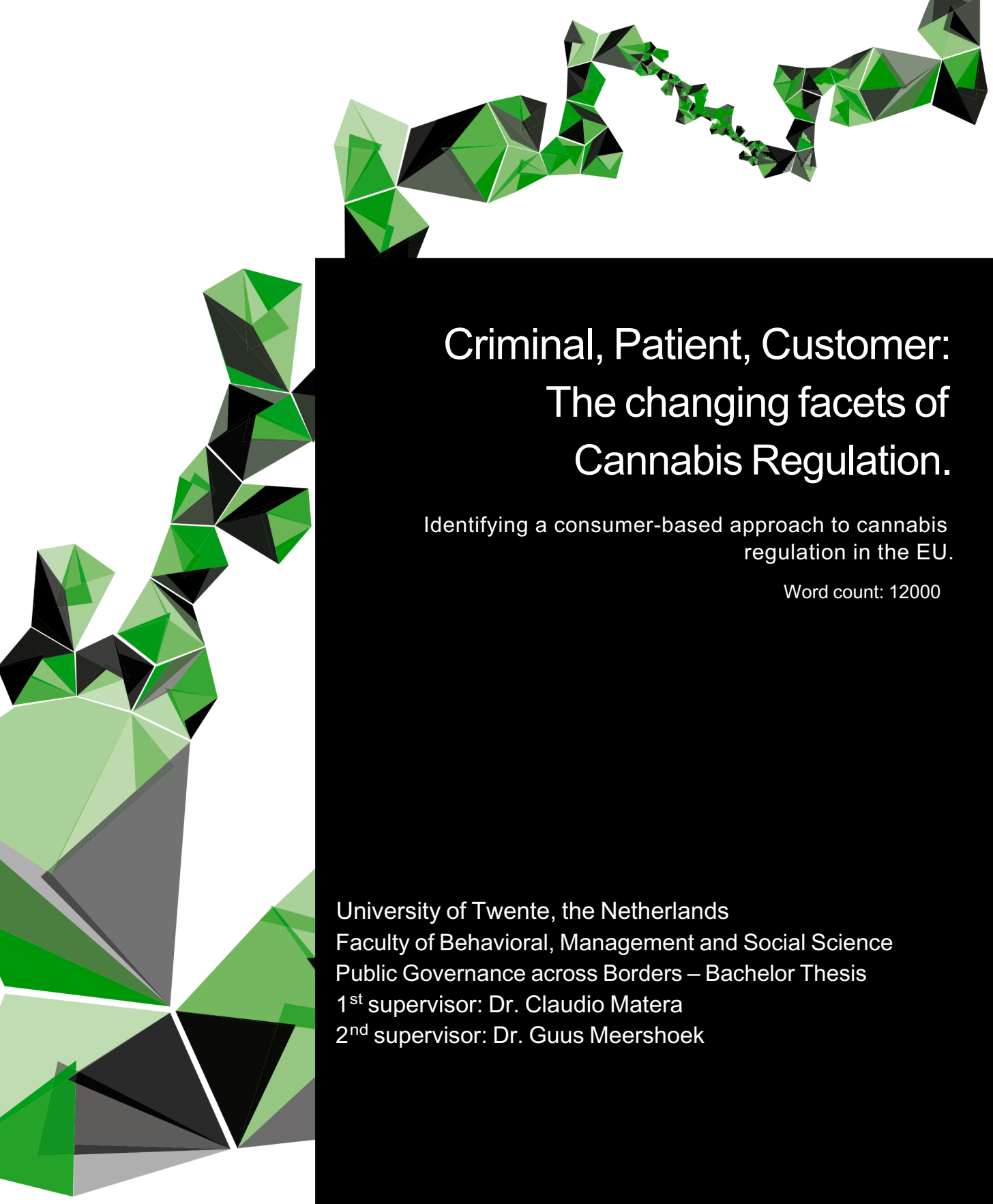

Criminal, Patient, Customer: The changing facets of Cannabis Regulation.

Identifying a consumer-based approach to cannabis regulation in the EU.

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Abstract

This bachelor thesis pursues legal hermeneutic research on the relation of drug policy and consumer protection in the EU. While many countries and states in the world are liberalizing their drug legislation, the EU member states are divided among ideological lines with millions of citizens being exposed to the conditions of the illegal market. To explore alternative drug policy, this thesis is looking for new and promising paths in legal research by answering the research question: *"To what extent can the EU protect recreational cannabis consumers through liberalized regulation of cannabis supply?"* Therefore, the law and history of Canadian and Dutch drug policy will be explained and examined regarding their consumer implications. The legal and institutional relations between national, international and EU level will be studied to elaborate on the feasibility of the internal market integration of cannabis. Having identified best practice and the theoretical construct of drug policy in the EU, consumer protection rights will be interpreted and applied in analogical fashion to build a concept of consumer protection for recreational cannabis. The consumer-based approach is unique in its attempt to align the policy areas of drug policy and consumer protection on the EU level and identifies a framework of responsible market integration of cannabis.

List of Abbreviations

ANEC – The voice of European Consumer in Standardization
CMA – Canadian Medical Association
CND – Commission on Narcotic Drugs
CUD – Cannabis Use Disorder
CSC – Cannabis Social Club
ECAD – European Cities Against Drugs
ECDC - European Center for Disease Prevention and Control
ECDD – Who Expert Committee on Drug Dependence
ECDP – European Cities on Drug Policies
ECOSOC – UN Economic and Social Council
EU – European Union
EMA – European Medicines Agency
EMCDDA – European Monitoring Center for Drugs and Drug Addiction
ICJ – International Court of Justice
INCB – International Narcotics Control Board
TEU – Treaty on the European Union
TFEU – Treaty on the Function of the European Union
UN – United Nations
WHO – World Health Organization

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Chapter 1: Introduction

1.1 Defining Problem and Relevance

"*Another challenge that I would like to highlight is the waning political attention on the drugs phenomenon in Europe"*
(EMCDDA director Wolfgang G tz, 27.01.2015)

This part serves as introductory overview of the goals, content and scientific and societal relevance this bachelor thesis pursues by laying out why the analyzed issue is a current problem and why this research contributes to the contemporary scientific discussion surrounding it.
Cannabis is the most common used illegal drug in the world (Caulkins 2016). The WHO reports 147million cannabis users with annual prevalence worldwide, representing 2,5% of the world's population (WHO 2020). In the EU, 24,7million citizens aged 15-64 reported having used cannabis in the past year, representing 7,4% of that age group (EMCDDA 2019 1) with national estimates ranging between 3,5% and 21.8% (EMCDDA 2019 2).
These people constitute a significant group of consumers predominantly exposed to a criminal market that does not provide any institutionalized protection standards. The stable consumption patterns indicate that prevailing law and policies are inconsistent with the scientific and societal reality. This thesis is of scientific and societal relevance, because it aligns consumer reality with EU consumer protection.
However, Drug Policy is by no means eternally rigid, as recent cannabis legalization across the world shows. Within the EU, a steady shift from criminal justice towards harm reduction philosophy can be observed (Chatwin 2011), eg. Portugal's decriminalization of all drugs in 2001. The WHO recommended the re-classification of cannabis under international law to the UN beginning of 2019, but the vote in the Commission on Narcotic Drugs was postponed to the 63 rd reconvened session in December 2020 (UNODOC 2020). The EU has observer status in the CND and coordinates the votes by its members, who supported the deletion of cannabis and cannabis resin from Schedule IV but recommended to postpone the vote and request further investigation of the WHO on extracts and tinctures as well as cannabidiol (European Commission 2019).
But the partly support indicates that the EU is open to changes. Member states are considering costs and benefits of other regulatory strategies generally (EMCDDA 2019 2) and 15 countries adjusted their cannabis legislation in the past 20 years (EMCDDA 2018). These adjustments followed the trends of prioritizing public health and slowly converging domestic policies, although this resulted from gradual and non-coordinated institutional transformation rather than explicit political choice (Bergeron & Colson 2018, Bergeron 2018).
Such an explicit attempt was undertaken by Luxembourg when it announced its plan to legalize cannabis in beginning of 2020 and called upon the EU-members to join. This seems a great opportunity to analyze the fragmented political and legal landscape of EU drug policy and identify prospects of consumer protection. To elaborate on such a concept-building goal, the research question is:

"To what extent can the EU protect recreational cannabis consumers through liberalized regulation of cannabis supply?"

