drinking-related problems.<sup>97</sup>

Obviously, permitting public cannabis consumption would not create the best of circumstances for increasing awareness of the drug’s risks.

Third, we do not think the irony would be lost on the public if the federal government permitted public consumption of cannabis, given that the federal, provincial and municipal governments have worked for more than three decades to prohibit public tobacco consumption. Fourth, following the protracted battles over the risks of second-hand tobacco smoke, why would the federal government resurrect these controversies in regard to second-hand cannabis smoke?

Finally, public consumption of cannabis outside the home raises issues of safe

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<sup>96</sup> Despite their popularity, mass media, public awareness and education campaigns have generally not been found to have a significant impact on behaviour. See for example, D. Lynam *et al.*, “Project DARE: No Effects at 10-Year Follow-Up” (1999) 67(4) *Journal of Consulting and Clinical Psychology* 590; A. Williams, *Research Results Digest 322: Public Information and Education in the Promotion of Highway Safety* (Washington, DC: National Research Board, 2007); and R. Yadav & M. Kobayashi, “A Systematic review: effectiveness of mass media campaigns for reducing alcohol-impaired driving and alcohol-related crashes” (2015) 15 *BioMed Central Public Health* 857.

<sup>97</sup> Babor, *supra* note 43, at 215.

transportation. In contrast to those frequenting the coffee shops in Amsterdam, Canadians would be far more dependent on private transportation to get them home from any venue permitting on-premise cannabis consumption.

## 5. Accessing Marijuana For Medical Purposes: Questions

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

The ongoing battle between the federal government and the courts over medical marijuana policy generated eight sets of complex regulations between 2001 and 2015, and a flood of *Charter* challenges. In our view, Health Canada's unduly restrictive approach to granting medical and compassionate exemptions precipitated many of the initial court challenges. Moreover, several of the regulatory amendments that the federal government enacted in response were clearly unworkable and constitutionally suspect. For their part, the courts did not require claimants to adduce compelling evidence that cannabis was an accepted medical treatment for their condition or that existing lawful medications were inadequate. Although framed in terms of the *Charter*, the courts' real concern often appeared to be the wisdom of the government's cautionary approach to granting medical cannabis exemptions. It is clear that individual criminal cases are not the appropriate forum in which to resolve research issues on the benefits, risks and alternatives to medical marijuana use.<sup>98</sup>

The current situation is extremely troubling. The medical marijuana access regulations made physicians reluctant gatekeepers, despite their ongoing and well-founded criticisms of the program. The Collège des Médecins du Québec was particularly blunt, stating that:

[d]espite the rulings of Canadian courts and existence of medical access programs, the dried form of this product is not a medically recognized treatment. The indications are not clearly defined, the therapeutic dosages are neither known nor standardized and there is a lack of valid safety data.<sup>99</sup>

Not surprisingly, the Collège has prohibited its members from prescribing cannabis except within the context of an accepted research protocol.

A recent newspaper article suggested that the number of lawful medical marijuana users is

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<sup>98</sup> For a detailed discussion of our concerns, see R. Solomon & M. Clarizio, "The Highs and Lows of Medical Marijuana Regulation in Canada" (2015) 62 *Criminal Law Quarterly* 536 [Solomon and Clarizio].

<sup>99</sup> Collège des Médecins du Québec, "Guidelines concerning the prescription of dried cannabis for medical purposes" (1 May 2015), online: <<http://www.cmq.org/en/MedecinsMembres/DossierMembreFormulaire/~media/Files/Cannabis/Guidelines-prescription-cannabis.pdf?51407>>.

increasing at a rate of 6,000 per month and will far exceed 400,000 by 2020.<sup>100</sup> The growth in medical marijuana users appears to be due, in part, to the aggressive marketing of medical marijuana authorizations by companies that portray cannabis as a benign cure-all. With the Canadian courts authorizing some medical marijuana users to cultivate hundreds of plants and maintain a multi-kilogram cannabis inventory to meet their needs, there is no effective means of preventing widespread diversion of lawfully-grown cannabis to the illicit trade. For example, in *Garber v. Canada (Attorney General)*,<sup>101</sup> one of the four plaintiffs was permitted to produce 486 plants, possess 1,000 grams of cannabis on his person and store almost 22 kilograms of the drug.

It would be preferable to have a single government monopoly system regulating both the medical marijuana and the adult recreational markets. However, a two-track system of access may need to be created. The *Charter* cases indicate that medical marijuana users must be allowed to cultivate cannabis, have others produce cannabis on their behalf or be provided with lawful access to large quantities of a broad range of cannabis products at reasonable prices.<sup>102</sup> In contrast, there are no such requirements regarding the adult recreational cannabis market. Providing recreational users with equally broad and cheap access to cannabis would greatly increase the harms resulting from legalizing recreational use.

