

# Cannabis

## Use

### General population

Cannabis use is common in Canada. 44.5% of Canadians 15 years and older reported Cannabis use in their lifetime and 12.3% reported cannabis use in the past year (CTADS, 2015). Lifetime and past year use has slightly increased overall in Canada since 2013. Across the Prairie Provinces, lifetime use has slightly decreased in Alberta and Saskatchewan and slightly increased in Manitoba (see Figure 1). Past year use has increased across Canada and the 3 Prairie Provinces. Reported past year cannabis use has increased by about 2% in Alberta and Saskatchewan and 1% in Manitoba (see Figure 2).

Nationally, men use cannabis more often than women. That is, 52.1% of men surveyed endorsed lifetime use (versus 37.2% of women), and 14.9% of men endorsed past year use (versus 9.7% of women; CTADS, 2015). The average age of first cannabis use increased from 17.8 for men and 18.1 for women to 18.4 years old for both men and women (CTADS 2013).

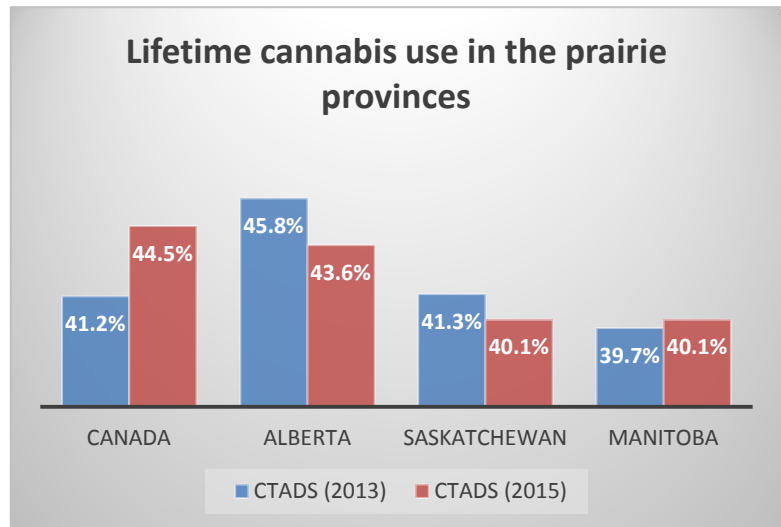


Figure 1. Sources: CSTAD (2013) & CSTAD (2015)

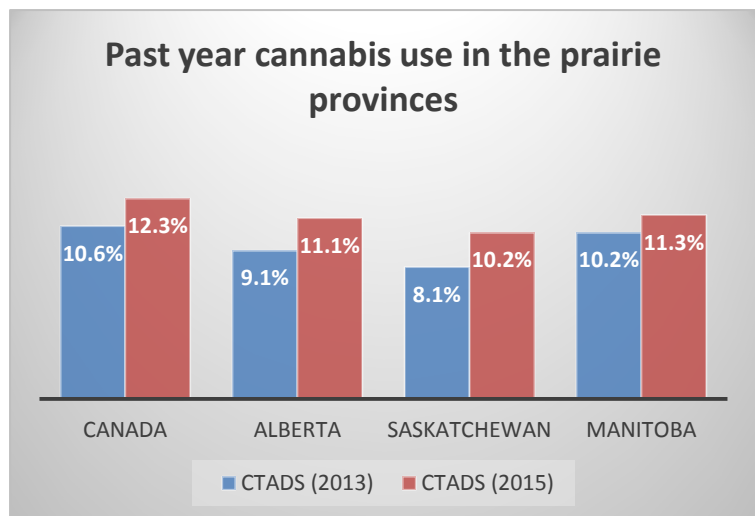


Figure 2. Sources: CSTAD (2013) & CSTAD (2015)

## Youth

The most recent youth drug survey (CSTADS, 2014-2015), suggested that the percentage of grade 7-12 students that have used cannabis (in the past year) has declined in Canada and the Prairie Provinces since 2012 (see Figure 3). However, the percentage of 7-12 students who indicated cannabis use still seems high, considering that the legal age to use cannabis will probably be similar to the legal age of alcohol use (CSTADS, 2014-2015).

