Getting Schooled

Hello and welcome to Getting Schooled. In this edition, Drs. Rebecca Haines-Saah and Deinera Exner-Cortens of the University of Calgary illustrate the implications of cannabis legalization for practicing school psychologists.

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Cannabis is Legal in Canada – What are the implications for School Psychologists?

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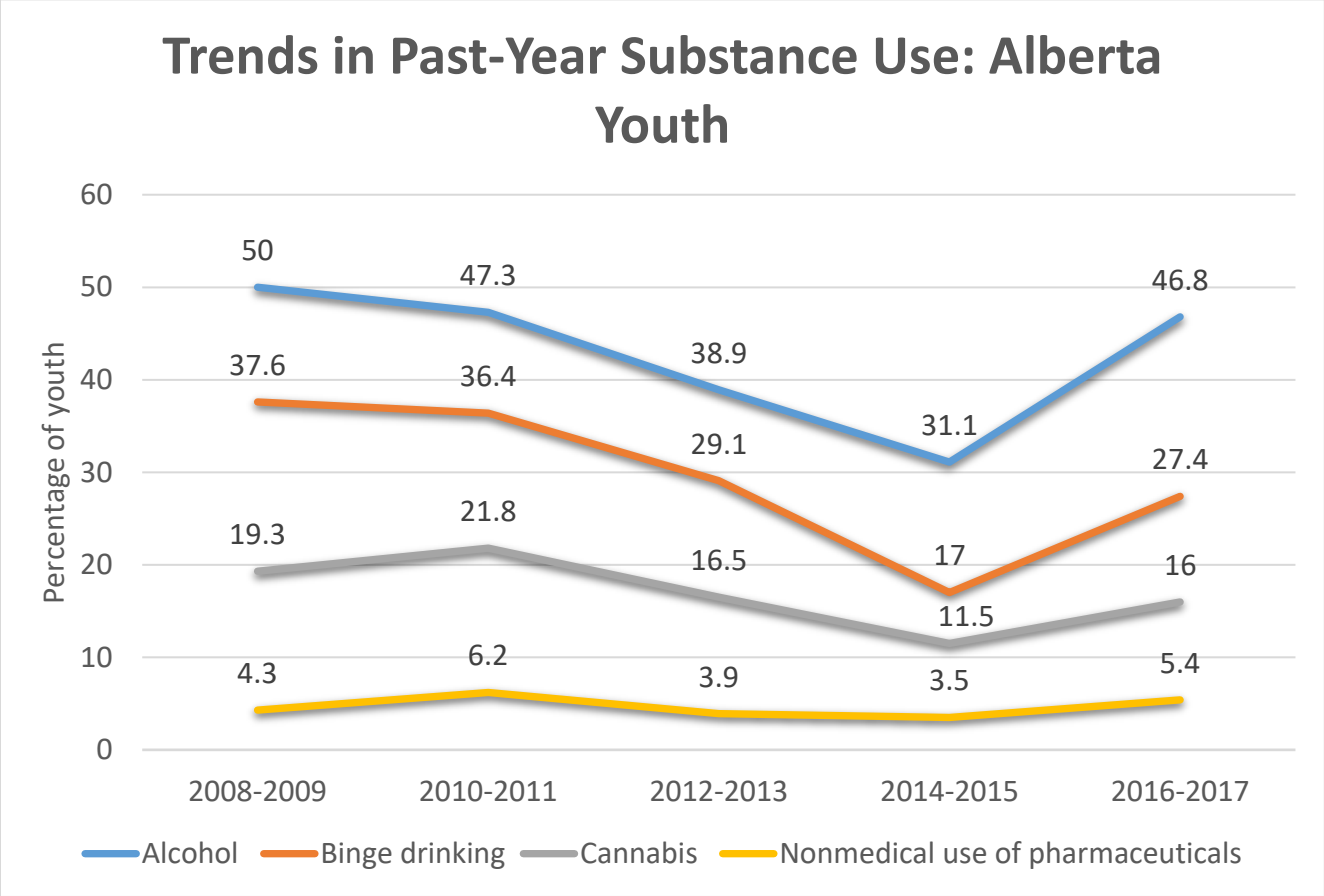
As of October 17th, cannabis is a legal substance in Canada. Since the announcement of plans for this policy change, concerns around potential consequences for children and youth have been front and center. Indeed, one of Canada's – and Alberta's – stated policy objectives for legalization is to "keep cannabis out of the hands of children." Federal regulators plan to achieve this policy objective by enforcing a minimum age for access; enacting strict regulation around sales and marketing; and by transitioning cannabis to a legal and strictly regulated market. Like the Federal policy set forth under Bill C-45, Alberta's provincial legislation is operating under a public health approach, with the goal of reducing the potential for harms associated with legalization. Specifically, Alberta's policy framework includes laws to address cannabis-impaired driving, impairment in the workplace, restrictions on public consumption, and how and where cannabis is distributed and sold in the province.

