Isfeld, Lori

From: Philip Seeman s.22(1) Personal and Confidential
Sent: Saturday, June 13, 2015 2:19 PM
To: Correspondence Group, City Clerk's Office
Subject: Legalizing marijuana hurts young people

To: MayorandCouncil@Vancouver.ca June 14, 2015.

It is wrong and irresponsible for Vancouver to legalize marijuana.

Consider Colorado. In 2000 they allowed a medical patient to possess 2 ounces of marijuana. In 2012, Colorado legalized recreational marijuana. 27% of Colorado students aged 18 to 25 became marijuana users, compared to 19% for the USA average. If one uses marijuana for two years, he/she loses 7 points in IQ, reducing his/her ability [3]to get an education or find a job[2] (Dr. M. Meier).

In two years, there was a 57% increase in marijuana-related emergency room visits in Colorado with an 82% increase in related hospitalizations. Marijuana exposures for children under 5 increased 300%.
Pets poisoned by marijuana have dramatically increased.

Over four years, Colorado traffic fatalities have doubled for people on marijuana, while overall traffic fatalities decreased.

Nine percent of users become addicted, with withdrawal symptoms when trying to stop. Lady Gaga says [3]You can get addicted to pot[2].

Most important is the fact that psychosis or schizophrenia develops in young people after marijuana usage. Cannabis use in the UK increased four-fold after 1970, leading to a 60% increase in the annual new cases of schizophrenia.

While marijuana legalization would provide tax money to Vancouver and Canadian governments and marijuana businesses, it would not make up for the high personal, medical, and life-long costs to Vancouverites and other Canadians.

The Governor of California advises waiting to see what Colorado does. But the latest poll says that the Colorado public realizes that they made a mistake. Vancouverites and Canadians should not make the same mistake.

Philip Seeman, O.C., M.D., Ph.D.,
Professor of Pharmacology and Psychiatry, University of Toronto (Discovered the human brain[1]s dopamine receptor for psychosis.)
s.22(1) Personal and Confidential

Isfeld, Lori

From:	hilary black s.22(1) Personal and Confidential
Sent:	Saturday, June 13, 2015 1:49 PM
To:	Correspondence Group, City Clerk's Office
Subject:	BCCCS Submissions to Health Canada and Senate Report
Attachments:	BCCCS Response to the MMPR (2013) (1).pdf; BCCCS Submission to HC - July 2011.pdf; BCCCS_response_amendments_MMAR.pdf; BCCCS_response_HC_MMAR_regs2001.pdf; HC_PPS_contract_report2007.pdf; roadmap_to_compassion.pdf; Senate Report.pdf

Dear Mayor and City Council,

As requested, please find attached a serious of reports the BC Compassion Club Society (BCCCS) has submitted to Health Canada over the years, offering them our expertise in designing a functional legal framework for medical cannabis.

Also attached is the Senate Committee on Illegal Drugs from 2002, recommending the BCCCS's model be replicated across the country.

Thank you again for your work on this complex issue.

I have faith you will find a way to not interrupt the healthcare services provided by the BCCCS.

Again, I am at your service if I can be helpful once the hearings are complete.

Warm Regards,
Hilary Black

--
"Almost anything you do will seem insignificant, but it is very important that you do it.
You must be the change that you wish to see in the world."
~ Mahatma Gandhi

BC Compassion Club Society

Submission to Health Canada Regarding Proposed Changes to the Marihuana for Medical Purposes Regulations (MMPR)

Bureau of Medical Marihuana Regulatory Reform,
Controlled Substances and Tobacco Directorate,
Healthy Environments and Consumer Safety Branch,
Health Canada,
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K1A 0K9
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February 2013
2995 Commercial Drive
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Coast Salish Territory

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EXECUTIVE SUMMARY

The British Columbia Compassion Club Society (BCCCS) is one of the oldest medical cannabis dispensaries in North America. Founded in 1997, we have been at the fore-front of the medical cannabis movement for 15 years and have extensive experience caring for patients whose symptoms can be alleviated by cannabis.

After examining the most recent proposal for a federal medical cannabis scheme, we have identified four key recommendations that would vastly improve the effectiveness of the program.

- A non-profit or price-regulated production and distribution systems should be developed which builds on the proven model of community-based dispensaries.
- Regulations need to include cannabis medicines such as edible products and concentrates.
- Patient Production Licenses should be continued.
- Patient needs should be a higher priority.

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2995 Commercial Drive, Vancouver, B.C. V5N 4C8, 604.875.0448 fax 604.875.6083
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I. INTRODUCTION

While some of the new proposed regulations will likely increase barriers to patients, and unnecessarily disrupt patient care, we'd like to commend Health Canada for adopting a number of changes we believe may improve the current program.

Testing and Quality Control: Including provisions to license laboratories in order to ensure the safety and quality of medicinal cannabis, is an essential and long awaited improvement to the regulations.

Access No Longer Requiring Health Canada Approval: Removing the requirement for Health Canada's authorization, and the new abbreviated healthcare practitioners form, will help remove barriers to patient access.

Ending the PPS Monopoly: We have been repeatedly recommending that the programs medicinal cannabis supply be decentralized to increase the quality, broaden the selection, and decrease the end-cost of the medicine, all of which are required to best meet the needs of patients. We also hope that this ends the practice of irradiating medicinal cannabis in Canada.

Allowing A Variety of Strains: The medical cannabis community recognizes the importance of this change, and is gratified to see provisions for their inclusion.

These are all steps that are important for basic standards of patient care to be met, however, we believe there are major flaws in the proposal as a whole. We put forward the recommendations that we believe will address a long list of concerns.

II. Dispensaries are an Important Community Service

In 2001, the BCCCS recommended that Health Canada's program provide for a non-profit, community-based model of distribution. In 2002, the Senate Special Committee on Illegal Drugs published a report that recommended that Health Canada work with dispensaries, citing "the considerable expertise currently residing in the compassion clubs."
Recognizing Compassion Clubs like the BCCCS would strengthen the program in the following ways:

Experience and Expertise
For 15 years medical cannabis dispensaries have been providing uninterrupted patient care, both the BCCCS and their cultivators have continued building on the experience and expertise cited by the Senate report. The BCCCS has shared this knowledge and developed standards for consistent, high-quality, medical-grade cannabis, edibles, tinctures, and concentrates. We have undertaken numerous research projects in the areas of patient care and medical cannabis.

Front Line Social Service

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We are a valuable front-line social service. In face-to-face interaction with our members we provide education, monitoring, referrals to other services, advocacy, counseling and a variety of healthcare care services.

Holistic Approach
Perhaps most critically, our non-profit structure and holistic approach to health care allows us to operate a Wellness Centre, where various therapies are offered for free or for as low as $5 per session. The health benefits can be quite dramatic, and by extension, so are the related savings to provincial health care.

The social support provided at medical cannabis dispensaries can be vital to the healing process, and helps ease the stigma associated with medicinal cannabis use.

Subsidized Access
For those living in poverty we provide subsidized access to a consistent and reliable supply of medical cannabis in various forms.

Supply Options
To ensure safe and efficient use of medical cannabis, patients must be able to access, concentrates, food safe-grade edible products, and the option to access an cannabis cultivated to organic standards. These options are all available through the BCCCS.

Accountability
The BCCCS's supply is cultivated under exclusivity contracts, ensuring against diversion to the non-medical market from suppliers and we actively discourage the diversion of medicinal cannabis to the non-medicinal market by patients.

Non-profit incorporation guarantees a transparent and accountable model, and ensures responsibility to the patient.

Compassion Clubs and their cultivators have been providing these valuable, patient-focused health care services for over 15 years. Failing to recognize this proven model needlessly continues to jeopardize the health care of Canadians.

The BCCCS recommends that an appropriate non-profit or price-regulated production and distribution system should be developed which builds on the proven model of community-based dispensaries (i.e. compassion clubs).

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III. Cannabis as a Whole Plant Medicine

Despite the fact that Cannabis is currently one of the most studied plants in the world, how its different constituents work together is still poorly understood. Attempts to separate and synthesize its components (Marinol, Sativex, Cesamet, Nabilone), have met with mostly unsatisfactory results in practice. Many patients claim problems predicting and controlling the dose, as well reporting unpredictable side effects. Combined with the prohibitive cost of synthetic preparations, they are a less attractive option than the whole plant medicinal cannabis that has been used therapeutically for thousands of years. We believe many of the short-comings of the current program are a direct result of the attempt to fit a whole plant medicine into a pharmaceutical model. While we understand the difficulty of regulating a medicinal plant that has the legal status of a controlled substance, we suggest there is a wealth of experience regarding plant medicines that could greatly inform this endeavor.