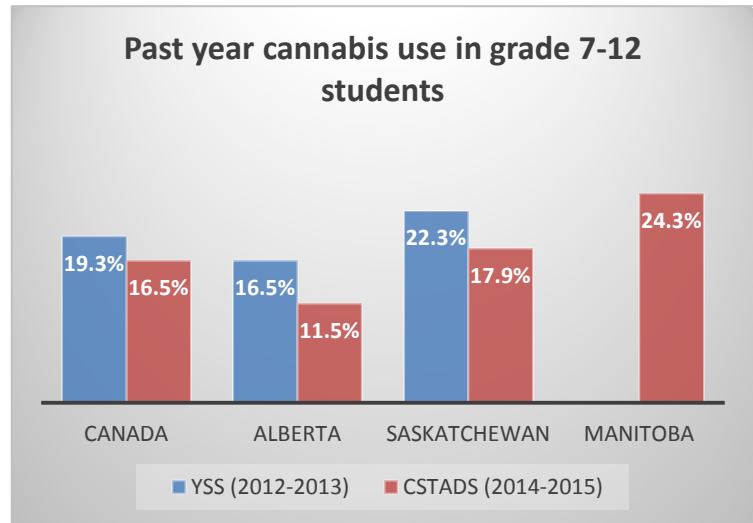


Figure 3. Sources: YSS (2012-2013) & CSTADS (2015). Manitoba did not participate in the YSS survey.

When junior high and high school students were compared, 5.7% of youth in grades 7-9 and 26.8% of youth in grades 10-12 endorsed past year cannabis use (CSTADS, 2014-15). A greater percent of youth in higher grade levels endorsed past year cannabis use compared to youth in lower grade levels, although overall use has declined across all grade levels since the 2012-2013 survey (see Figure 4).

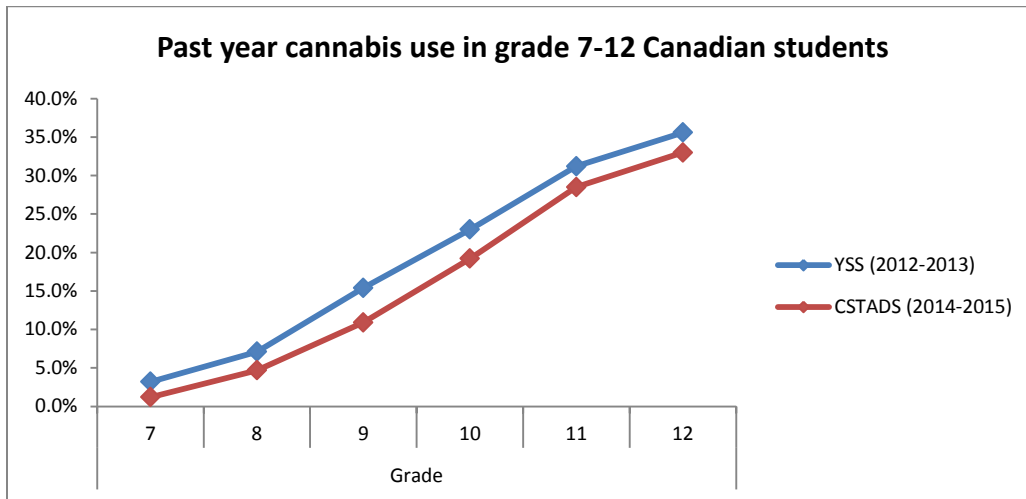


Figure 4. Sources: YSS (2012-2013) & CSTADS (2015)

The average age of first cannabis use was 13 for individuals in grades 7-9, and 14.5 for individuals in grades 10-12 (CSTADS, 2014-15). As mentioned above, in Canada males tend to use cannabis more than females (CTADS, 2013; 2015). However, cannabis use by males and females in grades 7-12 is nearly equal. That is, 16.8% of males and 16.2% of females endorsed past year use (CSTADS, 2014-2015).

## Lower-Risk Cannabis Use

There are many ways to minimize the risks associated with cannabis use. Researchers out of University of Toronto have developed 10 recommendations to reduce risk (please see table below) (Fischer 2017).