There are a number of implications of this significant policy and social change for school communities. To date, however, much of the discussion and public debates about cannabis legalization has been polarized, resulting in confusion for many about the potential impacts of this change. We argue that there is a need for balanced and evidence-based dialogue as we move forward in this new context, so that psychologists can accurately address this issue with young people and their families. In this article, we address a few key issues by grounding the conversation in what we know about substance use, in order to help psychologists as they navigate this new terrain.

Will use by youth increase?

A commonly raised concern about the legalization of cannabis is increased use by young people. While this concern is understandable, we offer two reasons to suggest why this may not be the case. First, we know that youth in Canada are already using cannabis. Data from the 2016-17 Canadian Student Tobacco Alcohol and Drug Use Survey (CSTADS) shows that past year use of cannabis for students in grades 7 to 12 was 17%, unchanged from the previous survey year (Government of Canada 2018). With this baseline of use already established, it may be unlikely that *actual* youth use will rise dramatically post-legalization – rather *reported* use may rise as the social stigma diminishes and people of all ages are more likely to disclose cannabis use. Second, we know that data from U.S. states that have legalized cannabis show no significant increases in adolescent use to date.

Still, this is an important area to monitor over time – recent data from Alberta demonstrate that although overall past year substance use has declined over the past decade, reported alcohol and marijuana use is on the rise (for alcohol, from 31% to 44%, and for cannabis, from 12% to 17%) (Government of Canada 2018). We do not yet have a clear explanation for this shift (for example, it could be related to the economic downturn in the province, or more permissive attitudes toward substance use generally), and it will be critical to understand how the legalization of cannabis aligns with future year prevalence rates.



SOURCE: Government of Canada, CSTADS.

What do we know about the risks?

A harm reduction, public health approach to cannabis use tells us that what we need to be concerned about is not necessarily the prevalence of use, but the proportion of harms associated with that use. The rationale for legalization has been based on this principle – that the harms of keeping cannabis criminalized far outstrip the potential for harms to health. This is especially true for our most vulnerable young people, for whom the impact of having a cannabis arrest can lead to a possession charge that alters numerous future opportunities (e.g., terms of employment, travel, community and social inclusion) (Valleriani & Haines-Saah, 2017).

However, while research tells us that the population level harms associated with cannabis use are less than other legal substances such as alcohol and tobacco, it would be misleading to say that use