Prohibition was vastly enforced since the 1950s, but demand persists across cultural and societal layers up today. The persistent demand in the western world and its criminalization established a criminal market system that harms people in production, transit- and production countries (Wainwright 2016).
This criminalization is anchored in international law under three UN Conventions, which impose obligations for national and EU legislation.
However, national constitutions often provide certain discretion for its central or peripherical lawmakers, who may establish regulatory alternatives to the sole prohibition and enforcement paradigm. The emerging of grassroots movements like 'Cannabis Social Club's and semi-regulatory models like 'Coffeeshops' undermine the proper implementation of international law (EMCDDA 2008)

since the UN conventions require domestic law to criminalize individuals for possession of substances not legally obtained even for personal use, but the provision is "[…]subject to the principles of its constitutions and basic principles of its legal system" (Babor 2018, p.229).
The impact of the long-lasting repression of the war on drugs led to significant administrative burdens regarding enforcement of personal use offences, which constituted over half of the 1,2million offences for drug use and possession in 2017 (EMCDDA 2019 2). Currently, states are required to allocate significant resources ranging between 0,01%-0,5% of their GDP on the domain of drug policy expenses and overwhelmingly for supply reduction measures (EMCDDA 2019 2).
To explore an alternative paradigm, aim of this research is to examine and compare liberalized regulation from a consumer-based perspective. The term 'liberalized' is chosen to compare Dutch commercial decriminalization (as most liberal drug policy in the EU) with legalization.

1.2 Research Design and Methodology

This section defines the sub-questions and explains their relevance. The outline is to analyze two cases of liberalized regulation, identify the institutional and legal framework in the EU context and review cannabis in the context of EU consumer rights.

Since "Neither the EU nor any of its Member States are […] currently drug policy innovators or leaders" (Directorate-General for Internal Policies 2016, p. 31), it is necessary to analyze a case outside the EU.
Jurisdictions outside the EU which have legalized cannabis to some extent are Uruguay, Georgia, South Africa, Canada and the US states Alaska, California, Colorado, Illinois, Maine, Massachusetts, Michigan, Nevada, Oregon, Vermont, and Washington.
For inference to the EU, a western country will be selected as case. The USA were excluded for the reason of national prohibition and complexity. Therefore, Canada was chosen to examine a comprehensive, unconstrained impression of national legalization in a G7 nation alike major EU-economies. The full commercial legalization in 2018/19 makes a great example of how all aspects of the phenomenon unfold. Hence, the first sub-question discussed in the 2 nd chapter will be:

1. *To what extent did liberal drug policy in Canada lead to consumer-based regulation of cannabis?*

While Canada showcases national cannabis legalization, the next step is to compare it to the most commercial and liberal regulation in the EU. Drug Policy in the EU can be regarded as continuum between two ideological paradigms: restrictive with focus on criminal justice like Sweden and liberal with focus on public health like the Netherlands (Chatwin 2011). This divide is so deep that it goes along city lines: the Frankfurt resolution 1990 founded the European Cities on Drug Policy (ECDP) promoting liberal policies and in response the Stockholm resolution 1994 formed the network of European Cities Against Drugs (ECAD) promoting war on drugs.
The Netherlands are selected as case, since the decriminalization of cannabis in 1976 led to commercialized 'coffeeshops' which can be regarded as de facto legalization of cannabis (Babor 2018). After 40 years of 'halfway regulation' (Blickmann 2014), the Netherlands display equal lifetime and annual prevalence rates and the lowest problematic consumption rate in the EU (EMCDDA 2019, Chatwin 2018).
To elaborate on the trajectory and regulation of liberalized regulation in the EU, the third sub-question discussed in the 3rd chapter will be:

2. *To what extent did liberal drug policy in the Netherlands lead to consumer-based regulation of cannabis?*

The 4th Chapter analyzes the interaction of relevant institutions and their legal discretion. This is of importance because it identifies the stakeholders and procedures included in the market integration of cannabis, which is the necessary precursor for the attachment of consumer rights. Therefore, the

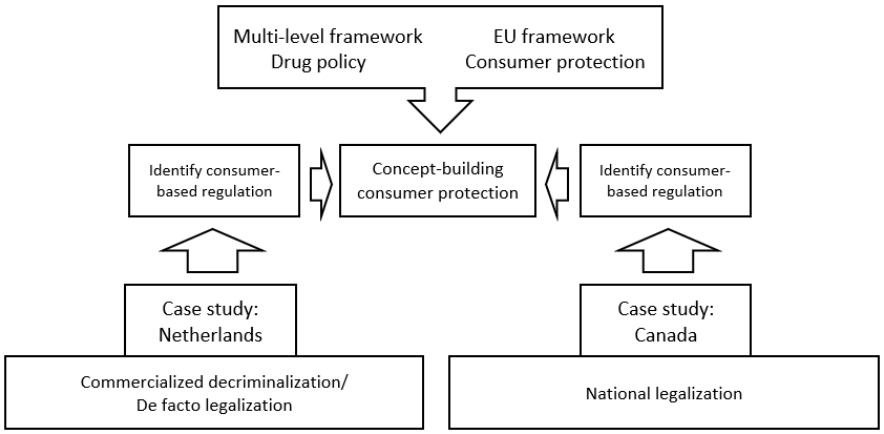
analytical scope will be narrowed down to legalization to enable discussion of cannabis as integrated market product.
To elaborate on the feasibility of cannabis legalization in the EU, international treaties, EU treaties and policies as well as national constitutions must be considered.
Accordingly, the first sub-question discussed in the 4 th chapter will be explanatory-experimental:

3. *To what extent does the institutional and legal multi-level framework provide opportunities for internal market integration of cannabis in the EU?*

In Chapter 5, EU consumer protection will be conceptualized through the five fundamental rights of consumer protection which are operationalized via analysis of corresponding directives.
The relevant legal basis is Article 114 TFEU defining the commissions competence in contributing to the establishment and functioning of the internal market in combination with Article 38 of the Charter of Fundamental Rights of the European Union and Article 169 TFEU.
From those, the five fundamental rights of consumer protection in the EU are derived: (1) Right to Health and Safety, (2) Right to protection of economic interest, (3) Right for reparation (4) Right to information and education and (5) Right for representation.
In the light of the foregoing, the second sub-question discussed in the 5 th chapter will be explanatory-experimental.

4. *What are the applicable principles of consumer protection in the EU?*

In the 6th chapter, the insights of the sub-questions will be set together to answer the instrumental-exploratory research question.



1.3 Key concepts

In this section the core concepts for this research will be introduced and their relevance for answering the research question will be explained.

a) Competences within the EU

Article 5 TEU defines that the EU shall only act upon the competences transferred to it by the member states. Regarding consumer protection and drug policy, neither of those is an exclusive competence of the EU.
However, especially in consumer protection, the EU practices self-authorization through "competence creeping" utilizing Article 114 TFEU to yield power in areas it regards as necessary for the establishment and functioning of the internal market (Weatherill 2013).
Article 5 TEU further includes the principle of subsidiarity and proportionality. The principle of subsidiarity enables the Union to act in areas which are not its exclusive competence but where the objectives of the proposed action cannot be sufficiently achieved at national level due to reasons of scale and effect.

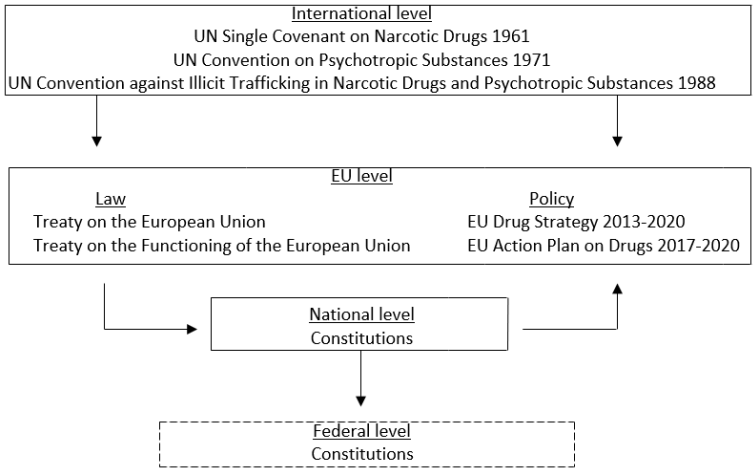
b) Consumer protection

Consumer protection in the EU is a shared competence strongly intertwined with the process of economic integration, that gradually developed since the Single European Act 1986.
However, to secure the establishment and functioning of the internal market, the EU regards it as duty implied under Article 114 TFEU.
Further, Article 168 TFEU obliges the EU to consider public health in its policies and support member states to achieve their health goals. Such can be achieved by uniform protection standards, which are important for the free movement of persons, goods, capital and services laid out under Article 28 TFEU, since it is necessary to treat consumers in the internal market as entity which can rely on minimum security standards and non-discrimination (Article 21 Charter of Fundamental Rights of the European Union, Article 6 TEU, Article 19 TFEU).
Various directives resulted from this which will selectively be examined in Chapter 5. Further included is the case *Tobacco Advertising which* frames consumer policy via case law (Weatherill 2013).