**Table 1. Lower-Risk Cannabis Use Guidelines**

### RECOMMENDATIONS

**Recommendation 1:** The most effective way to avoid any risks of cannabis use is to abstain from use. Those who decide to use need to recognize that they incur risks of a variety of—acute and long-term—adverse health and social outcomes. These risks will vary in their likelihood and severity with user characteristics, use patterns, and product qualities, and so may not be the same from user to user or use episode to another. *[Evidence Grade: None required.]*

**Recommendation 2:** Early initiation of cannabis use (i.e., most clearly that which begins before age 16 years) is associated with multiple subsequent adverse health and social effects in young adult life. These effects are particularly pronounced in early-onset users who also engage in intensive and frequent use. This may be in part because frequent cannabis use affects the developing brain. Prevention messages should emphasize that, the later cannabis use is initiated, the lower the risks will be for adverse effects on the user's general health and welfare throughout later life. *[Evidence Grade: Substantial.]*

**Recommendation 3:** High THC-content products are generally associated with higher risks of various (acute and chronic) mental and behavioral problem outcomes. Users should know the nature and composition of the cannabis products that they use, and ideally use cannabis products with low THC content. Given the evidence of CBD's attenuating effects on some THC-related outcomes, it is advisable to use cannabis containing high CBD:THC ratios. *[Evidence Grade: Substantial.]*

**Recommendation 4:** Recent reviews on synthetic cannabinoids indicate markedly more acute and severe adverse health effects from the use of these products (including instances of death). The use of these products should be avoided. *[Evidence Grade: Limited.]*

**Recommendation 5:** Regular inhalation of combusted cannabis adversely affects respiratory health outcomes. While alternative delivery methods come with their own risks, it is generally preferable to avoid routes of administration that involve smoking combusted cannabis material (e.g., by using vaporizers or edibles). Use of edibles eliminates respiratory risks, but the delayed onset of psychoactive effect may result in the use of larger than intended doses and subsequently increased (mainly acute, e.g., from impairment) adverse effects. *[Evidence Grade: Substantial.]*

**Recommendation 6:** Users should avoid practices such as "deep inhalation," breath-holding, or the Valsalva maneuver to increase psychoactive ingredient absorption when smoking cannabis, as these practices disproportionately increase the intake of toxic material into the pulmonary system. *[Evidence Grade: Limited.]*

**Recommendation 7:** Frequent or intensive (e.g., daily or near-daily) cannabis use is strongly associated with higher risks of experiencing adverse health and social outcomes related to cannabis use. Users should be aware and vigilant to keep their own cannabis use—and that of friends, peers, or fellow users—occasional (e.g., use only on 1 day/week, weekend use only, etc.) at most. *[Evidence Grade: Substantial.]*

**Recommendation 8:** Driving while impaired from cannabis is associated with an increased risk of involvement in motor-vehicle accidents. It is recommended that users categorically refrain from driving (or operating other machinery or mobility devices) for at least 6 hours after using cannabis. This wait time may need to be longer, depending on the user and the properties of the specific cannabis product used. Besides these behavioral recommendations, users are bound by locally applicable legal limits concerning cannabis impairment and driving. The use of both cannabis and alcohol results in multiply increased impairment and risks for driving, and categorically should be avoided. *[Evidence Grade: Substantial.]*

**Recommendation 9:** There are some populations at probable higher risk for cannabis-related adverse effects who should refrain from using cannabis. These include individuals with predisposition for, or a first-degree family history of, psychosis and substance use disorders, as well as pregnant women (primarily to avoid adverse effects on the fetus or newborn). These recommendations, in part, are based on precautionary principles. *[Evidence Grade: Substantial.]*

**Recommendation 10:** While data are sparse, it is likely that the combination of some of the risk behaviors listed above will magnify the risk of adverse outcomes from cannabis use. For example, early-onset use involving frequent use of high-potency cannabis is likely to disproportionately increase the risks of experiencing acute or chronic problems. Preventing these combined high-risk patterns of use should be avoided by the user and a policy focus. *[Evidence Grade: Limited.]*

# Synthetic Cannabinoids

## Use

### Youth

Synthetic cannabinoid use has nearly tripled in Canadian youth since 2012 (see Figure 5); however this drug is used much less often than either alcohol or cannabis. Use appears to have increased in both junior high and high school students since 2012, with high school students using more often than junior high school students (see Figure 6). Mean age of first use is similar for both men and women (13.8 years and 13.4 years old, respectively). Unfortunately, patterns of synthetic cannabinoid use are very much unknown in adults in the Prairie Provinces and across Canada.