Hash and Cannabis Oils

As with many medicines, differing individual circumstance can require different methods of ingestion. Smoking or vaporizing dried cannabis is one the most fast-acting methods of ingesting cannabis. For some who choose this method, concentrates such as hash and oils can be important, as they provide a higher concentrated dose with less combustible material.

Alternatives to Smoking

Inhalation may not be the most effective method for all, nor may it be possible for health reasons. Edibles provide an alternative ingestion method that can prove most effective for some patients, some will benefit most from topical applications, while others find the most effective relief in oral alcohol or glycerine preparations. In addition, many patients are not able to smoke in their homes, while in the hospital or treatment centres, and are unable to make their own medicinal preparations.

Prescribing Rights

In 2001, we recommended that "authorization to recommend cannabis use must not be limited to allopathic physicians. Other health care providers, such as naturopathic doctors, and doctors of traditional Chinese Medicine, are trained in the clinical application of herbal medicines and must also have the authority to recommend access to cannabis." We suggest that the current dissatisfaction both the Canadian Medical Association(CMA), and the Canadian Pharmacy Association(CPhA) have expressed in regards to these proposals stems from a comparative inexperience with natural health products in general, and with cannabis in particular. Including those experienced with plant medicines we believe will lessen the burden both the CMA and the CPhA feel is being foisted upon them.

Outdoor Cultivation

The exclusion of outdoor cultivation will directly impact those patients who claim better relief from cannabis cultivated in nature. It is also worth pointing out that outdoor cultivation is more sustainable, conserves both power and water, and provides the lowest-cost option available under the current scheme.

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Regulating cannabis in a manner consistent with other whole plant medicines would provide numerous benefits to the program

The BCCCS contends that regulations for cannabis in forms other than dried plant matter only are necessary in order to provide safe, effective medicine to all patients that require medical cannabis, and reiterates its call for prescribing rights to be granted to those most experienced with whole plant medicines.

IV. Patients' Right to Grow

The Cost Benefit Analysis of Regulatory Changes to Access for Marihuana For Medical Purposes this last December claims that 60% of program participants access cannabis through their own cultivation, and that another 20% access through designated growers. This same document claims 75% of the programs participants have "Category 1 medical conditions (i.e., severe arthritis, spinal cord injury, spinal cord disease, multiple sclerosis, cancer, AIDS/HIV, epilepsy or others)." Many of these patients have found the specific strains that are effective for them, often after much effort, time, and cost. Many may also cultivate to organic standards, which are not provided for under the proposed scheme.

Pricing-Out Patients

The Cost Benefit Analysis also estimates approximately 15% of these patients will 'opt-out' of the new program, and continue cultivating their own cannabis, which will now be criminalized. Those that stay with the program will have to find a Licensed Commercial Producer willing to supply the same strain consistently, at a vastly increased price, or access less effective strains

While Prairie Plant Systems produced cannabis is $11.00-$12.00/g, the estimated costs under the new program is expected to be around $8.80/g (not including monthly shipping and/or other fees). The cost of dispensary cannabis is estimated in the document at $10-$12/g (though regular BCCCS prices are between $7-$9.00/g, and can fall to as low as $3/g with our subsidies). The estimated cost of self-supply is $1.80/g and of designated growers is $2.80/g. The elimination of these licenses represents an unconscionable cost increase to patients, many of whom are already burdened by extensive medical expenses.

Many find that cultivating their own medicine can be an integral part of their healing process. For these patients, the loss of autonomy, and the disruption of their medicine supply represents a severe impact on their quality of life.

The BCCCS recommends that Personal Production Licenses be retained, and that a program of education and support be implemented.

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V. PATIENT FOCUS

In 2011, we recommended that Personal Production Licenses not be revoked under this scheme, noting the probability that many patients would be unwilling to give up this right. The Cost Benefit Analysis also identifies this likelihood. We suggested at that time that there should be some compensation for those program participants that had invested effort, time, and money, into cultivating their own medicine. These patients made this investment in good faith, in order to obtain their medicine at the lowest-cost option under the current regime. If the proposed scheme goes through, these patients will now be criminalized for continuing to make use of that investment they made in compliance with current regulations. The recent introduction of mandatory minimum sentences increases the impact this may have on very ill Canadians.

Low Cost Access

While the current proposals make provisions for on-site dispensing, it is through the untested model of hospitals, pharmacies, doctors and nurses. It remains to be seen how this will work with the proposed Licensed Commercial Producers(LCP). In addition, we find that the lowest-cost option under these new regulations would only be available to those who could afford to purchase a month's supply directly from the LCP, plus the shipping and insurance, and maintain a fixed address. The next lowest-cost option would be available to those who can afford a months supply from a hospital, pharmacy, doctors' offices, or nurse practioners' offices, and related fees. The less the patient can afford per purchase, the more visits they have to make, likely resulting in a greater accumulation of dispensing fees. We believe a more patient-centred approach would ensure that those that have less, aren't paying more.

On-Site Distribution

In terms of consumer protection, it remains to be seen whether or not hospitals, pharmacies, doctors or nurse practioners will be just shipping addresses where patient's medicine can be sent and stored for a period of time, or whether they will allow for visual inspection and choice prior to purchase. We have found that this helps ensure satisfaction with the product, as both visual and olfactory inspections can often be strong indicators when choosing appropriate strains. Providing for smaller purchase amounts can also be important to enable the patient to try a small amount of various strains to determine the efficacy of each. A more patient-centered approach would not create needless barriers to access, nor compromise health care choices.

Compassion Clubs provide this service, and the resulting face-to-face interaction allows patients to discuss their medical needs with those knowledgeable about the therapeutic use of cannabis, and can provide valuable referrals to social support programs and services. It also allows us to operate a wellness centre, and create a community. We believe a patient-focused program would promote a holistic model of health.

The requirements surrounding obtaining and operating an LCP are cost-prohibitive, and we feel that the large-scale commercial model proposed addresses participants as consumers first, and patients second.

The BCCCS recommends that an effective medical cannabis program would make patients concerns a high priority, and allow for compassionate access.

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VI. Additional Considerations

Decentralized Regulation
Provincial jurisdiction over health care issues should include regulating medicinal cannabis dispensaries as it regulates other health care bodies, and should cover medicinal cannabis as part of its overall coverage schemes. Many of the recurring difficulties with various incarnations of this program might have been avoided by taking this step.

Amnesty for Current Medical Cannabis Providers and Patients
While Canadian courts have found that those who are supplying, or producing medicinal cannabis are providing an essential health care service, some Canadians have still been saddled with criminal records for providing or using medicinal cannabis. To restore justice and include those most knowledgeable, medicinal cannabis users, distributors, and their suppliers must immediately be given amnesty.

The British Columbia Civil Liberties Association has expressed concern that in the current legal climate, the lack of standardized identification marking a patient as an authorized medicinal user of cannabis unfairly exposes patients to increased risk of being stopped, detained or arrested by police. The potential for confusion, unnecessary stigma and stress patients are subjected to constitute a further barrier placed on medicinal cannabis patients. As long as cannabis remains classified as a controlled substance in Canada, the lack of a clear system of identifying medical cannabis patients must be addressed.

VII. CONCLUSION

Taken together, these new regulations do show some significant improvement over the old regime, but there are still some serious concerns, and some large projected gaps in patient care. We find we must still echo the findings of the Senate Special Committee on Illegal Drugs when they said:

"The regulations made in 2001 by Health Canada, even though they are a step in the right direction, are fundamentally unsatisfactory. They do not facilitate access to therapeutic cannabis. They do not consider the experience and expertise available in compassion clubs. These regulations only govern marijuana and do not include cannabis derivatives such as hashish and cannabis oils. It is for these reasons that the Committee recommends that Health Canada amend the *Marihuana Medical Access Regulations* in order to allow compassionate access to cannabis and its derivatives."

To continue dismantling programs and experimenting with un-tested models of medicinal cannabis production and distribution on a large-scale while ignoring a proven model takes needless risks with patient care.

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We believe adopting the recommendations outlined in this document would provide a solid foundation for a functioning, effective medical cannabis system that respects the autonomy of the patient, and is part of a more holistic approach to health care.