The establishment of a two-track system has drawbacks. It would likely increase the number of users seeking medical exemptions and increase diversion of medical marijuana to the illicit trade. Nevertheless, this approach appears preferable to having tens of thousands of medical marijuana users growing large quantities of cannabis or authorizing others to do so on their behalf.

In response to a federal court decision,<sup>103</sup> the federal government enacted the ninth set of medical marijuana regulations since 2001, the *Access to Cannabis for Medical Purposes Regulations (ACMPRs)*.<sup>104</sup> The details were released on August 11, 2016, only two weeks before the *ACMPRs* came into force and replaced the *MMPRs*. Pursuant to the *ACMPRs*, individuals who have been authorized by a health practitioner to have access to medical marijuana may register with Health Canada to produce their own cannabis or designate someone to do so for them. Like their predecessor, the *ACMPRS* contain detailed provisions that attempt to prevent

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<sup>100</sup> Bastien, *supra* note 18.

<sup>101</sup> 2015 BCSC 1797.

<sup>102</sup> In addition to *Garber v. Canada (Attorney General)*, *ibid*; see *Allard v. Canada*, 2014 FCA 298; and *R. v. Smith*, 2015 SCC 34.

<sup>103</sup> *Allard v. Canada*, *ibid*.

<sup>104</sup> Health Canada, News Release, “Understanding the New Access to Cannabis for Medical Purposes Regulations” (11 August 2016), online: <<http://healthycanadians.gc.ca/publications/drugs-products-medicaments-produits/understanding-regulations-medical-cannabis-medicales-comprehension-reglements/index-eng.php>>.

unlawful production and diversion of lawfully-produced cannabis to the illicit trade.<sup>105</sup>

It should be noted that Health Canada's initial regulations licensing home cultivation by medical marijuana users or their designates generated numerous successful court challenges and ensuing amendments. Home cultivation was no longer permitted under the *MMPRs*, which came into force in 2013.<sup>106</sup> The new system of home cultivation under the *ACMPRs* appears to be less vulnerable to obvious court challenges and more workable than its predecessor. However, it is unnecessary to go into any more detail, because the *ACMPRs* were enacted as a stopgap measure. In the words of Health Canada, "These regulatory changes should not be interpreted as being the longer-term plan for the regulation of access to cannabis for medical purposes, which is presently being determined as part of the Government's commitment to legalize, strictly regulate and restrict access to marijuana."<sup>107</sup>

## Conclusion

MADD Canada believes that legalizing possession of cannabis by adults and creating a legal source of supply will significantly increase the drug's availability and related health and safety problems. If, as it appears, the federal government is committed to legalizing recreational cannabis use, the issue becomes which legalization option best protects the public interest. Granted, the adverse effects of legalization will vary across the country, having less impact in those areas in which the availability of illicit cannabis has already reached saturation levels. Nevertheless, as indicated, there are federal legalization models that will generate fewer problems than others.

MADD Canada generally agrees with the objectives that the Task Force set out on the first two pages of the Discussion Paper. However, as indicated, many of the objectives are mutually exclusive, in that attempting to achieve some will come at the expense of others. Given these conflicts, MADD Canada would urge the federal government to adopt a legalization regime that maximizes public health and safety, even if this results in failing to meet consumer expectations and failing to dramatically undercut the illicit trade.

Of particular concern to MADD Canada is the impact that legalization will have on cannabis-impaired driving crashes, injuries and deaths. The survey data, roadside screening studies and post-mortem data attest to the normalization of driving after cannabis use,

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<sup>105</sup> *Ibid.*

<sup>106</sup> For a review of the cycle challenges amendments, court challenges, amending regulations, and subsequent court, see Solomon and Clarizio, *supra* note 98.

<sup>107</sup> Health Canada, News Release, "Statement from Health Canada concerning access to cannabis for medical purposes" (11 August 2016), online :< <http://news.gc.ca/web/article-en.do?nid=1110389>>.

particularly by young Canadians – a constituency that is already uniquely vulnerable to crash deaths and injuries. Through no fault of the police, the current system of drug-impaired driving enforcement is simply not working; nor has or will any amount of public awareness campaigning significantly alter this troubling reality.<sup>108</sup>

As indicated, MADD Canada would vehemently oppose any legalization initiative until effective means are in place to address the increased rates of driving after cannabis use that would otherwise occur. As one American researcher aptly stated, “Legalizing and commercializing marijuana prior to having effective laws in place to identify and deal with its consequences is akin to skydiving without a parachute.”<sup>109</sup>

MADD Canada would urge the federal government to amend the *Criminal Code* to create a *per se* impaired driving offence for having care and control of a motor vehicle with a THC level above a prescribed limit. That limit should be set at a level akin to the .05% BAC limit for drinking and driving. The federal government must also move from its exclusive reliance on SFST and DRE, and work toward enacting a system of mandatory roadside saliva testing for cannabis and other commonly-used drugs. In our view, the European and Australian approach, with appropriate modifications, provides a useful model for developing a far more effective system of drug-impaired driving enforcement in Canada.