c) EU drug law and policy

Drug policy can be defined as set of administrative action including programs to prevent initiation, health, and social service as well as laws, regulations and initiatives to control the supply (Elvins 2018).
Drugs are mainly associated to social policy, therefore harmonization progressed with every treaty since the SEA. While initial harmonization focused on police cooperation against trafficking, an explicit provision to combat drug-related public health damage (Art. 169 TFEU) was firstly established in the Treaty of Lisbon.
A variety of drug-related EU-institutions emerged over time. The first institution CELAD founded in 1987 and formulated the first EU Action Plan on Drugs. CELAD resolved and operates nowadays as K4 Group/ Article 36 Committee. The European Information Network on Drugs and Drug Addiction (REITOX) emerged from the first Action Plan in 1993 and transformed into the European Monitoring Center for Drugs and Drug Addiction in 1995. While this marked the beginning of cross-national drug data in the EU, the beginning of EU wide legal policy on drug control is recognized as the 'hard harmonization' of definitions and minimum penalties for drug trafficking by Council Framework Decision 2004/757/JHA (Chatwin 2011). While the EMCDDA is predominantly a research institution, it cooperates closely with Europol and the Horizontal Working Party on Drugs (HDG).
The contemporary role of the Commission is to monitor and evaluate actions, propose EU-wide control measures, enforce EU law to prevent use of chemical substances for manufacture of drugs, support

cooperation by providing financial assistance, ensure the coherence of EU positions in international forums and supporting cross-border projects against illicit drugs (Elvins 2018).
However, decision-making over law, policy design and implementation remains competence of the national level, overwhelmingly coined by the commitment to the prohibitionist principle anchored in international law (Elvins 2018).
The three relevant conventions coining international law are the 1961 UN Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances.
Ratification of all three UN conventions is compulsory for accession to the EU (Babor et. al 2018) and applicant countries are provided help to fit the "Acquis Communautaire" by the 'Multibeneficiary Drugs Programme'.
Concluding, the EU does not yield exclusive competences in the regulation of illicit substances but assists the member states within the scope of shared competence under Article 4 Nr. 2 k) j) TFEU.
Articles specifically relevant to drug policy are Article 83 TFEU defining minimum rules for drug offenders, Article 169 TFEU assigning the EU complementary competence in securing Public Health, Article 114 TFEU regulating the internal market (in combination with Article 207 TFEU) as well as Article 84 TFEU covering judicial cooperation.
Contemporary policies of the legal framework are the EU Drug Strategy 2013-2020 which is based "first and foremost on the fundamental principles of EU law" (Article 2, Preface) and its main policy instrument the 'EU Action Plan on Drugs 2017-2020', which based on recommendation by the European Monitoring Center for Drugs and Drug Addiction.
Another crucial Framework Decision based on prior drug strategies is the Council Framework Decision 2004/757/JHA, which in combination with Article 218 (9) TFEU authorizes the EU to determine its members voting position in the CND.



d) Cannabis liberalization

Cannabis liberalization comprises decriminalization/depenalization of offences and legalization of cannabis supply. The related ideology regards addicts as patients rather than criminals and accepts them as part of society. While 'decriminalization' circumscribes removal of penalties, 'depenalization' means a reduction in the severity of penalties (Babor 2018).
Cannabis legalization is the replacement of illicit market production and distribution with a regulated industry (Caulkins 2016). Although specific regulatory constraints can apply, legalized cannabis becomes subject to common market laws and business conduct.
Further distinction is made between "medical cannabis" and "recreational cannabis". While cannabis use for medical purpose can be subject to exemption under Article 2 Nr. 5 b) of the UN Single

Convention on Narcotic Drugs, recreational cannabis describes legal non-medical consumption.
Next to the categorial distinctions, supply options must be regarded as continuum ranging from the extreme option “Prohibition and increase sanctions” to “Repeal only of state prohibition” (Kilmer 2017).

1.4 Body of Knowledge

This part outlines key authors and main issues in the debate about cannabis liberalization.
For cannabis trends and legislation in Europe, the EMCDDA is the most significant provider of research and data. The EMCDDA operates technically independent from the political EU-bodies and provides evidence-based reports but faces political constraints by national and EU level regarding its research scope and publications (Bergeron 2018). Therefore, cross-national EMCDDA data may not be good enough to provide certain recommendations due to data scarcity, poor data quality and comparability, weak causal inference and unknown generalizability. (Chatwin 2011). Paradox, the EMCDDA yields much soft power and made its controllers increasingly dependent upon it, since it established focal points in every member state, developed common epidemiological indicators, excels with its expertise and is the central knot of all drug related information within the EU (Bergeron 2018).
But despite occasional obstacles at national level, the nature of the drug problem is similar across the EU, all members are sensitive to international trends and “[…] the statistics pay homage to the universal lack of success of national drug policy across Europe […]” (Chatwin 2011, p. 84).
The debate in the recent decades reached some milestones which were heavily debated in the past. Firstly, the acknowledgement of therapeutic value of cannabis. This led to widely legalization of medical cannabis and the recent recommendation of the WHO to the UN, to delete cannabis from schedule IV and changing it from Schedule II to Schedule I in the 1961 UN Convention, hence assigning it less dangerous properties and therapeutic value.
Secondly, cannabis prohibition has not proven to be an effective instrument to reduce illicit cannabis markets or health harms and imposes heavy burdens on the criminal justice systems (TNI 2016) and therefore public health approaches steadily increase in the EU (Chatwin 2011).
But contrary, removement of prohibition could lead to dramatically reduction of production and distribution costs and might be affecting retail prices, which could encourage youth usage albeit it strongly depends on the mode of regulation (Kilmer 2013).
Hence much debate is concerned about the aspects which need to be considered in the policy design, eg. Production costs, profit motives of business and states, regulating bodies, promotion and advertising, prevention and treatment, policing and enforcement, penalties, prior criminal records, potency, product types, purity, prices and taxation (Kilmer 2019). Further technical issues of operation like maximum amount per person and per retail store, opening hours, cross-border shopping, financial transactions etc.
Despite Luxembourg’s recent announcement, none of the EU countries ruling governments considers legalization so far, but there has been a constant decrease in severity of punishments for cannabis possession offences over the past 20 years (EMCDDA 2018).
This thesis aims to pick up on the discussions about ‘what has to be done to protect consumers’ and to transform it into the question of ‘how can it be done in compliance with the EU context’.
Therefore, “the question facing Europe today is no longer whether or not there is a need to reassess and modernize cannabis policies, but rather where and when to do it” (Blickmann 2014, p. 16-17).

Chapter 2: Case Study Canada

2.1 Introduction

This chapter is a case study about the legal and societal development which led to the legalization of recreational cannabis in Canada. More specifically the purpose of this chapter is to answer the sub-question: *To what extent did liberal drug policy in Canada lead to consumer-based regulation of cannabis?* This chapter will firstly examine a chronological review of historical turning points and legislation (2.2), outline the contemporary regulation (2.3) and finally subsume its implications for consumer protection (2.4).

2.2 Historical development: trajectory and challenges

When the Cannabis Act came into force on 17. October 2018, it remarked a milestone of national and global cannabis regulation, ending 95 years of prohibition in Canada.

The first Canadian drug policies were introduced from 1908-1911 and gradually increased prosecution to contain the spreading of recreational opioid usage. While the International Opium Commission recommended to add cannabis to the list of proscribed drugs in 1909, it was not until 1923 that Canada added cannabis to the schedule of restrictive drugs mainly influenced by the increasing prohibition in the United States. This became known as solution without a problem, since cannabis was widely unknown, and the first cannabis related arrest took place more than a decade later in 1937 (Braun 2017).

In 1954 the maximum penalty for drug offences got increased up to 14 years imprisonment before the UN Single Convention on Narcotic Drugs of 1961 increased maximum punishment to lifelong sentences.

The following decade was marked by public outrage, because most cannabis consumers were well-educated, white, young men who subsequently faced severe criminal punishments (Braun 2017). Therefore, judges were granted the option to only sentence a fine in 1969.

A special commission was established in 1972 which concluded that damage of prohibition outweighs the benefits. Members of the Commission came to different recommendations including legalization of cannabis (Bertrand 1972).

A new era in global drug policy was invoked in 1986, when Ronald Reagan intensified the war on drugs formerly declared by Richard Nixon in 1971. In response Canada introduced the Canada Drug Strategy 1987-1992 (renewed until 1997) which was rather liberal with a volume of 210 million Canadian Dollar allocated to harm and demand reduction measures and research (Riley 1998).

A breakthrough of liberal policy happened in 1996, when the *Controlled Drugs and Substances Act (CDSA)* established de facto decriminalization by setting a maximum punishment of 1000$ or 6 months imprisonment for possession of under 30g cannabis.

The next gamechanger was the foundation of Health Canada in 2001 which introducing the Marijuana Medical Access Regulations. Subsequently, the number of registered patients grew rapidly from 376 in 2001 to over 330.000 in 2018, accompanied by a growing number of semi-legal dispensaries offering recreational cannabis under medical disguise (Braun 2018).

Besides a few attempts to further decriminalize (Bill C-38 and Bill C-17), drug policy remained rather steady for a while. Pace increased again after the Liberal Party putted forward a priority policy resolution to Legalize and Regulate Marijuana in 2012. Before the Liberal Party won the election in 2015, now-prime minister Justin Trudeau sparked public debate after admitting to smoke cannabis in 2013.