Prepared by the staff of the BCCCS on behalf of its Members and Board of Directors,
The BC Compassion Club Society
Vancouver, BC
Coast Salish Territory
February 2013

VIII. CONTACT

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British Columbia Compassion Club Society

Response to MMAR Amendments

Vol. 138, No. 43 — Canada Gazette, Part I, October 23, 2004

November 19, 2004

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INTRODUCTION

The MMAR programme was established to remedy the unconstitutionality of the Cannabis prohibition laws, which force Canadians to choose between their liberty and their health, by providing a legal route for those who use cannabis medically. Since its inception in 2001, the programme has failed to meet that goal.

Considering that this programme has provided licenses for legal possession to only 800 Canadians, production licenses to only 500, and has supplied only 80 of the estimated 400,000 who use it medicinally, it cannot be said to be remedying the unconstitutionality of the prohibition laws. In fact, it would leave the vast majority of medical users potentially subject to increased criminal sanctions and fines under the proposed Bill C-17.

Moreover, this programme has been found unconstitutional in the courts. The latest amendments to the MMAR programme continue to evade the court ordered remedies and their responsibility to Canadians.

These amendments purportedly address the concerns of all the programme's stakeholders. Indeed, they do appear to meet the needs of law enforcement. They also address some of the concerns of physicians, although it is yet uncertain if it will be sufficient to encourage them to embrace the previously rejected role of gatekeeper. Glaringly, the needs of medical cannabis users – the primary stakeholders – continue to be unmet by these Regulations.

The BC Compassion Club has responded below to the proposed amendments with recommendations that adhere to the overarching goal of providing optimal health care to all those in need.

RESPONSE TO THE PROPOSED AMENDMENTS

The amendments that have been proposed address the needs of some of the programme's stakeholders. However a few key points require further consideration if this programme is to successfully meet the needs of medical cannabis users.

1. Elimination of the Personal Production Licenses

Health Canada's plan to fade out Personal Production and Designated Person Licenses is of no benefit to the most important stakeholders in this programme; the patients. For many, growing their own source of medicine not only allows for control over the mode of production (e.g. organic cultivation) and strain selection, but also minimizes some of the costs associated with purchasing cannabis from another party.

The MMAR must continue to allow personal production and designated person licenses, and must also implement the court remedy of allowing Designated-Person Production License holders to grow for more than one holder of an Authorization to Possess License, and more than three holders of licenses to produce and cultivate together.

2. Monopoly over Production

The amendments propose that the only legal source of medicine be produced by Prairie Plant Systems (PPS). To date, PPS has produced such a poor quality product that many of the few license holders who have ordered it have returned it.

The stated need for a standardized and quality-controlled source of marihuana can be addressed through the licensing of laboratories to carry out the appropriate tests.

International drug conventions can also be respected in regards to the requirement for a government agency to have tight control through the establishment of licensing protocols.

Establishing a monopoly over production will not address the need for a wide variety of strains, stronger product, and safer cultivation techniques. These goals would best be achieved through the contracting of a large number of small-scale producers who possess the expertise and experience necessary for this important undertaking.

The MMAR must accommodate competition in a free market in order to increase the quality, broaden the selection, and decrease the end-cost of the medicine, all of which are necessary to meet the needs of medical cannabis users.

3. Authorization to Recommend Access

The proposed amendments still require a patient in the new 'Category 2' to be assessed by a specialist, discriminating between levels of medical assessment warranted for different symptoms based on the existing state of scientific knowledge.

Considering the dearth of research due to the prohibition of Cannabis, as well as the lack of commitment to research demonstrated by Health Canada, in effect this amendment arbitrarily discriminates between Canadians equally deserving relief from their symptoms. This injustice is exacerbated since this option does not address the obstacle of waiting lists for specialists, nor the fact that specialists are more resistant to the programme than general practitioners.

This amendment demonstrates a lack of respect of the medical opinions of health care practitioners and interferes in their relationship with their patients.

Regardless of the condition in question, one recommendation from a health care practitioner must be sufficient to authorize legitimate use of Cannabis or access Health Canada's medicinal cannabis programme.

Amendments to the MMAR state "Health Canada will continue to require the opinion and support of a physician, since physicians are the professionals best positioned to assess medical need. Decisions by the courts have lent support to the continued involvement of physicians, including specialists."

The amendments reject the natural health care professionals, since "with few exceptions, controlled substances can be sold or provided to a patient only by, or under the direction of a physician, dentist or veterinarian." Cannabis must be also considered an exception, since it is a relatively harmless herb, unlike most other controlled substances.

For optimal health care, authorization to recommend access to herbs must be extended to the health care practitioners most experienced with herbal medicine, such as Naturopathic Doctors and Doctors of Traditional Chinese Medicine.

4. Natural Health Product

The amendments to the MMAR claim that "Marihuana is a drug as defined by the Food and Drugs Act and is not a natural health product as defined by the Natural Health Products Regulations."

For the purposes of those Regulations, a substance or combination of substances or a traditional medicine is not considered to be a natural health product if its sale, under the *Food and Drug Regulations*, is required to be pursuant to a prescription when it is sold other than in accordance with section C.01.043 of those Regulations.

According to these amendments, pursuant to a confirmation of diagnosis, and ministerial approval, a patient is legally licensed to access cannabis without a prescription. Therefore

according to the purposes of the Natural Health Product Regulations, cannabis could be classified as a Natural Health Product.

Cannabis must be regulated as a Natural Health Product in order to eliminate the obstacles presented for patients, doctors, and the governing bodies of the medical community that arise from attempting to regulate and administer this herb as a pharmaceutical product.

5. Pharmacy Distribution

Amendments made to physician forms appear to have been designed specifically to place cannabis in "a more traditional health care model." There is an underlying assumption that this model entails only physicians and pharmacies, and that this model is the only one that will "enhance protection of the health and safety of Canadians."

While pharmacies may provide a base level of service and facilitate access for some, this model is not sufficient to meet the needs of all medical cannabis users. Pharmacies traditionally do not have the capacity to provide the additional information and close monitoring of patients postulated in the amendments. They also will not be providing access to the variety of strains and delivery options needed to address the many symptoms of medical cannabis users.

Health Canada must recognize Compassion Clubs as the ideal compliment to the pharmacy model, allowing the needs of all medical cannabis users to be met.

ADDITIONAL REQUIRED AMMENDMENTS

The proposed amendments have failed to address some of the major concerns articulated by medical cannabis users.

1. Licensing of Compassion Clubs

The court-ordered remedies, which have been ignored in these amendments, were meant to clear the way for licensing of Compassion Clubs. In court, Health Canada stated that these clubs addressed the supply issue since they "historically provided a safe source of marihuana to those with the medical need" and that " these 'unlicensed suppliers' should continue to serve as the source of supply for those with a medical exemption." Despite their own claims, Health Canada has still not integrated Compassion Clubs into the legal framework.

For over seven years, Compassion Clubs operators have been risking arrest and criminal prosecution in order to address the pressing medicinal needs of Canada's critically and chronically ill. This vital work has been recognized by numerous Canadian courts, as well as governmental bodies such as the Senate Special Committee on Illegal Drugs. Compassion Clubs serve a clear and necessary purpose, and have the strong support of their local communities and of the Canadian public as a whole.

Compassion Clubs across Canada have garnered unique and invaluable experience supplying cannabis to over 8000 medical cannabis users, including many MMAR license holders. The BC Compassion Club Society (BCCCS) provides access not only to clean, high quality cannabis, but also provides education, monitoring, support and other natural heath care services to their members - all at no cost to the taxpayer.

Community-based distribution through Compassion Clubs could meet both the needs of medical cannabis users and the other goals articulated by the MMAR by adhering to the following standards:

- Non-profit incorporation to guarantee financial transparency and ensure responsibility to the consumer.
- A minimum level of production and distribution standards based on Good Lab Practices (GLP) and Good Agricultural Practices (GMP) guidelines.
- The exclusive use of organic cultivation practices.
- Participation in inspections to ensure standards are being met

Community-based, non-profit Compassion Clubs are an effective, affordable, sensible, and time proven way, not only to distribute medicinal cannabis, but also to provide suffering Canadians with valuable services no other model can offer.