is benign and has no health effects. We know that the move towards legalization has sparked a great deal of debate in the health and scientific communities about the short- and long-term effects for youth. While research on these outcomes is still emerging, we feel there are two things we can say conclusively, based on Canada's Lower Risk Cannabis Use Guidelines (LRCUG), an evidence-based intervention led by the Canadian Research Initiative in Substance Misuse, and endorsed by the Centre for Addiction and Mental Health and the Canadian Medical Association, among others (Fischer, Russell, Sabioni, van den Brink, Le Foll et al 2017). First, we know that the earlier use is initiated, the greater the potential for harm, with data showing that people who begin using cannabis before the age of 16 are much more likely to subsequently develop mental health and education problems, and problematic use including cannabis dependence. For example, while the overall prevalence of Cannabis Use Disorder in the general population is about 9%, when use begins in the early teens, this rate rises to 17%. Second, we know that frequent or intense (high potency THC) use is more strongly associated with negative health and social outcomes. There is also a link between these two domains, as research shows that those who start using earlier tend to use heavier and more frequently. For these reasons, the LRCUG recommend 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" and that if use has already begun, "users should be aware and vigilant to keep their own cannabis use – and that of friends, peers and fellow users – occasional (e.g., use only on one day/week, weekend use only, etc.) at most to avoid problems" (Fischer et al 2017).

How should we educate kids in schools?

Given the issues raised above, there is strong interest in developing new cannabis educational campaigns in both school and health contexts. However, while this is understandable and important, it is vital that these new campaigns are evidence-informed. While it may seem counterintuitive, research consistently shows that most programming that focuses on adults delivering 'drug facts' to children and youth is not effective. Indeed, the literature shows that most prevention, including mass media campaigns, has had weak to moderate effects on behavioural outcomes (Strang, Babor, Caulkins, Fischer, Foxcroft et al 2012). While it is important to have universal drug education and prevention resources, we argue that our approach to substance use prevention has been generally ineffective because it does not account for the individual factors that place some youth at higher risk of early initiation of substances and pathways into problematic use (i.e., a consideration of what works for whom). For example, new approaches from Canadian researchers that target prevention to personality traits (i.e., sensation seeking) shows exciting promise for outcomes such as delaying initiation of cannabis use (Mahu, Doucet, O'Leary-Barrett, & Conrod, 2015). Other classroom-based programs that move away from didactic approaches and engage youth in activity-based learning that targets social skills and behavioural regulation have also shown positive impact on preventing substance use (Strang et al 2012). Moving even more 'upstream' (i.e., away from a focus on the individual), we see that another reason why our approaches to drug prevention have had limited success is that they often fail to account for the social and peer contexts that wrap around substance use initiation and use (one Canadian approach that does place substance use within the context of relationships is the Fourth R) (Crooks, Wolfe, Hughes, Jaffe & Chiodo 2008). And, while it is true that many youth experiment with substances, those in contexts where there is more social marginalization due to aspect(s) of their identity are even more vulnerable to the potential for harms. To this end, broader social factors such as poverty, violence, gender discrimination and racism are closely associated with substance use harms, but

are rarely considered when we think about how to best 'protect' young people from using substances such as cannabis.

While we are still working to determine the most effective approaches to reducing cannabis harms for all youth, one thing we know for certain is that approaches based on fear or scare tactics, or that preach abstinence only, are not effective. Instead, an approach to education and prevention based on 'abstinence-plus' (i.e., an approach that equips youth with information in a non-biased, open and honest way) is a promising way forward for reducing harms (Rosenbaum 2016). Like other issues such as sexuality and mental health, creating a context for dialogue and trust, and working to empower young people with strategies for reducing harms in their individual context, should be the starting point. Given what we know about the past failures of drug prevention and education, we argue that the best prevention has little to do with educating young people specifically about drugs and their effects and instead, focusing our efforts on the school, community and broader social contexts that wrap around the child and create the context for use and potential harms.

Questions for school psychologists to consider:

We close with several questions you may wish to consider with your broader school community.

- What is the current prevalence of cannabis use in our school? How can we monitor this rate moving forward?
- What supports are in place for students who are showing early intiatiation of cannabis use?
- What prevention tools are we using, and what is the evidence base for these tools? How will we consider the diversity of our student body when deciding on our prevention approaches?
- What are our regulations around smoking at school by students or staff? How will we handle medical vs. non-medical use?

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