Election promises became true with Bill C-45, an act amending the Controlled Drugs and Substances Act, the Criminal Act, and other Acts. Its known as the *Cannabis Act,* which was introduced 18 months after Trudeaus election on 13. April 2017, and came into force on 17. October 2018. Legalization of edibles was delayed for one year and came into force October 2019, due to concerns of dosage and

youth appeal.

2.3 The Cannabis Act: regulation and limitation

The primary goal of the Cannabis Act is to redirect the focus from criminalization towards a public health approach, restricting youth access and promotion, introducing safety and quality requirements, deterring the criminal market and relieving the criminal justice system (Cox 2018).
Instead of prohibition under the Controlled Drugs and Substances Act, cannabis becomes subject to the Food and Drug Act which controls safety, efficacy, and quality of the product.
Regulation is divided between the federal and province/territorial level. While the federal level is responsible for the licensing of production, the provinces manage distribution and sales albeit within the scope of the federal guidelines.
This research places a special focus on the public health impact of cannabis to identify consumer protection practice rather than public safety implications related to criminal activity.

a) Federal regulation

The federal regulations oversee production and manufacture while the provinces and territories regulate distribution and sale (within the scope of federal guidelines).
The framework prescribes a maximum amount of 30g possession in public (referring to dried flowers, varies by product type) and an absolute ban of consumption in vehicles. Further it bans advertising, decides upon industry rules for different products, serving sizes, potency of derived products, prohibition of certain ingredients, good production practice and tracking requirements.
A national cannabis tracking system monitors the production levels, inventory, and sales volume of businesses. This 'seed-to-sale' tracking ensures that no quantity of cannabis is directed into the illicit market and enables product recalls (Health Canada 2016). Regarding the safety of the product itself, producers are obliged to provide records about pesticides, fertilizers, recall procedures and testing. This enables better compliance control over rules on packaging, composition, labelling and product testing.
Restriction on youth access is one of the most important aspects of the Cannabis Act. It is achieved by setting a legal age and strict prohibition of advertising as similar to the *Tobacco and Vaping Products Act* 2018. It restricts products to plain packaging with uniform color, company name, strain, price, THC/CBD amount, warning and labelling requirements. Endorsements, Sponsorships and branding are forbidden, just as display of bright colors, cartoon mimics, recognizable fruits or other youth appealing imagery. Packaging must be further opaque, re-sealable and childproof (Health Canada 2016).
Federal regulation facilitates important business factors like usage of the banking system, stock-market transactions and capital raising funds.
The industry is kept accountable for the cost of legalization. Business must pay fees for the screening and processing of license applications at Health Canada, a security screening fee and annual regulation fees. Cannabis producers further pay either a varying flat rate on packaged products (flower, non-flower, seed) or a product value-based ad valorem excise tax of 2,5% upon delivery. Further, provinces have the option to include Pigouvian Taxes to cover for negative externalities, eg. Manitoba established a "Social Responsibility Fee" which is a 6% tax rate on revenues (Bourque 2019). Consumers pay a Harmonized Sales Tax (GST/HST) on goods and services which varies by province (5%/13%/15%).
The overall tax and duty income will be shared 75% to the provinces and 25% to the federal government, while the federal income is capped at 100Million annually with the surplus flowing to the provinces (Shanahan 2019). The revenues are spent in favor of consumer health, with priorities on health care, job skills training, cannabis-related public education, and deficit reduction (Braun 2019). Additionally, the Government dedicated $46 million to education and awareness activities targeted

especially at youth over the course of 2018-2023.

b) Provincial regulation

While the federal guideline is unified, it is important to point out provincial differences in the implementation. These differ mainly in licensing and regulators, legal age (can be raised, not lowered), home cultivation, public consumption, and online sales.

The licensing system implemented varies substantially in its degree of commercialization. According to Cox 2018, the market model can be distinguished into Public (government monopoly), Private (Commercial free market) and Hybrid (Government and private industry). State monopoly provides more opportunity to structure the market, minimize health harms of the product and tends to yield more revenue (Babor 2018). The private model trumps with product expertise, innovation and market expertise, making it extremely capable of combating the illegal sector. On the other hand, the commercial free market system can be expected to prioritize profits over the public health objective (Cox 2018). Therefore, a hybrid model could represent compromise based on a tightly regulated and health-oriented market with the capacity for innovation and flexibility.

The minimum age prescribed by federal law is 18 years. Of the ten provinces, eight set the legal age to 19 years. 21 years represents the age the Canadian Medical Association advocates for. The brain is completely developed by 25 but this legal age still resembles a compromise of youth protection and the potential to deter the illicit market (Kelsall 2017). Further, quantity and potency should be restricted for those under 25 to discourage use and underage sharing (CMA 2016).

Most provinces allow for cultivation of up to four plants, but with differing guidelines (eg. locked indoor, not visible from street, etc.). The regulation of home cultivation was often subject to court cases in the realm of medical cannabis. On one hand, the Quebec Superior Court has ruled prohibition on home cultivation as unconstitutional (Shanahan 2019), on the other it is contrary to the main prerogatives of product quality, potency, and illicit diversion and legal certainty (Kelsall 2017). Lack of s afety is also a concern because many fires are caused by failure of indoor cultivation equipment (Bourque 2019).

Most provinces completely banned public consumption, only Nova Scotia established designated public places. Three provinces take an equal stance to tobacco and ban it close to children, essentially schools, parks, and playgrounds. Although cannabis is treated more like tobacco in terms of public consumption, the alcohol laws for impaired driving were extended to cannabis by applying a zero tolerance policy resulting in license suspension, fines and treatment for novice and commercial drivers (Shanahan 2019).

Online sales are mostly allowed in public regulated jurisdictions and serve as safety element besides the convenience of delivery. Delivery via mail is supposed to be safer, reduce nuisance and prevent diversification into criminal sector but lacks the producer-consumer relation and possibility for meaningful information (Braun 2018).

2.4 Case conclusion: Consumer implications and protection

Canada fulfills the right to education and information as well as the right to product safety nationwide, with additional security options through discretion at local level.

While no effective cap on THC for dried flowers is applied, all products must bear detailed information and a standardized certificate, and manufactured cannabis-based products are further subject to special restrictions.

To protect uninformed, underage and addiction adverse individuals, Canada restricts marketing and mandates cannabis-related educational skills and activities. E.g. nationally, the Cannabis Act prohibits promotion by limiting it to educational purposes, therefore forbidding to utilize cartoons or other incentivizing imagery especially appealing to youth on cannabis products and related accessories and

services (Watson & Erickson 2018). To achieve this, the plain packaging regulation with rotating health warnings was introduced. Indeed, a study of Goodman et. al (2019) concluded that health warnings and plain packaging reduce appeal of cannabis products to young people in a legal regime. Another study of Leos-Toro et. al (2019) found evidence that pictorial warnings and quitline numbers further increases the effectiveness of discouragement.

However, cannabis producers attempt to lobby for advertisement under the disguise of informational campaigns that allegedly reduce health harms to self or others and social harms like criminalization and stigmatization (Cr pault 2018).

An additional provincial measure for information and safety can be found in the “Division 5: Social Responsibility” of the *Manitoba Safe and Responsible Retailing of Cannabis Act,* which obliges shop owners to post public service notes in their stores and specifies the training courses employees must have accomplished.

Protection of economic interest may vary with the provincial degree of commercialization but is arguably given through the inclusion of businesses in the cost of legalization, which flows back into consumer related activities. The national cannabis tracking system helps to keep every aspect of the supply chain accountable and facilitates claims for reparation if applicable.

Chapter 3: Case Study Netherlands

3.1 Introduction

This chapter will analyze the development of Dutch drug policy and its relation to consumers by answering the question "*To what extent did liberal drug policy in the Netherlands lead to consumer-based regulation of cannabis?"*. Starting with a chronological review of the historical development (3.2), the contemporary standpoint of regulation will be summarized (3.3) and discussed to answer the sub-question (3.4).

3.2 Historical development: trajectory and challenges

The contemporary model of Dutch drug regulation is legally anchored in the *Opium Act* which was established in 1919 and amended over time. Obliged by the Geneva Convention 1925, the import and export of cannabis was added to the Act in 1928.

But it was not until the 1950s that cannabis use reached the Netherlands, introduced by musicians, sailors, and US soldiers after WWII (Chatwin 2013). Use, sale and possession of cannabis was criminalized in 1953-55 up to the measures against opiates and heroin.

Cannabis usage rapidly increased in the 1960s youth culture, especially among white, educated males, as symbol of counterculture (Spapen 2014). The black market flourished, and Dutch drug policy developed its ambiguous muddling-through approach.