To ensure the future success of a medical cannabis programme, Health Canada must respect Compassion Clubs as an effective distribution model that has already proven the ability to meet the needs of many medical cannabis users and save the government a significant amount of money.

2. Cost Coverage

These amendments fail to address the vital concern of cost coverage that primary stakeholders expressed directly to Health Canada during the consultation session in Ottawa in February 2003. The failure to act on this important issue will continue to force many legitimate users of medicinal cannabis into poverty.

Cost coverage must address all costs of medicine, including personal cultivation and purchases from Compassion Clubs and must not be limited to Health Canada's product, which is below quality standards for potency, variety, and safety.

Health Canada must establish affordability and reimbursement of the costs through the provincial health insurance system, private insurance companies and tax deductions for all use of cannabis for recognized medical conditions and symptoms.

3. Amnesty

Canadian courts have found that those who are using, supplying or producing medicinal cannabis are providing an essential healthcare service. Unfortunately some Canadians have received a criminal record for providing or using medicinal cannabis.

To restore justice, medicinal cannabis users, distributors and their suppliers must immediately be given amnesty.

4. Decentralization of Authorization

The Office of Medical Cannabis has spent millions of dollars operating an unnecessary bureaucracy that has produced little benefit to Canadians. Compassion Clubs, by contrast, implement high standards of eligibility and provide quality medicine to thousands of Canadians at no cost to Canadian taxpayers.

The decentralization of the Office of Cannabis Medical Access programme and the legitimization of Compassionate Clubs will not only save Health Canada precious resources, it will also address many of the concerns expressed by those who could benefit from the medical use of cannabis.

Like other natural health products and pharmaceutical medications, the lawful possession of medicinal cannabis must not require authorization from a centralized federal body, the Office of Medical Cannabis Access.

CONCLUSION

Health Canada has been put in the challenging position of balancing the needs of law enforcement, the medical establishment and medical users of cannabis.

The implementation of our recommendations is necessary to meet the needs of the hundreds of thousands of Canadians who could alleviate their chronic pain, improve their appetite and relieve their nausea, while staying productive and maintaining a level of hope and happiness despite their serious condition.

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BC Compassion Club Society

Submission of the British Columbia Compassion Club Society to Health Canada Regarding Proposed Changes to the MMAR

July 2011

2995 Commercial Drive, Vancouver, B.C., V5N 4C8

BCCCS

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Executive Summary

We welcome this opportunity to offer our response and feedback on the proposed changes to the Marihuana Medical Access Regulations. The focus of our response is on the omission of Medical Cannabis Dispensaries from the legal options available to patients under the MMAR. This omission ignores the successful operation of dispensaries for nearly 15 years and does a great disservice to the 30,000 patients across Canada who have chosen dispensaries to be their provider of medical cannabis.

The BC Compassion Club Society has been in operation since 5 years before Health Canada's program was established. In the absence of government licensing in the interim, we have collectively gone to great lengths to ensure that our practices, policies and procedures are in line with the highest standard of diligence possible. The best practices that we have developed have become the informal standard for credible dispensaries nation-wide. Together with being the oldest and largest dispensary, it is our best practices and diligence which distinguish the BC Compassion Club Society as Canada's leading Medical Cannabis Dispensary.

This submission shares many of the practices and policies of our organization developed over the past 14 years. It is offered with the hope for Health Canada to understand the model we have developed, as well as the care involved in creating and maintaining this model as a benefit to our community. We continue to see extraordinary opportunities for enhancing levels of care for the seriously and terminally ill members of our society.

In the upcoming changes to the regulations, we view a significant opportunity for Health Canada to add tremendous value to the MMAR program through the inclusion of qualified dispensaries, with an end benefit of enhanced care to patients and overall cost savings to the health care system. Towards this end, we have been a leading contributor to the establishment of the Canadian Association of Medical Cannabis Dispensaries (CAMCD), which is dedicated to facilitating the transition of Medical Cannabis Dispensaries into the legal framework. With over 85 years of collective experience in operating dispensaries on the board of directors of the Canadian Association of Medical Cannabis Dispensaries, we believe CAMCD is the appropriate body to ensure that best practices are being followed by dispensaries across the country and that patients are being served with consistent and high-quality care.

We propose that the time has come for Health Canada to include regulated and certified dispensaries as a legal option provided to patients under the MMAR. A national system of dispensaries regulated in accordance with the best practices and standards of the industry offers a historic opportunity to assist Health Canada in successfully meeting the goals of the MMAR and the needs of the patients that the program serves. We offer the particulars of our own case as an example of how the dispensary model can work with great success to benefit the seriously and terminally ill of our country.

1. The BC Compassion Club Society – An Introduction to Canada's Leading Medical Cannabis Dispensary

The BC Compassion Club Society (BCCCS), founded in 1997 and located in Vancouver, is the oldest and largest Medical Cannabis Dispensary in Canada. Our mission is to provide high quality medicinal cannabis and other natural health care services to those in need, promoting a holistic approach to healing and living. In over 14 years of operation, we have served more than 6,800 members with serious or terminal illnesses.

In complement with our Cannabis Dispensary, we have been operating an adjoining Wellness Centre since 1999. In the BCCCS Wellness Centre, we provide access to licensed practitioners in 10 natural therapies. The cost per treatment is offered to our members on a sliding scale from $5-35 based on income. As a non-profit organization, we subsidize over 88% of the actual cost of providing treatments to members on an annual basis.

As Canada's original and still largest Medical Cannabis Dispensary, we have taken seriously our responsibility to show leadership as a pioneer in this field. We have gone to extensive and meticulous lengths to develop policies and practices that ensure the safety and highest quality of care for the patients who access our services. In 2006, we co-published the "Guidelines for the Community-Based Distribution of Medical Cannabis in Canada", which remains the informal guide to best practices for dispensaries in Canada. This document replaced our earlier "Operational Standards for the Distribution of Medicinal Cannabis", which was the previous benchmark for the industry.

Our philosophy is one based on *Client-Centred Health Care*, which informs our offering of natural therapies in complement with medical cannabis. We understand medical cannabis to fit within a larger framework of holistic health care that can offer patients with serious illnesses alternatives to conventional treatments that they may have found less effective. This focus on patient care extends to our intake and education process, combined with face-to-face consultations and support, as well as additional services.

Our organization has grown to 48 staff dedicated to our mission, including 3 Registered Nurses, 2 Doctors of Traditional Chinese Medicine (TCM), as well as licensed practitioners in 10 modalities of natural health care. We have established on-going relationships with a wide range of health care agencies and providers, regularly receiving referrals of patients from them. In turn, we refer our own members to the services of these organizations when appropriate. Over the course of the year, we provide presentations and education to a variety of health care and social service organizations. We very much understand our work as being on the front lines of care for seriously and terminally ill patients. We are part of the social safety net for a vulnerable demographic, who we provide for through supportive staff, on-site counselors, as well as advocacy and referrals to other services.

We are well-established in our community and enjoy healthy relationships with both the City of Vancouver and local law enforcement. We are located across the street from a private school (K-12) as well as a kindergarten. Not only have we received no complaints during our time as neighbours, the biology class of the private school has toured our facilities several times during the course of their study of cannabinoids. We are regularly featured in articles or asked by media to comment on issues related to medical cannabis. We have hosted visits from Senators, MPs, MLAs, Mayors, city councillors, city staff, as well as doctors and health care providers of every kind.

Over the past year, we have been a leading contributor to the establishment of the Canadian Association of Medical Cannabis Dispensaries (CAMCD). One of CAMCD's mandates is to formalize the standards and regulations necessary to guarantee best practices by dispensaries across Canada through a stringent certification process. We support CAMCD in its dedication to facilitating the transition of Medical Cannabis Dispensaries into the legal framework.

For nearly 15 years now, the BC Compassion Club Society has been contributing valuable services to patients and the community. The value we have contributed to our community has been noted and welcomed by nearly all who have walked through our doors. In a variety of ways, we have been privileged to play an important or profound role in many people's lives, collecting many testimonials along the way to attest to this service.

2. Patient Care and Services

While Health Canada has proposed that the provision of medical cannabis be carried out by licensed commercial producers sending medicine to patients through the mail, patients have overwhelmingly indicated that they find many advantages from the services and resources provided by a qualified dispensary. The services we offer to patients include:

A) Patient Intake

Patient intake begins with initial registration of the application, which must be submitted via fax and stamped from the practitioner`s office. The referral is then verified, in addition to the current validity of the practitioner`s license. Each new patient is then booked for a 60-to-90 minute initial one-on-one appointment with our intake staff.