We have set out below some key principles and policies that address other aspects of the Discussion Paper. For the most part, we have not elaborated on measures that we believe have been adequately dealt with in the Discussion Paper.

- Establish minimum price levels that reflect the THC content of the various products; limit the potency and range of available cannabis products; establish a strictly enforced minimum age of purchase and possession of 21; ban all cannabis advertising, promotions and marketing; and limit the quantity of cannabis that can be purchased at any one time.
- Prohibit home cultivation of cannabis by adult recreational cannabis users.
- Establish a single, federally-mandated production system modelled after the existing regulations governing the 34 licensed producers of medical marijuana.
- Create a single, federally-mandated distribution system. If there are to be retail cannabis outlets, they need to be run by a government monopoly, akin to that of the current

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<sup>108</sup> MADD Canada strongly supports public awareness and education initiatives because it believes that the public should be put in a position to make informed decisions about alcohol and drug policy and the impaired driving law. Nevertheless, MADD Canada recognizes the limited impact that these initiatives have on changing behaviour, particularly in the face of substantial increases in alcohol and drug availability and ineffective impaired driving countermeasures. See generally *supra* note 96.

<sup>109</sup> E. Wood, “Skydiving without a Parachute” (2016) 4(1) *Journal of Addiction Medicine and Therapy* 1020, at 1020.

provincial liquor licensing program. However, MADD Canada believes that it would be inappropriate to sell alcohol and cannabis at the same retail outlets.

- There should be a single framework for the retail distribution of cannabis, and there should be no private sector retail outlets.
- Enact comprehensive mitigation measures that, among other things: maintain the criminal status of unauthorized cannabis possession; streamline the arrest and charge process; replace the current trial procedures with a ticketing system that does not require a court appearance; and deem cannabis possession offenders who have no subsequent criminal convictions within two years to have no criminal record.
- Prohibit public cannabis consumption.
- Establish a single government monopoly system regulating both the medical cannabis and the adult recreational market, but which includes one set of rules governing access for recreational users and a second set for authorized medical cannabis users.
- Take steps to prevent the aggressive marketing of medical authorizations and the advertising of medical marijuana as a risk-free cure-all.

In framing the preceding comments, MADD Canada has been mindful of Canada's less than stellar impaired driving record. On July 8, 2016, the Centers for Disease Control and Prevention in Atlanta, Georgia released a report indicating that Canada had the highest percentage of alcohol-related crash deaths among 19 comparable countries.<sup>110</sup> While the media appeared to be shocked, this should not have come as a surprise. Canada had long had, and continues to have, a very poor impaired driving record.

The persistence of drinking and driving was not a problem that was unique to Canada. However, while most comparable countries introduced effective impaired driving countermeasures, Canada did not. Instead, the federal government enacted a series of amendments, addressing specific loopholes and increasing the maximum penalties for the impaired driving offences. While most provinces introduced some progressive countermeasures, they also dramatically increased the availability of alcohol.<sup>111</sup> The public discourse centered on enacting "tough laws," and there were numerous calls to increase awareness and education initiatives. Canada's poor impaired driving record did not just happen; rather, it was the inevitable result of our alcohol and impaired driving policies.

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<sup>110</sup> E. Sauber-Schatz *et al.*, "Vital Signs: Motor Vehicle Injury Prevention — United States and 19 Comparison Countries" (2016) 65(27) *Morbidity Mortal and Mortality Weekly Report* 672, online: <<http://dx.doi.org/10.15585/mmwr.mm6526e1>>.

<sup>111</sup> For a review of Canada's impaired driving record and policies, see Half Measures, *supra* note 94; and R. Solomon, E. Chamberlain & C. Lynch, "Canada's New Impaired Driving Legislation: Modest Gains and Missed Opportunities" (2010) 56 *The Criminal Law Quarterly* 51.

Canada currently has relatively high rates of cannabis use, driving after drug use (particularly cannabis) is commonplace, and there are no effective means of detecting, apprehending, and charging drug-impaired drivers. The federal government is poised to legalize recreational cannabis use for adults, which will increase availability. It is for these reasons that MADD Canada is extremely concerned that the mistakes made regarding drinking and driving will be replicated with respect to cannabis.

However, as outlined in this submission, there are legalization schemes and drug-impaired driving measures that may reduce the harms that will result from legalizing adult recreational cannabis use. If these measures are not adopted, Canada may well make international headlines again – this time for having one of the worst drug-impaired driving records among comparable countries.