Ratification of the 1961 convention took eight years of parliamentary debate -including legalization discussions- and was finally concluded to set punishments domestically regarded as appropriate based on drug profiles (Korf 2019). But even one year prior to the ratification, Amsterdam made its experimental decision to permit "house-dealers" at two subsidized youth centers in 1968, highlighting 'social context' and that the problem cannot be contained but its consequences (Spapen 2014, (Grund & Breeksma 2018). This can already be regarded as de facto decriminalization.

Those policy experiments were accompanied by favorable media reporting and led to the establishment of two expert commissions in 1971/72, which stated that repression would result in an endless negative spiral and that solely penal approaches are inadequate (Spapen 2014).

Facing increasing heroin addiction in the 1970s, a harm reduction and public health approach based on the separation of markets for soft and hard drugs was recommended. The recommendations were adopted and hence decriminalization via the revision of the Opium Act in 1976 was formalized.

The Board of Prosecutors issued a national guideline in 1979 to not actively investigate small-scale sale of cannabis by introducing the "expediency principle" to Paragraph 167 of the Dutch Code of Criminal Procedure, since it is "[…] believed to not serve the public interest, but to stigmatize many young people and isolate them from society" (Korf 2019, p. 3). This guideline paved the way for off-the-record rules on police conduct concerning house-dealing and coffeeshops which should later formalize into the AHOJ-G criteria but were very inconsequently interpreted and applied (Grund & Breeksema 2018).

The institutionalization of Coffeeshops in the 1980s was an unintended policy outcome through unexpected entrepreneurship, which was legitimized via case law that extended the expediency principle to house-dealers. (Korf 2019). However, supplying coffeeshops remained illegal.

This faced stern international criticism, especially by Germany and France in the prospects of the Schengen Agreement in 1985 (Spapen 2014). Indeed, the free movement of goods and people ushered a new period of Dutch drug policy via the emerging of drug houses as border shops and the influx of drug tourists causing nuisance in the bordering cities.

The 'Dutch style' organized crime which developed since the 1970s increasingly supplied foreign markets, approximately exporting 80% of all homegrown cannabis in the Netherlands (Spapen 2014). Subsequently, police enforcement increased in the 1990s with the new purple government coalition (Grund & Breeksema 2018).

The formal introduction of the AHOJ-G criteria took until 1991 and the official nationwide enforcement until 1994. In 1995, the maximum amount per transaction was reduced from 30 to 5 grams and the maximum stock in coffeeshops fixed to 500g (with municipal discretion for further limitation). In 1996 the minimum age was raised and harmonized from 16 to 18, coffeeshops were declared as alcohol free zones as of 2000, licensing systems were institutionalized, and municipal discretion strengthened via the option for a zero-tolerance policy. Administrative enforcement options increased significantly with the 1999 Damocles Act (Opium Act Art. 13b), the 2002 Victor Act and the Integrity Assessment BIBOP, which in sum enabled mayors to close down coffeeshops based on nuisance and other criteria, as well as mandates background screening for licenses (Grund & Breeksema 2018).

From 2000 on, tension between local and national governments grew because the supply problem was still unsolved about 30 years later, but the national government rejected regulation proposals because its neighboring countries still stagnated in their drug policy and therefore anxiety over economic and diplomatic disputes prevailed (Grund & Breeksema 2018).

An expert commission of 2009, the Adviescommisie Drugsbeleid, recommended that coffeeshops should return to their original purpose of public health protection rather than follow the commercialized development. In response, the government reacted with a policy letter in 2011 aimed at implementing the additional criteria of residence (I Ingezetenen) and private club registration (B Besloten) by 2012. Several municipalities participated under protest of local authorities , but even though coffeeshop tourism declined, the project failed soon due to privacy concerns and citizens turned to a prospering illicit market instead (Korf 2019). Therefore, (B) was abolished and implementation of I a local decision (Grund & Breeksema 2018). Further, the government announced that coffeeshops are no more tolerated in a radius of 350m around schools. This policy turned into local discretion and is applied by a vast majority of municipalities in an even narrower range of 250m around schools.

In 2013, 23 majors published the *Manifest Joint Regulation*, which calls upon regulating the supply of coffeeshops via social clubs to finally solve the “backdoor problem”. Its key objectives are the better protection of public health, improved safety in the neighborhood and control of organized crime. As of 2018, the document was signed by 54 mayors and is endorsed by the Union of Dutch Municipalities (VNG).

In February 2017, the Opium Act was revised by the narrow adoption of the *Closed Coffeeshop Circuit Act* attempting to conduct experiments for the regulation of cannabis supply by licensed growers. Despite the incumbency of a new government with diverging views later that year, the experiment received consent under harsh restrictions, an expert commission was established in 2018, and in 2019 the *Experiment Act* and underlying administrative decrees were prepared. The experiment is currently in the implementation stage and evaluation is scheduled around 2025 (Knottnerus 2018, Korf 2019).

3.3 The Opium Act: regulation and limitation

The primary goal of Dutch drug policy is a liberal harm reduction approach separating the markets for hard and soft drugs and prioritizing treatment over prosecution. It is based on the abovementioned expediency principle, which “ […] is a watered down version of the Swiss “Legality Principle” questioning the illegality of a substance where such a position is not in the general interest” (Chatwin 2011, p.11).

Another cornerstone of Dutch Drug Policy is the concept of “normalization” of drug use, which was formally introduced in 1985 and signals the acceptance and inclusion of drug users into society.

In a tradition of administrative openness, legal regulations and public guidelines are laid down more openly, thus enhancing legal protection of drug users and addicts in the Netherlands (Van Dijk 1998).

Local municipalities frequently oppose the national government and the ‘local triangle’ (mayor, public prosecutor, municipal chief of police) are responsible for coordination of local policing (Grund & Breeksema 2018). Therefore, coffeeshops are subject to criminal and administrative law (Spapen

2014).
From the standpoint of contemporary regulation, the Opium Act yields its primary control via the AHOJ -G(I). Summarizing, A (Affichering) prohibits advertising. Exemption to this are minor references inside the shop. H (Harddrugs) prohibits possession and sale of hard drugs inside the shop. O (Overlast) proscribes that no nuisance must be caused, including annoyance indirectly caused by the store, like noise, litter, exhausted parking lots and encounters with customers in the neighborhood. J (Jongeren) sets the legal age to 18 years. G (Grote hoeveelheden) defines maximum amounts of transaction volume and store stock. The quantity for transactions is 5g per customer per day and the maximum selling stock is 500g. The I-criterion (Ingezetenen) permits only residents to enter but is rather new and not consequently applied. It is easy to temporally close down coffeeshops if hard drugs are found, and permanently after repeated violation, but it is legally difficult based on Nuisance, even though zero-tolerance policy can be applied after 'tripartite consultation'. But overall, coffeeshops are complying with all criteria because it is a lucrative business and municipalities enjoy the benefit of an estimate 400million euros a year in tax revenues (Spapen 2014, Rollens 2014).
The biggest limitation of the Opium Act is its inability to regulate the "backdoor", the supply side of the coffee shops. This turned into a self-fulfilling prophecy for the Dutch government, it is reinforcing the problem it is trying to fight (Grund & Breeksema 2018). While a regulatory issue of de jure legalization is that "The tighter the restriction and the higher the taxes, the greater the risk that an illicit market will develop to evade them" (Caulkins 2016, p.105) , Dutch de facto legalization arguably marks the other end of the spectrum with regulations so loose that criminal markets develop to exploit them.

3.4 Case conclusion: Consumer implications and protection

Dutch decriminalization lacks the ability to ensure the right for product safety, because it cannot control potency and quality of the product, neither in its final form nor during the process of production. It is not able to establish market transparency and rather shifts criminal involvement from street dealing to backdoor proliferation.
Leaving the supply to criminal markets, producers and their practice cannot be identified or made accountable, hence making claims for reparation impossible.
Economic interest of consumers is only regulated by the free market, and coffeeshop reputation can be judged as rather weak threshold to ensure good business practice, eg. that indicated weight and strain of a transaction fit the price.
Information and education follow a similar scheme in the absence of training requirements as for "budtenders" in legal markets.
Consumers hardly enjoy institutionalized representation compared to unions of coffeeshops or municipalities. Also, consumers in urban areas profit asymmetrically of the regulation, since 52% of coffeeshops are located in the five biggest communities (over 200.000 inhabitants) and only 1% of coffeeshops in communities under 20.000 inhabitants (EMCCDA 2008).
Afterall, consumer rights remain scarce, but one must consider that this was never the intention. The path dependent policy outcome rather established a thin line between patient and consumer. The regime designed with the premise of public health increasingly commercialized (EMCCDA 2008).
Even though rights can be judged as insufficient, it is important to highlight the achievements of Dutch drug policy. As often questioned, increased availability though coffeeshops is not associated with higher prevalence rates of cannabis consumption. The monthly usage rate of Dutch people (5,4% of 15-64 years old) are below the European average (6,8% of 15-64 years old) (Monshouwer 2011). Statistics further report no significant differences in cannabis consumption between the Netherlands and Sweden, the most restrictive drug regime in the EU (Chatwin 2011).
The goal of separating the market for soft and hard drugs appears to be successful as well. Even though an underground market exists in every municipality, 70% of cannabis is bought in coffeeshops, enabling restriction on hard drugs and legal age (EMCCDA 2008). Concluding, just 14% of cannabis

users in the Netherlands report that other drugs are available from their source, while this number in Sweden is with 70% substantially higher (Rolles 2014). Further, except of ecstasy, prevalence of hard drug usage in the Netherlands is with 0,6% below the European average of 1,2% (Monshouwer 2011). Albeit Dutch de facto legalization lacks quality criteria and guarantee due to its intertwined nature with the illegal supply market, a measurable positive health impact on the population level is evident.