The intake session includes: a review of relevant medical history, including current use of other medications and previous use of cannabis; education on effective use of medical cannabis; development of personalized treatment plan based on individual needs; a tour of the facilities and all related services; as well as review and agreement to the patient`s rights and responsibilities as a member of the society. The intake session may also include a referral to one of the practitioners in our Wellness Centre for complementary health care. The intake session also includes identification of patients who may require specific support or monitoring, such as those with primary or secondary mental health diagnoses, in keeping with the protocols we have developed for patients with these needs.

Upon completion of the intake session, the patient is issued a photo identification card indicating that they are a member of our society and that their use of cannabis has been verified to be for medical purposes.

B) Patient Education

During their introductory appointment, education is provided to patients on the effective use of medical cannabis. This education includes supporting patients in identifying the most efficacious strains for their condition, as well as consideration of options for modes of ingestion, which include a variety of alternatives to smoking. Education on effective use includes harm reduction, focused on avoiding or minimizing side effects and recognizing inappropriate use.

While education on effective use is valuable for all patients who use medical cannabis, it is of vital importance for first-time cannabis users. Over half of our membership are aged 50 years-old

and up (*see Appendix A*). We have noted a trend where a significant portion of our new members are seniors and first-time cannabis users. Typically, they may have never considered using cannabis, but are being referred by their physician after trying many more conventional treatments. With little or no previous knowledge of medical cannabis use, these patients frequently have many questions and require further on-going support.

After the initial intake appointment, members continue to be able to access support and information from staff in a variety of ways: by phone to reception or relevant department, email, or face-to-face visit.

C) One-on-One Consultation and Support

Patients receive one-on-one consultations and on-going support in the appropriate selection of strains or products. Consultations are provided by trained staff who have an understanding of the effects of different strains and products. Detailed records of sales are kept and patients can provide information about their experience with different strains and products. This face-to-face interaction provides a human dimension to receiving personal support, where patients become recognized members of a community and experience the Compassion Club as a welcoming and supportive environment.

Consultations also provide opportunities for patients to ask questions about their use of cannabis and for staff to continue dialogue with patients about safe and effective use, as well as convey other pertinent information. It also permits additional support to be given to patients with particular needs, such as those with mental health or palliative diagnoses. Emergency appointments with counselors in our Wellness Centre are available to support members in crisis.

D) Availability of Strains & Non-Smoking Preparations

On a daily basis, we provide a range of 10-15 strains of cannabis and 3-10 products that offer an alternative to smoking. As Health Canada has recognized in its proposed changes to allow strain diversity, access to specific strains is vitally important for patients with a range of conditions and symptoms. Each strain presents a different formulation of the cannabinoid, flavonoid and terpenoid ratios that account for the range of its therapeutic effects. We provide our members choice among approximately 80 strains in total. Approximately 2/3 of our strains are organically grown. Non-smoking options include a variety of baked goods—including sugar-free and wheat-free options—as well as tinctures, cannabis-infused butter or olive oil, and vapourizer devices.

E) On-Site Purchase

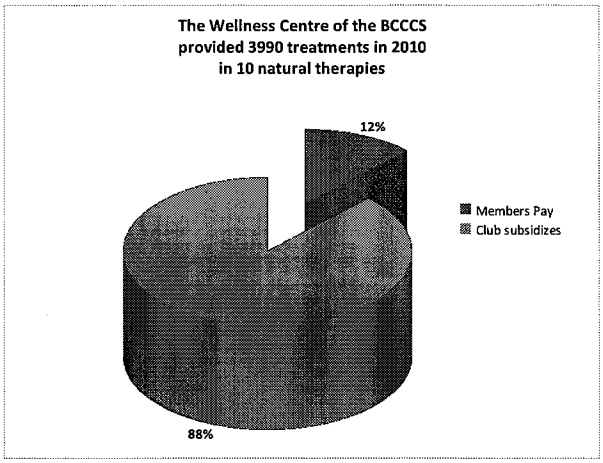
On-site purchase permits visual and olfactory inspection, which helps ensure satisfaction with the product and are often strong indicators for choosing appropriate strains. On-site purchase also permits valuable face-to-face interaction and the convenience of immediate service. On-site purchase is an essential option for patients on low or fixed incomes, who can afford only small purchases at one time and cannot afford the additional costs of secure mail or courier services. It is clear from our experience that many patients prefer to come to the dispensary in person if possible.

F) Subsidized Medicine

We maintain and subsidize a number of programs for low and fixed-income membership, providing cannabis that is donated or sold below-cost. In 2010, we provided 15,000 grams below cost through these programs, which were accessed by 1029 members.

G) Complementary Natural Health Care Services

The BC Compassion Club Society has been operating a subsidized Wellness Centre since 1999, where members can access 10 types of natural therapy--including acupuncture, clinical counseling, nutritional counseling and holistic massage--for as little as $5 per treatment. In 2010, we subsidized 88% of the actual cost of providing nearly 4,000 treatments, where members on average paid $8 per treatment while the actual cost of providing the services was $66 per treatment. These additional therapies have benefited thousands of patients for over a decade at no cost to taxpayers.



H) Referrals to other Health Care and Social Services

As we have on-going interactions with patients, we are able to make referrals for other kinds of support as the need arises. We have established relationships with a variety of health care and social service organizations. We both provide and receive appropriate referrals to and from these organizations. In this way, we act as part of the front-line social safety net for vulnerable members of the population.

I) Social Capital and Community

People with serious or chronic illnesses or disabilities are a vulnerable demographic of society. They face the physical and psychological challenges of their condition, often combined with social isolation and the poverty that may be a consequence of being removed from the job market due to their illness. We provide a community environment, where patients feel support and compassion among others who understand their situation. We offer free events and workshops through the year, including an annual winter party and summer picnic, that help build and support this feeling of community. Our quarterly newsletter informs members and supporters of the latest news from the BCCCS, as well as relevant political, legal and research news.

3. Health Care Practitioners

The BCCCS commends Health Canada for taking several important strides towards patient accessibility in their proposed changes. We strongly support the removal of the condition/symptom categories, as well as the need to seek the support of specialists, as these have been significant barriers to access for many patients. We also applaud the removal of the federal approval process to a system of authorization via physician referral. This is very much in line with current dispensary practices and we have found it an effective and efficient means of verifying valid medical need.

Over 3,400 health care practitioners have now submitted applications for their patients to access our organization's services. While the large majority of these are physicians, we also accept referrals from Doctors of Traditional Chinese Medicine and Naturopaths due to their ability to prescribe herbs in British Columbia.

While many practitioners have submitted our application forms, it is apparent that the "legal grey zone" occupied by dispensaries continues to be a barrier for a great many patients in finding support from their physicians. Many patients who come to seek our services report that their doctors are often unwilling to even consider signing any forms related to medical cannabis. It is clear that doctors require more education to feel informed in referring patients where it is appropriate.

We strongly approve of Health Canada taking responsibility to provide pertinent research and information to physicians, and for creating an expert advisory board to support this need. We admire the work of the Canadian Consortium for the Investigation of Cannabinoids (CCIC) in educating physicians on the clinical information necessary to making informed choices around recommending cannabis. The BC Compassion Club offers tours and education sessions for health care practitioners in order to facilitate their knowledge of the appropriate use of medical cannabis. We offer ourselves as a valuable resource to Health Canada to support physician education in this regard.

4. Safety Practices

The BCCCS addresses issues of safety through a variety of practices:

A) Safety and Quality Of Medicine

The primary way we ensure safety and quality of medicine is through the experience and expertise of our cultivators. One-third of our cultivators have 10 or more years of experience in growing cannabis. Our most senior cultivator has 30 years of experience. 70% of our strains are organically-grown, which is a more expensive growing method with a smaller yield than chemical processes. Even those which are not fully organic use only natural predators and natural pesticides.

Each batch is inspected tactilely and visually for molds, mildews and fungus by knowledgeable staff. Each strain we carry is lab-tested bi-annually for microbiological contaminants. We wish to obtain services for more comprehensive testing, including heavy metals, but this has been a barrier due to legality. We follow procedures for Batch Tracking, Handling & Storage to minimize risk of contamination and permit identification of problematic material. All of our baked goods are *FoodSafe*-certified and our tinctures made by clinical herbalists.