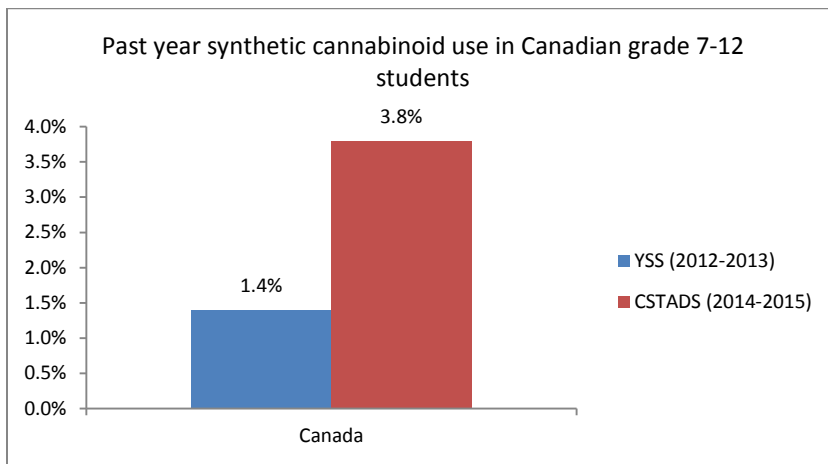


Figure 5. Sources: YSS (2012-2013) & CSTADS (2014-15)

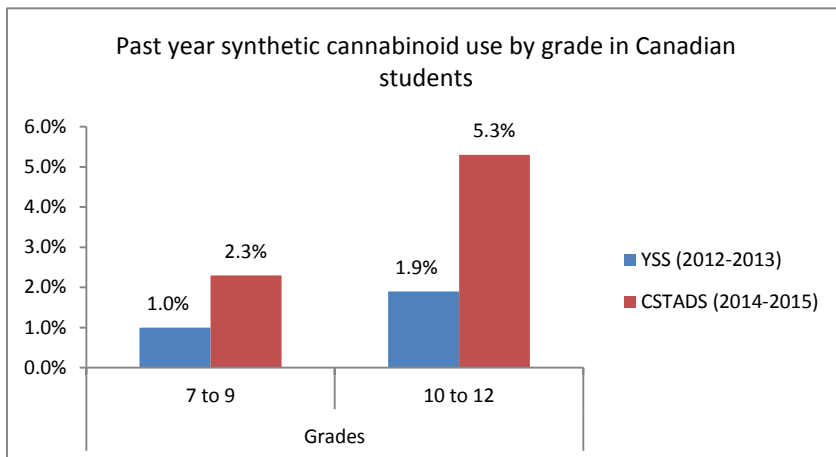


Figure 6. Sources: YSS (2012-2013) & CSTADS (2014-15)

## Links

### 2017 Cannabis Fact Sheet

<http://www.ccsa.ca/Resource%20Library/CCSA-Canadian-Drug-Summary-Cannabis-2017-en.pdf>

### Policy & Social Costs

[https://www.camh.ca/en/hospital/about\\_camh/influencing\\_public\\_policy/documents/camhcannabispolicyframework.pdf](https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/documents/camhcannabispolicyframework.pdf)

## References

Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS, 2014-15). *Government of Canada*. Retrieved from: <https://www.canada.ca/en/health-canada/services/canadian-student-tobacco-alcohol-drugs-survey/2014-2015-supplementary-tables.html#t13>

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Fischer, B., Russell, C., Sabioni, P., van den Brink, W., Le Foll, B., Hall, W., ... J., Room, R. (2017). Lower-risk cannabis use guidelines: A comprehensive update of evidence and recommendations. *American Journal of Public Health, 107*(8):e1-e12. Advanced online publication. doi: 10.2105/AJPH.2017.303818.

Youth Smoking Survey (YSS, 2012-2013). *Government of Canada*. Retrieved from: <https://www.canada.ca/en/health-canada/services/publications/healthy-living/youth-smoking-survey-2012-2013-supplementary-tables.html#t13>