Chapter 4: Multi-level framework

4.1 Introduction

This part will analyze the relevant stakeholders and their interactions, as well as legal possibilities to formulate policies in conformity with obligations imposed by international law. Accordingly, the sub-question is "*To what extent does the institutional and legal multi-level framework provide a basis for internal market integration of cannabis in the EU?".*

Historically, the EU launched two commission into investigating the nature of the drug problem. The first was the Stewart-Clark commission 1986 who attained no majority conclusion and recommended to maintain restrictive ideology. The second was the Cooney commission 1991 where the majority was in favor of liberal approaches but rejected legalization because the EU should adhere to the UN and the minimalization of drug consumption (Chatwin 2011).

Therefore, the EU is limited in the market integration of cannabis to the extent that it is classified in the 1961 UN convention and to the extent the regulation surrounding the classification leaves room for discretion. UN treaty reform therefore circumscribes changes in the obligations imposed by the UN treaties and conformity discretionary action without changing the UN treaties.

Exploring these options is necessary to identify and apply a coherent framework of consumer protection, since the legal status of cannabis in the EU is a necessary precursor for the attachment of EU consumer rights.

4.2 Conventions Reform

International law obliges the 183-189 UN members that ratified the three UN conventions to prohibitionist measures. Reclassification of cannabis would therefore be necessary for market integration, since the UN treaties exempt scheduled drugs from the assumption of superiority of competition and free movement of goods (Babor 2018).

Responsible bodies for the implementation of the respective UN treaties are the Commission on Narcotic Drugs (CND), the World Health Organization (WHO) and the International Narcotics Control Board (INCB). The INCB consists of 13 ECOSOC members based on personal competence rather than nationality and serves as 'quasi-judicial' body which monitors production, authorizes import/export, writes annual reports and recommends measures to states which do not comply with the treaties (Babor 2018). Hence it is more concerned with the administration while WHO and CND are responsible for regulation.

Options for UN treaty reform are amendments, reservations, rescheduling and denunciation. Amendments can be put forward by any member, but it was only utilized twice, in the 1972 treaty revision and Bolivia's downvoted attempt to delete coca chewing in 2009 (Babor 2018).

Reservations can be made by the time of signing, accession, or ratification. After Bolivia failed by amending it withdrew from the Single Convention (Article 46) and then re-accessed with reservations (Article 50) which are valid if not objected by 1/3 of all 183 members after 12 months (TNI 2011). Since ratification of the UN treaties is conditional for EU accession and numerous trade treaties, withdrawal of all EU members and their re-accession with reservation is extremely unlikely, considering different national ideologies and its commitment to international organizations.

Recommendations on scheduling can be put forward by the WHO's Expert Commission on Drug Dependence (ECDD). The proposal will be subjected to majority vote by the 53 representatives on the CND, which serves as legislative and policymaking body elected from the UN Economic and Social Council (ECOSOC).

Denunciation violates the implicit treaty goals of universality (all countries) and coverage (all substances) and could thereof further fuel debate over reform (Babor 2018).

After the legal status of cannabis changed under international law, the EU could arguably claim responsibility based on the principle of subsidiarity by claiming that internal market integration and European public health cannot be achieved on national level. Art. 115 TFEU could further support the argument that EU intervention is necessary for the proper functioning of the internal market because the freedom of movement for persons and goods could spread unstandardized and potentially

threatening products across the Schengen-area.
The European Commission could delegate the task of licensing production and wholesale distribution to the European Medicines Agency (EMA) comparable to the function of HealthCanada in Canadian legalization. The EMA also pursues the central role of the medical cannabis system in the EU and authorized EPIDYOLEX as first cannabis plant derived medicine in the EU along with a risk management plan in 2019 (EMA 2019).
However, this would also depend upon various other stakeholders including DG Home Affairs, the HDG of the European Council, the LIBE committee of the EP, the EMCDDA as well as representatives of civil society, NGO's and national governments.

4.3 Conventions Conformity

Notwithstanding the existing international legal framework and its restrictive stance on cannabis, it is nonetheless possible to identify a range of national and international principles and norms that can be interpreted as mitigation factors of said restrictive framework. Namely, these are argumentation via constitutional exceptions, human rights violations, and medical and scientific purposes.
The first mitigation factor that needs to be discussed are human rights. Art. 14 (2) of the 1988 Trafficking Convention stipulates that treaty implementation "shall respect fundamental human rights" and Art. 14 (2) emphasizes the aim of "reducing human suffering and eliminating financial incentives for illicit trafficking". Major proponent of the Human Rights approach is Uruguay which -with support of the EU, Argentina, Bolivia and Switzerland- initiated Resolution L.16 on the 51 st CND session 2008. The resolution attempted to achieve consistency of the drug control conventions with human rights instruments by calling for balancing of supply reduction measures with proportionality criteria to not criminalize consumers (Fultz 2017). Furthermore, Mexico's supreme court made the first step towards "jurisprudential thesis" when he ruled prohibition on personal producing, processing and consuming of cannabis as violating human rights, including the free development of personality in Art. 22 of the UN Universal Declaration of Human Rights (Aguinaco 2017). In Mexico, supreme court decisions have only guiding character but become binding when the court rules five times in the same way.
A second factor would be the argumentation via constitutional provisions. Constitutional discretion is provided by interpretation of Art. 35 of the 1961 Single Convention which states that implementation of national and international preventive action is "Having due regard to their constitutional, legal and administrative systems…". Subsequently, Art. 36 stipulates that the penal consequences each state should adopt are "subject to the constitutional limitations of a party, its legal system and domestic law". Lastly, Art. 3 (1) c of the Trafficking Convention states that necessary penal measures and sanctions are "subject to [its] constitutional principles and the basic concepts of its legal systems". Famous proponent of this approach are the Netherlands who established a distinction between soft and hard drugs in their legislation.
Another possibility to circumvent and introduce a consumer-oriented cannabis policy could be provided by the medical and scientific purpose exception in the 1961 UN convention. Such provisions within the UN Convention on Narcotic Drugs are Art. 2 (5) b exempting medical and scientific research and Art. 4 (1) c exempting medical and scientific purposes. Argumentation over the medical realm is rather exhausted since medical cannabis is legalized in many jurisdictions.
Scientific reasons, however, are not clearly defined and only referred to as "including clinical trials" under direct party control and supervision. Clinical trials are human experiments which are therefore lawful under sufficient regulation and instruction (Fultz et. al 2017). While the scope of scientific purposes is not explained within the treaties, its limitations are defined by Art. 19 in combination with Art. 2 (5)b of the Single Convention, by obliging that estimates of the drugs required to fulfill medical and scientific purposes must be provided while only strictly necessary amounts are permitted. Subsuming, no effective cap on quantities is in place as long as it is deemed necessary.
The final decision upon the definition of 'scientific purposes' under international law is at the International Court of Justice (ICJ). The ICJ elaborated on the purposes of 'scientific research' in the

Whaling in the Antarctic case 2014, when it judged lethal methods of the 'Japanese Whale Research Programme under Special Permit in the Antarctic' (JARPA II) as lawful under the scientific exemption by Article VIII of the *International Convention on the Regulation of Whaling.* The case triggered international criticism that the venture is rather commercial than scientific (Fultz 2017). The ICJ provided its definition of "scientific purpose" in Art. 97 of its judgement, thereby making a special definition of "scientific research" obsolete because its nature goes beyond that:

"The Court observes that a State often seeks to accomplish more than one goal when it pursues a particular policy. Moreover, an objective test of whether a programme is for purposes of scientific research does not turn on the intentions of individual government officials, but rather on whether the design and implementation of a programme are reasonable in relation to achieving the stated research objectives"

It is important to note that the ICJ is not judging upon the merits of the project nor about whether it resembles the best possible mean to achieve the stated objective. The program is regarded as reasonable if scale and sampling methodology fit the objective and if scientific output is generated based on proper coordination.

The contemporary EU objectives in the field of drug policy are laid out under Paragraph. 9 of the EU Drug Strategy 2013-2020, namely measurable reduction of demand and dependence, disruption of illicit market, coordination through analysis of development and challenges, strengthening of dialogue and cooperation, as well as to understand all aspects of the drug phenomenon by better monitoring, research and result evaluation. Art. 11 details the strategy to be grounded in the policy fields of supply and demand reduction as well as upon the cross-cutting themes coordination, international cooperation and research, information, monitoring and evaluation.