B) Patient Safety

The Compassion Club endeavours to provide an environment which is safe, friendly, supportive, and secure. Members and staff are expected to act in accordance with this purpose.

Each member is issued a photo identification card upon registration which must be renewed annually. The member card is the property of the Society and must be surrendered to the Society when the card expires. Members are encouraged to keep this card with them whenever they have cannabis or cannabis products in their possession. The BCCCS also maintains thorough records of each member through a Point-of-Sale System (POS). The POS system allows for us to verify identity for every interaction, track patient sales and history, enforce purchase limits, as well as communicate any other pertinent information.

All patients who become members agree and sign a written contract to their 'Member Rights & Responsibilities'. The Member Rights and Responsibilities include expectations of conduct, as well as consequences for violations and courses of appeal. We have a conflict resolution committee

composed of staff to help resolve member-related conflicts. The conflict resolution committee investigates incident reports, relays consequences for breaches of the Member Rights and Responsibilities, or may attempt informal resolution of conflicts. In addition, we have a conflict resolution panel, composed of an elected committee of members, to hear appeals.

The one-to-one support provided in our dispensary also increases patient safety. As staff get to know our membership, they are in a position to refer members in crisis to appropriate agencies of support or provide our Wellness Centre clinical counselors for emergency counseling. Patient Safety also extends to education on the safe use of cannabis, which includes recognizing inappropriate use and avoiding or minimizing adverse effects. Members education also include basic safety practices such as not driving while medicated and not smoking in public.

C) Cultivator Safety

All of our cultivators are chosen after a lengthy interview process conducted by staff with expertise in cultivation. Contracts are made only with knowledgeable cultivators, which decreases the likelihood of accident, mishandling or improper technique. Cultivators sign contracts to provide exclusively to us to help ensure that there are no ties to organized crime. All growing methods used by our cultivators are vetted and approved. Cultivators agree to inspection on 48 hours notice. *(See Appendix E for more information on our cultivators)*

D) Dispensary Safety

The BCCCS takes all typical safety precautions necessary for our type of operation, including alarm systems, safes and cameras. In over 14 years of operation, we have had no major theft or robbery, despite being located in a densely-populated residential area. We attribute this in part to the support we enjoy in the community and the immediate neighbourhood.

E) Community Safety & Relations

As part of ensuring community safety and continued support, we educate members about expected conduct in the neighbourhood, which includes not smoking in public. We enjoy open communication with the City of Vancouver, local law enforcement, and our immediate neighbours, including a private school. We are invited to offer education and provide information at events in the community throughout the year. Awards we have received include the Roger Inman award for community development, a certificate of recognition from our MP Libby Davies, and a $25,000 infrastructure development grant from Vancity Credit Union in 2006.

5. Cost Savings

To date, we have served over 6,800 patients providing them with medical cannabis at no cost to the taxpayer. We have been an operating a Wellness Centre for over a decade that provided nearly 4,000 treatments by licensed practitioners in 2010. The BC Compassion Club subsidizes approximately 88% of the cost of providing treatments in our Wellness Centre, which is also at no cost to the taxpayer. In this way, we contribute hundreds of thousands of dollars annually in natural health care benefits directly to patients and have been doing so for over 12 years.

These treatments often complement or replace more conventional treatments, also reducing health care costs carried by government and taxpayers. Many of our practitioners support preventative modes of health and well-being. For example, our nutritionist is able to help patients maintain

optimal health, support recovery and prevent further disease—especially important for those on low incomes who cannot afford a nutritionist's typical rates. Clinical herbalists are able to prescribe and compound natural remedies, which may help patients reduce or replace their use of pharmaceutical drugs. Education in harm reduction also represents cost savings in the harm it prevents.

As a front-line organization that is an unofficial part of the social safety net, our ability to make appropriate referrals to support agencies helps reduce the burden on other government services. We employ a staff of 48 and pay all taxes typical of a non-profit society, contributing to the tax base of Canada.

6. Research

The BC Compassion Club Society holds the following stance regarding Research and Knowledge Sharing: "The BCCCS actively engages in research with the purpose of improving the health of our members and the diverse communities we serve and support. The types of research we engage in adhere to the BCCCS Ethical Guidelines and Standards for research. We initiate and participate in research to increase the body of knowledge about cannabis and other natural medicines, and to create new knowledge that can improve access to whole plant medicines and other natural remedies."

The BC Compassion Club Society employs a part-time Research Coordinator, who is also a registered nurse, to facilitate our participation in research and development of our research studies and collaborations. We see significant opportunities to increase our role in contributing to the further understanding of medical cannabis and other natural therapies, due in large part to our membership which is comprised of patients across many conditions. *(See Appendix A: Member Demographics By Condition)* Many members have indicated their willingness to participate in research based on the relationships of trust and respect that we have built and maintained with them.

Recently completed research collaborations include:

"Effects Of Evidence Service On Community Based AIDS Service Organizations Use Of Research Evidence: A Randomized Controlled Trial." (2010, Project Investigator together with the Ontario HIV Treatment Network)

"Same Sex Relationship Abuse and Its Effects on HIV/AIDS" (2010, Primary Investigator with Healing Our Spirit BC Aboriginal AIDS Society.)

In 2010, we submitted an application for a Community-Based Research grant from the Canadian Institutes of Health Research (CIHR), as Principal Investigator in partnership with Co-Investigators Thomas Kerr, PhD, of the BC Centre for Excellence in HIV/AIDS and Lynda Balneaves, Associate Professor at the UBC School of Nursing. Our proposal "Evaluating Medicinal Cannabis in the HIV/AIDS Community: Examining access, barriers and facilitators of Medicinal Cannabis for people who live with HIV/AIDS" also included 7 collaborating agencies comprised of community-based organizations who serve patients with HIV/AIDS, including the BC Persons With AIDS Society, AIDS Vancouver Island and Positive Women Network. The proposal received support letters from Vancouver and Victoria city councillors, 2 provincial MLAs & a federal MP, researchers from Harvard Medical School and McGill

University, as well as organizations such as the Canadian AIDS Society, Donald King Senior Centre and BC Civil Liberties Association. Our proposal ranked 6th out of all the applications received by CIHR, where 4 proposals received funding. We plan to resubmit this grant application with CIHR's recommended changes this fall.

The BC Compassion Club website at www.thecompassionclub.org also features a BCCCS members log-in area, where patients are able to offer condition-specific feedback on all strains, non-smoking products and Wellness Centre services available at the BCCCS. This is part of an effort to create a database of feedback specific to different conditions. Members with user accounts are then able to search the database for feedback or ratings on strains, services or products provided by other members sharing the same condition. The members area of our website also features condition-specific forums, where patients are able to share resources, experiences and information with other members sharing the same condition.

Conclusion & Recommendations

The BC Compassion Club Society has been Canada's leader in the development of best practices for the dispensary model of providing medical cannabis to patients. Dispensaries provide valuable services that meet patient needs and can support the goals of the MMAR. Regulations should allow for the provision of these services so that they may enhance care for patients and offer vital support in the effective use of medical cannabis. These services should be available for access without fear of legal repercussions.

The establishment of the Canadian Association of Medical Cannabis Dispensaries represents the creation of an independent national regulatory body that is capable of ensuring best practices and standards for the industry are being met by dispensaries which submit to its certification process. Certification of dispensaries which meet these standards will help patients, health care professionals, law enforcement, and the community-at-large distinguish credible dispensaries.

Inclusion of certified dispensaries into the MMAR as a legal option will contribute immensely to resolving the constitutional access issues which have been hounding the program. It offers a tremendous opportunity to enhance the MMAR program at no cost to the government or taxpayer. It would permit the successful functioning of an essentially private option that does not require government subsidization. It is a private option that is composed of primarily non-profit, community-based social enterprises, which turn their profits into social capital that benefits and provides vital support to seriously and terminally ill patients. The further integration of Medical Cannabis Dispensaries with existing health care and social service agency networks will create an end result of increased access for patients together with enhanced service and care, while at the same time generating significant overall savings for the health care system.

The BC Compassion Club Society recommends the inclusion of certified Medical Cannabis Dispensaries as legal providers of medical cannabis for patients under the Marihuana Medical Access Regulations.