Albeit the strategy is subject to national (restrictive) control, it displays starting points for satisfiable objective formulation that can be reasonably designed and implemented. Eg. a union-wide, intergenerational public health or criminal justice study on cannabis legalization in cooperation with the member states.

As outlined throughout the thesis, various attempts have been made to re-classify cannabis based on growing scientific evidence and with at least partly support of the EU. Concluding, the institutional and legal multi-level framework provides a basis for internal market integration to the extent that treaty reform would be the probable, and treaty conformity a possible scenario. The terms probable and possible are limited to institutional and legal prospects. D espite increasing public harm approaches in the EU, member states are unlikely to unanimously consider legalization and confer their sovereignty in drug policy to the EU (Chatwin 2011).

Chapter 5: Consumer protection

5.1 Introduction

"Since 1987, the EU has had the strictest rules on consumer protection in the world, with a comprehensive set of consumer rights in place today" (European Commission 2018). Although EU consumer protection and drug policy both emerged with the uprising of harmonization of social policy, they developed with different pace and purpose. While the previous chapter focused on possibilities of market integration of cannabis in the EU, this part will present central Directives of EU consumer protection and discuss their ability to cover a recreational cannabis market. Therefore, this part attempts to locate cannabis in the sphere of general consumer protection measures of the EU by answering the sub-question "*To what extend can recreational cannabis consumption be aligned with existing EU consumer protection law?".*

5.2 Fundamental Rights of Consumer Protection

a) Right for Product Safety

In Directive 2001/95/EC on general product safety, a product is defined as "any item intended for sale to, or likely to be used by, consumers, whether it is new, used or reconditioned". Arguably, cannabis falls under this definition regardless of its legal status, since the definition refers to "any item intended for sale" and "likely to be used by consumers".

The product is considered safe if it meets certain national or EU standards. If none exist, the assessment will be based upon commission guidelines, best practice, state of the art and technology and reasonable consumer safety expectations. This thesis attempted to overcome the absence of commission guidelines by identifying best practice through case studies.

Neither the Dutch nor Canada really provide satisfiable solutions because they do not regulate the potency indicated by THC of dried flowers. The Netherlands attempted to ban cannabis with over 15% in 2014 but failed (Rollens 2014) what showcases how difficult it is to cap potency retrospectively. Canada only regulates potency of derived products because high potency dried cannabis could still dominate the illegal market. Still, Canadian regulation can be regarded as best practice and state of the art and technology, because manufactured products -which vary extremely between dried flowers (up to 30% THC) and product specifications (between 0,3%-90% THC or unmeasurable)- are still subject to specified regulation (Canada 2019). The EU could integrate the Canadian regulations and extend them with own reasonable consumer safety expectations.

Directive 2001/95/EC further proscribes that products must bear information like health warnings, content information and be traceable by product reference and manufacturer identity. In Canada, labels must contain a standardized cannabis symbol, mandatory health warnings and specific product information. These must include name, telephone and email number of the license holder , product brand name, lot number, storage conditions, packaging date, expiry date if applicable, rotating health warnings, and a standardized cannabis symbol obtained from the ministry of health if the product exceeds a THC concentration of 10 g/g (Cannabis Regulations, Article 123).

In the EU, national authorities monitor the market and exchange information about unsafe items via the EU Rapid Information System (RAPEX) which is a system of vertical (commission/state) and horizontal (state/state) cooperation. RAPEX has two branches covering food products and non-food products. Just as Cannabis is regulated under the Canadian Food and Drug Act, it arguably fulfills the characteristic to be subject to the branch of food products. RAPEX, resembling a national cannabis tracking system like in Canada, would further facilitate recall and redress mechanisms.

Concluding, in relation to cannabis, this directive goes rather in breadth than in depth but still provides important securities. Since the Netherlands do not provide comprehensive standards for cannabis, Canada could inform decision making as best practice, albeit their regulation leaves much leeway which would require the EU to rely on reasonable consumer safety expectations. The Directive further

covers the requirement of a product tracking and provides labelling requirements.

b) Right for Information and Education

The right for information and education can be understood in a variety of ways, covering prevention, youth education and skilled workers in dispensaries. These were briefly discussed in Chapter 2 and should not be the aim of this part. Labelling requirements which enable informed consumer choice are arguably a major component of education and information but are also covered as aspect of product safety under Directive 2001/95/EC in 5.2.a).

Instead, this part is going to discuss the issue of advertising, as the demarcation between promotion and information is rather thin and prohibition of advertising is not the case everywhere.

In the EU, advertising is defined in Art. 2(a) of Directive 2006/114/EC on misleading and comparative advertising as "the making of a representation in any form in connection with a trade, business, craft or profession in order to promote the supply of goods or services, including immovable property, rights and obligations" and Art. 2(b) defines that it is misleading when it affects the economic behavior of whom it reaches or injures competitors based on its deceptive nature (Weatherill 2013). Accordingly, appeal to young people as especially regulated in Canada (See Chapter 2) could be regulated within the scope of Directive 2006/114/EC

In Canada, the Cannabis Act Division 2 18 (1) regulates false promotion of cannabis (value, quantity, composition, strength, concentration, potency, purity, quality, merit, safety, health effects, health risks). Besides general prohibition of advertisement, regulated exceptions for informational purposes and at point of sale are allowed. The Netherlands pursue a similar strategy by prohibiting advertising under A (Affichering) but allow minor references inside the shop.

While advertising is prohibited in both examined cases, it is regulated differently in the USA. In the USA, the cannabis industry successfully attempts to dodge prohibition on advertisement with the argument of freedom of speech or under the disguise as informational campaigns (Caulkins 2016).

But also, in the EU, prohibition of advertising harmful substances does not always pass uncontested, as the case of *Tobacco Advertising* shows. The case was triggered by Directive 98/43 in 1998, which stated that advertising tobacco products on ashtrays, billboards and parasols deters the internal market and should therefore be prohibited and was legally based on Art. 114(3) TFEU.

Germany successfully contested this in front of court and marked the first time a member state contested the utilization of Art. 114 as harmonization measure in the consumer interest (Weatherill 2013). The court annulled the directive but agreed that the treaties require policy integration between market making and public health matters and consumer protection based on Art. 12, 114(3), 168(1) and 169(1) TFEU, therefore technically delivering a blueprint for legislature to successfully cross the threshold the first directive missed (Weatherill 2013). The annulment of Directive 98/43 led to the much stricter Directive 2003/33, which prohibits advertising of tobacco products towards press and printed publications, radio broadcasting, information society services, tobacco-related sponsorship, and free sample distribution. Exception to this is information and samples between professionals. The content of the annulled directive was further recommended as soft law.

Concluding from the analogy to tobacco, cannabis advertisement could be subject to the same abovementioned restrictions as specified by the case of *Tobacco Advertising*.

c) Right for Representation

Since EU drug policy is an area of subsidiarity, decisions have to be made as close to the citizen as possible, operated in a system of multi-level participation -including stakeholder and civil society organizations besides governmental bodies and experts- at civil, subnational, national and transnational level (Chatwin 2018).
This is similar in EU consumer protection, where consumers have a right for representation, which manifests in their ability to participate in the process of standardization. According to Art. 52 of Regulation 1025/2012 on European standardization, standardization is an EU competence based on subsidiarity and proportionality since member states cannot produce EU-standards effectively and efficiently.
With Commission Decision 2009/705/EC on setting up a consumer consultative group, an institution for informational exchange and advice to the commission was established that assists in standardization matters. It is composed of representatives from national and European consumer organizations which are non-governmental, non-profit-making and independent from industry and commerce. Their primary task is the protection of consumer health, safety, and economic interest in at least half of the EU countries (per organization) and to provide detailed accounts of funding, membership, and internal rules. Such are 'The European Consumer Voice in Standardization' (ANEC) or the non-profit expert organization "European Norm Association".
For drug policy, evidence suggests that the EU commits to citizen participation at the local level championed by ENCOD, a non-governmental organization campaigning for more humane European drug policies (Chatwin 2018). Arguably, ENCOD could be integrated into the European Consumer Consultative Group just like ANEC, to participate in the process of standardization.
Proposed standards are examined by a technical committee and the standstill-principle freezes all activities surrounding the product in the member states. After the committee finished the draft, it will be presented to the public and is open for input (eg. citizen interest). If the member states agree, the standard will be implemented as European standard and translated into national standards. If member states reject, the standard will be reworked based on grounds of the objection.
This could provide a democratic procedure to be sensitive to the shifts in ideology and demographic changes within the European society, balance national interests and ultimately converge drug policy and product standards in the EU.

d) Right for Reparation

In its 'New Deal for Consumers' the commission concluded that existing redress mechanisms are not sufficient in 'mass harm situation' and that "The EU must find answers to new consumer policy challenges whilst ensuring a fair Single market for both consumers and businesses." (European Commission, p.3).
The crucial legislation for redress in the EU is Directive 85/374, known as Product Liability Directive, which is based on Art. 115 TFEU. As amended by Directive 1999/34 its scope extends to primary agricultural products. The cultivation of cannabis belongs to the agricultural/horticultural sphere and may be included within the meaning of the Product Liability Directive.
Art. 1 of the Directive defines that the producer shall be liable for damage caused by a defect in his product. Liable producers in accordance with Art. 3 and 2, are manufacturers of movable finished products, raw materials, or components.
Therefore, cannabis consumers who experience damages based on consumption of cannabis plants, derived or related products are eligible for redress. "Defectiveness" is defined in Art. 6 as where a product does not provide the safety which a person is entitled to expect. Two aspects are important regarding cannabis. The Directive stipulates relative safety and not absolute safety, which can presumably not be warranted when consuming any drug. Secondly , Art. 6(1) upholds the definition of defectiveness even if the damage is result of foreseeable misuse. Since 80% of all cannabis is consumed

by roughly 20% of heavy users, it is arguably likely that profit-driven industries target these users and try to create more of them (Caulkins 2016).
While the liability is quite comprehensive, damages resulting from the drug use would need to be defined. Drug-related harm can be classified as physical harm, dependence, and social harm (Coomber 2013). Dependence and social harm would arguably not be applicable based on the assumption of rational consumers who's economic behavior is not deterred by unfair practices. But also, physical harm – which includes non-fatal overdose, injuries, accidents, and organ damages – could be difficult to assign to exact usage of a specific product and its producers.
Further, a producer is not liable when he is able to identify his producer or supplier according to Art. 3(3). Hence, implementation of a European cannabis tracking system as applied in Canada could facilitate reparation claims along the supply chain.
Art. 8(2) stipulates that a producer is not liable if the product is not intended for economic purposes. Considering that sale of drugs in coffeeshops remains a criminal offense which is not prosecuted by the Public Prosecution Service based on policy of tolerance, this regulation does not apply in the Netherlands.
Concluding, the scope of this direction could reach tremendous dimensions in legalized jurisdictions based on the definition of damages that would be applied. While social harms and dependence are most likely to be self-harms of the consumer, consumers may have a claim for reparation of physical damages where they could reasonably have expected a different level of safety.

e) Right for Protection of Economic Interest

This part is examining to what extent 'misleading commercial practices' (Art. 6) and 'aggressive commercial practices' (Art. 8) of Directive 2005/29/EC on unfair commercial practices can be applied to cannabis regulation. While the Directive on misleading and comparative advertising only prescribes minimum harmonization, this Directive is built to achieve maximum harmonization in consumer protection measures.
However, in Nr. 9 of the recitals stating the objectives it is defined that member states are still able to introduce or retain measures to restrict or prohibit commercial practices regarding, alcohol, tobacco, or pharmaceuticals. Cannabis could therefore be regulated much stricter than the maximum harmonization of this Directive obliges.
According to Art. 5 (2), practices are unfair if they distort choices of average consumers based on false information but also protects especially vulnerable groups under Art. 5 (3) if they could be foreseeable affected. Thus, the directive particularly protects addicts and youth.
Annex 1 sets out commercial practices which are in all circumstances misleading. Nr. 1-4 prohibits the display of a trust or quality mark without authorization and claims of public endorsement for products and practices, which can prevent false assumptions of health or officialdom by unsafe products. Similarly, Nr. 17 prohibits false claims that the product cures illness, or malfunctions. Nr. 6 prohibits 'Bait and switch' tactics which is promotion of one product with the intention of tricking customers into buying another one. This can be particularly important to prevent increased initiation into cannabis or diversification of consumption into higher potency, tobacco, or mixed products.
Aggressive commercial practices are listed under Nr. 24-31 and prevent a range of issues associated to pressuring consumers or their children into buying a product based on harassment methods. They can arguably be regarded as characteristic of criminal markets, the function of the listing Nr.24-31 is rather beneficial for the separation of licit and illegal cannabis distributors and thereby protects consumers.
Concluding, this directive ensures the good business conduct and consumer trust generally, since it prohibits pressuring and manipulative features which are associated risks of criminal markets.

5.3 Sub-Conclusion

Concluding, the directives governing consumer protection in the EU provide a general system of fair market conduct in which cannabis can be partially integrated.
However, this system does not provide sufficient account for the special risks cannabis can impose as psychoactive and potentially addictive substance. That is, because it reacts differently varying by strain and consumer biology and its usage can cause social harms.
The directive on general product safety revealed criteria upon which cannabis regulation would be informed, prescribes monitoring of the supply chain, and obliges to accurate provision of product labelling. The latter could be oriented at the labelling requirements for tobacco products (Directive 2001/37) or alcoholic beverages (Regulation 1169/2011).
Since the EU only regulates misleading and comparative advertising, the case of *Tobacco Advertising* is more suitable to inform decision-making about prohibition of advertising.
Additional legitimacy in decision-making cannabis standards can be ensured by the incorporation of consumer voices as provided by organizations like ENCOD.
The directive on 'Unfair Commercial Practices' provides a range of tools especially valuable to prevent blurs between criminal and legal business.
Finally, the 'Product Liability Directive' displays cues for the scope of accountability which distributors in an EU market could face.
Albeit the analyzed directives are designed to serve broad concepts of consumer protection which do not pay sufficient attention towards the peculiar characteristics of cannabis, they still provide guiding frameworks and reflect fundamental values of the EU.

Chapter 6: Conclusion

This thesis aimed to identify a framework of consumer protection regulation for cannabis consumers in the EU, based on the main research question: *To what extent can the EU protect consumers of recreational cannabis through liberalized regulation of supply?* Framed differently, this would be the protection of public health and safety via consumer rights in commercialized markets.

Cr pault 2018 points out that no universally accepted definition of a public health approach to cannabis exists. Moreover, goals are rather oriented at risk factors on the population level rather than the substance itself by 'responsibilizing' individuals : availability (locations and sale hours), accessibility (price and advertisement control), product (potency and quality) and education targeted at high-risk groups.

Therefore, the EU can protect cannabis consumer through liberalized regulation of supply to the extent that it could provide a guiding framework of minimum harmonization for production and manufacture, industry standards, prohibition of advertisement and legal age. National discretion could regulate operational factors and enforce stricter measures. Such a framework would prioritize public health over criminal sanctioning, separate the markets for soft and hard drugs and keep consumers from interaction with the criminal world while remaining sensitive to national interests. This could lay a market foundation where rational consumers could make own decisions, while vulnerable groups are subject to tight protection measures.

The EU is contemporary limited within their competences to achieve these goals because decision-making remains at the individual member states following diverging ideologies. But observing historical and contemporary trends (See Chapter 1.3 on EMCDDA), gradual increase of sovereignty at EU level over the course of the next decades is probable. Internally, the EU is a hub of diverse drug policies that gradually diverge towards harm reduction objectives. Externally, the global political environment became extremely turbulent over the recent decade, with the North American, Latin American, and Oceanian regions, plus other countries, pushing towards the legalization of cannabis.

The influence of economic processes overruling the sphere of legal enforcement in a globalized world of interconnected markets presumably incentivizes a stronger position of the predominantly economic EU, based on Art. 114 and 168 TFEU, to secure a functioning internal market with overarching public health objectives. Subsidiarity, thus far the principle binding competences to the nation states, could turn in favor of the EU, as soon as the discourse about normative grounds lags behind economic and safety considerations pushed forward by liberalizing members such as Luxembourg or the Netherlands.

The challenge to come is therefore to provide a balanced approach between an industry powerful enough to drive out the established structures of the criminal market while maintaining the public health priority. It is partly possible to align the five fundamental rights of consumer protection in the EU with the regulation of cannabis. The EU could thus provide a foundation for market conduct that firstly introduces institutionalized rights to some extent, but only as theoretical forecast and not as immediate, practical option. However, as the case studies have shown, planning and explicit political choice for liberalization in Canada provides the more sophisticated and consumer-based regulation than the path-dependent muddling-through of the Netherlands.

Therefore, the consumer perspective is a unique approach and clearly adds value to the scientific debate because it puzzles together pieces of different origins to create a framework for consumer-based decision-making in the scenario of liberalization.

Future research should pick up on this and attempt to integrate cannabis into the frameworks of tobacco and alcohol regulation in the EU to support the breadth of fundamental consumer rights with the depth of specialized regulation. Further cues could be provided by a comparison of the interaction between federal and state level in the USA towards the EU context as well as sophisticated examination of proportionality. Sole prohibition, however, has provenly failed as status-quo.

Concluding, the EU lacks the competence to liberalize supply-regulation and thus cannot protect consumers of recreational cannabis, though legal-institutional possibilities for legalization and subsequent consumer protection exist to a limited but evident degree. As for the degree of protection inherent to liberalization itself, comparison of the cases has shown that legalization establishes detailed protection measures that commercialized decriminalization cannot provide.

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