Additional Recommendations

1) The removal of personal and designated production licenses deprives patients of what may be the only or most cost-effective means of securing their medicine. We believe that the removal of the personal production option will likely result in continuing issues related to access, as we forsee many patients unwilling to give up this right. The question also arises as to whether patients with existing gardens will be compensated for their investments. Rather than removal of personal production licenses, we support addressing associated safety issues through education, guidance and appropriate regulations by municipal bodies.

2) We support coverage of costs to patients for medical cannabis in federal, provincial/territorial and private drug benefit programs. Cannabis is a medicine which has proven its value to many thousands of patients across Canada and it should be included in cost coverage to ensure that affordability is not a barrier to access for the patients who require it. In addition, the physician's fee for submitting applications to the MMAR or Medical Cannabis Dispensaries is also a barrier for many patients and should likewise be included in cost coverage plans.

3) Many questions remain unanswered regarding the criteria and nature of the licensed commercial producers proposed by Health Canada to provide medical cannabis to patients. We would like to examine and consider further information regarding the criteria, selection process and regulation of these producers and offer our feedback and recommendations to ensure that patients are being served in the most effective manner.

4) Our opinion is that the name of the legal regulations itself should reflect the clinical name for the medicine in question, namely Cannabis. Continued usage of the outdated colloquial slang term, "Marihuana" is both inaccurate and a source of confusion for most people.

We thank you greatly for your attention and serious consideration of the matters we have raised.

Prepared by Jeet-Kei Leung, Communications Coordinator
on behalf of the BC Compassion Club Society

Vancouver, B.C.
July 31, 2011

BC Compassion Club Society

Member demographics by condition

Ameliorate Side Effects of Primary Treatment	**2251**	**44.09%**
AIDS/HIV	1013	19.84%
Hepatitis C (and B)	602	11.79%
Cancer	589	11.54%
Chemotherapy/Radiation Therapy	47	0.92%
Chronic Pain Conditions	**2357**	**46.17%**
Chronic Pain	1143	22.39%
Arthritis	512	10.03%
Fibromyalgia	322	6.31%
Migraines	306	5.99%
Paraplegia/Quadriplegia	74	1.45%
Sleep Disorders	**2150**	**42.12%**
Sleep Disorders	2150	42.12%
Neurological Conditions	**514**	**10.06%**
Multiple Sclerosis	254	4.98%
Seizure Disorders	100	1.96%
Brain / Head Injury	88	1.72%
Epilepsy	51	1.00%
Parkinson's Disease	21	0.41%
Bowel Disorders	**313**	**6.13%**
Irritable Bowel Syndrome	168	3.29%
Crohn's Disease	95	1.86%
Colitis	50	0.98%
Mental Health	**2351**	**46.05%**
Depression	848	16.61%
Anxiety /panic	815	15.96%
Calming	410	8.03%
ADHD & ADD	135	2.64%
Bipolar	98	1.92%
Phobia	21	0.41%
Obsessive-Compulsive	18	0.35%
Psychosis	6	0.12%
Other Conditions	**563**	**11.02%**
Diabetes	160	3.13%
Anorexia	129	2.53%
Asthma	109	2.14%
Substance Addiction and Withdrawal	93	1.82%
Glaucoma	62	1.21%
Muscular Dystrophy	8	0.16%
Alzheimer's	2	0.04%

AGE DEMOGRAPHICS:

under 18	0	0.00%
18 - 24	39	0.99%
25 - 34	423	10.74%
35 - 49	1502	38.15%
50 - 64	1650	41.91%
65 +	323	8.20%

GENDER:

male	3353	65.02%
female	1785	34.61%
trans	19	0.37%

*1476 don't report date of birth
138 invalid dates
Total numbers are out of 4036

PRIMARY SYMPTOM MANAGEMENT

General Pain Relief	2980	58.37%
Nausea	1339	26.23%

(As of December 9, 2009 from 5105 members reporting conditions (includes reporting of multiple conditions)

2995 Commercial Drive, Vancouver, BC V5N 4C8

BC Compassion Club Society

Wellness Centre

The Wellness Centre is the other half of the BCCCS where members may access an array of natural health care services as a complement or preference to allopathic medicine. Operating since 1999, our Wellness Centre is one of the most important ways we serve our membership and create our model of non-profit community-based health care.

Currently, treatment from our licensed practitioners is available in the following modalities: acupuncture, counselling, nutrition, herbal medicine, reiki, craniosacral and massage therapy, and yoga. Please inquire about expected wait list times.

Typically these services can be expensive to access since they are not covered under provincial health care plans (acupuncture has recently been included). Part of our non-profit model for over a decade has been to use revenue from cannabis sales to subsidize greater access to affordable natural healthcare.

At the Wellness Centre, members access treatments on a sliding scale of $5-$30 per visit. Our members can also purchase vitamins, nutritional supplements, as well as herbal teas and formulas produced from organic and wild-crafted herbs, at a reduced cost.

In 2008, the BCCCS subsidized 89% of the actual cost of providing 2,524 treatments in the Wellness Centre.

Wellness Centre:

- Since 1999, offered to members on $5-30 Sliding Scale
- Holistic, complementary—natural health & cannabis
- Client-Centred Care: 10 modalities
- Acupuncture
- Clinical Counseling
- Nutritional Counseling
- Homeopathy
- Clinical Herbal Medicine
- Craniosacral Therapy
- Reiki
- Holistic Massage
- Yoga
- Infrared Sauna
- Providing Subsidized Natural Health Care at no cost to the taxpayer for over a decade
- Model for subsidizing natural health care

2995 Commercial Drive, Vancouver, BC V5N 4C8

BC Compassion Club Society

Constitution Of The BC Compassion Club Society

1. The name of the society is the British Columbia Compassion Club Society.
2. The purposes of the society are:
   (a) To operate a non profit entity to facilitate the transition of the market for cannabis and cannabis products for medical purposes from an illicit one to a licit one, to ensure cannabis for medicinal use is accessible in a manner that is consistent with the highest standard of care, including but not limited to ensuring access to a wide variety of strains, methods of delivery and models of distribution;
   (b) To ensure the availability of a supply of cannabis and cannabis products for medical purposes only that meets appropriate quality standards regarding unadulteration, sanitation and other requirements;
   (c) To provide a safe, friendly, supportive and secure environment for clients, herein synonymous with members, to receive cannabis for medical purposes only and on prescription, written authorization or confirmation of diagnosis from an appropriately licensed health care practitioner; or through self-prescription when appropriate;
   (d) To educate physicians, patients, politicians and the general public about the beneficial medical uses of cannabis and cannabis products;
   (e) To raise funds and accept donations to encourage and facilitate research into all aspects of the medicinal use of cannabis of interest to those who use cannabis for medicinal purposes, excluding research that involves animal testing and the facilitation of the production of pharmaceutical products or patenting of life forms;
   (f) To provide information to legislators and policy-makers to enable them to regulate the production, distribution, use and possession of cannabis and cannabis products in a manner that is consistent with the highest standard of care, including but not limited to ensuring access to a wide variety of strains, methods of delivery and models of distribution;
   (g) To provide access to and information regarding natural therapies;
   (h) To participate in the approval, control and regulation of distributors and producers of cannabis and cannabis products for medicinal purposes, to ensure cannabis is accessible in a manner that is consistent with the highest standard of care, including but not limited to ensuring access to a wide variety of strains, methods of delivery and models of distribution;
   (i) To provide for the lawful possession of cannabis and cannabis products for clients upon prescription, written authorization or confirmation of diagnosis from the appropriately licensed health care provider or pursuant to any subsequent relevant legislation.
   (j) To operate with and to serve as a working model of alternatives and solutions, which includes the utilization of consensus decision-making.
3. No member of the society or of the board of directors, in that capacity, shall request or receive from any member of the staff of the society, or in any other way obtain any information which would reveal the identity of the clients of the society.
4. The purpose of the society shall be carried out without purpose of gain for its members and any profits or other accretions to the society shall be used for promoting its purposes.
5. On the winding up or dissolution of the society, funds or assets remaining after all debts have been paid shall be transferred to a charitable institution in British Columbia or elsewhere in Canada with purposes similar to those of this society, or, if this cannot be done, to another charitable institution recognized by Revenue Canada as qualified under the provisions of the Income Tax Act of Canada.
6. Notwithstanding clause two of this constitution, all purposes shall be organised and operated exclusively on a non-profit basis.
7. No director or officer shall be remunerated for being or acting as a director or officer, but a director or officer may be reimbursed for all expenses necessarily and reasonably incurred by him or her while engaged in the affairs of the society.
8. No part of the income of the society shall be payable or otherwise available for the personal benefit of any proprietor, member, director, officer or shareholder.
9. Paragraphs 3, 4, 5, 6, 7, 8, and 9 of this constitution are unalterable in accordance with the Society Act.

BC Compassion Club Society

Mission, Vision, Values

Mission

Our mission is to provide high quality medicinal cannabis and other natural health care services, promoting a holistic approach to healing and living.

Vision

We envision a world in which Cannabis and other natural therapies are readily accessible and socially supported. They will be legally protected and regulated in a manner that is consistent with the highest standard of care. Those who use, produce and distribute these medicines will be free from legal, social and political sanctions. We will each take responsibility for our individual, collective and environmental health while honouring the diversity in each other and in the natural world.

Core Values

The work we do at the BC Compassion Club Society and the services we provide are a reflection of these core values:

- Compassion.
  Compassion has called us to engage in civil disobedience because the current laws fail to make medicinal marijuana available for those in need. Cannabis is an important therapeutic plant that must be readily accessible. Cannabis provides effective relief for persons living with critical and chronic illnesses. Cannabis is also an effective harm reduction tool.

- Diversity.
  The diversity of humans, plants and animals is a vital component of health. We honour the diversity in each other and in the natural world. Diversity is embodied by our staff, board, and members. The diversity in cannabis and other plants is the key to their efficacy. We provide and advocate for access to a wide variety of cannabis strains, methods of delivery and models of distribution. We do not engage in research that involves animal testing, nor would lead to patenting of life forms.

- Empowerment.
  The individual is the primary authority when it comes to making personal healthcare decisions, including the decision to use Cannabis medicinally. The individual must also have the right to produce their own medicine and access it in a manner that best meets their needs. Empowerment encourages the individual to take control of his or her own healing.

- Natural Health Care.
  Natural therapies are an effective alternative or compliment to allopathic medicine. Natural therapies must be available to everyone who would choose to make them part of a healthy lifestyle--not just to those who can afford them.

- Alternative Solutions.
  We provide Cannabis and other natural therapies because they are important alternatives to some of the potentially harmful tools of allopathic medicine. We utilize consensus decision-making as an alternative to hierarchical structures because consensus empowers the individual and the community. We serve as a working model of these alternative solutions.

2995 Commercial Drive, Vancouver, BC V5N 4C8

BC Compassion Club Society

About our cultivators

The cultivators for the BCCCS are not your typical cannabis growers. They are motivated to relieve suffering, not by profit. They are compassionate members of our community working diligently to produce high quality medicine. They do so on a clandestine basis because of the gray area in relation to the law surrounding the production of cannabis for medical purposes for a Compassion Club.

The cultivators for the BCCCS :

- Are driven by the motivation to help patients in serious medical need
- Earn significantly less then market value, approximately 25% less
- Donate significant amounts of cannabis for those living in dire poverty, particularly in the holiday season.
- Engage in a contractual agreement to provide exclusively to us, they are small scale, independent and not involved with any organized crime groups
- Are experienced in growing high quality cannabis

The medical cannabis they produce for us is different from standard "street cannabis":

- Stringent cultivation standards are upheld. Each strain we carry is lab-tested bi-annually for microbiological contaminants to ensure safety for those with compromised immune systems.
- 80% of our strains are organically grown, which is a more expensive growing method with a smaller yield than chemical processes

Each producer specializes in one or two "strains", allowing us to provide specific medicines for specific symptoms.

- While THC is acknowledged to be the most active ingredient in cannabis, THC on its own has many uncomfortable side effects and it is clear that the ratios of the other cannabinoids as well as other constituents, such as the terpenoids and flavonoids, play an important role in modulating therapeutic function and efficacy.
- Each strain presents a different formulation of the cannabinoid ratios that allows us to predict its general therapeutic effects and thus meet the range of symptoms and needs of our membership.
- Our cultivators provide approximately 80 strains in total, giving our members choice they need to medicate effectively. Many became breeders in order to create a particular strain with specific symptom relieving effects. When we lose the cultivator of a strain, we risk losing the very strain they have maintained.

BC Compassion Club Society

Court Rulings

During the past decade many court rulings have recognized the importance, legitimacy and necessity of medical cannabis cultivators and distributors.

- Medical cannabis dispensaries should be licensed by Health Canada.
- Distributers of medical cannabis are meeting a medical need where Health Canada has failed to do so.
- Producers of medical cannabis should not be criminally prosecuted.
- BC Compassion Club Society is akin to a neighbourhood pharmacy providing medical services.

Hitzig vs. Canada

(2003), 177 CCC (3d) 449 (ONT C.A.)

The Courts cleared the way for Health Canada to license medical cannabis dispensaries, as they themselves testified that although the federal regulations are not meeting the medical need for cannabis, there is no supply issue as unlicensed suppliers, (the Compassion Club) should continue to serve as the source of supply.

[174] "A central component of the Government's case is that there is an established part of the black market, which has historically provided a safe source of marihuana to those with the medical need for it, and that there is therefore no supply issue. The Government says that these "unlicensed suppliers" should continue to serve as the source of supply for those with a medical exemption. Since our remedy in effect simply clears the way for a licensing of these suppliers, the Government cannot be heard to argue that our remedy is unworkable."

Regina vs. Lucas

(July 5, 2002), No. 113701C, Victoria Registry (B.C.P.C.);

The Court recognizes those distributing medical cannabis are ameliorating the suffering of others and provide that which the Government was unable to provide, a safe and high quality supply of marijuana to those needing it for medicinal purposes.

[49] "I find that while there is no doubt that Mr. Lucas offended against the law by providing marijuana to others, his actions were intended to ameliorate the suffering of others. His conduct did ameliorate the suffering of others. By this Courts analysis, Mr. Lucas enhanced other peoples lives at minimal or no risk to society, although he did it outside any legal framework. He provided that which the Government was unable to provide a safe and high quality supply of marijuana to those needing it for medicinal purposes. He did this openly, and with reasonable safeguards. The fact that he has stated he will continue this activity points to the sincerity of his principles, and points to our need as a society to get this thorny issue resolved quickly by either Parliament or the Supreme Court of Canada. If he re-offends, he will have to argue his case again, and may find a discharge difficult to attain in the future. This court hopes that cooler heads will prevail pending the final resolution of issues regarding the medical and nonmedical use of marijuana."

Regina vs. Small

(February 9, 2001) [2001] B.C.J. No. 248 (BCCA);

The Court heard evidence that the Vancouver Police are aware of the BCCCS's activities, but due to the stringent protocols developed and abided by, they are a low priority.

[7] "There was also evidence to the effect that, at least in Vancouver, the police are essentially 'turning a blind eye' to the activities of the Compassion Club as long as they remain satisfied that the drug is being sold strictly for medicinal purposes. A spokesperson for the Police

Department is quoted as saying that " if the Club abides by certain rules and regulations, they are not a priority for us. We are very much aware of the organization and what is going on there.""

Regina vs. Slykerman March 1, 2000

(March 1, 2000), No. 102370-01-T, Vancouver (B.C.P.C.);

The Court recognizes the BCCCS has a difficult problem obtaining medical cannabis and it can not be done legally, but the producers should not be criminally prosecuted.

[4] "It's acknowledged by Mr. Slykerman that he knew, of course, that he was breaking the law by undertaking this venture. That, in it's self, of course, does not excuse his behaviour, but it explains why it is essentially that he was doing what he was doing. The Compassion Club, in attempting to assist its members, obviously is faced with a difficult problem in obtaining marihuana which is to be used for medicinal purposes, and of course as things presently stand, and certainly as they stood in July of 1998, any obtaining of marihuana would not be able to be done essentially in any lawful fashion if done in Canada. I am satisfied that it is not necessary for me to pass a sentence on Mr. Slykerman today."

Regina vs. Richardson

(January 26, 2000), No.33558, North Vancouver Registry (B.C.P.C.);

The courts found the BC Compassion Club Society is akin to a neighborhood pharmacy providing medical services; their patients and suppliers exempt from the prohibition against marihuana.

"Some patients will have to secure their medicinal marihuana from some kind of retail outlet. Those in need of other drugs, the possession of which for recreational purposes is prohibited, may get those from their neighborhood pharmacy. The pharmacy in this case, known to and tolerated by the police, is the Compassion Club Society. Marihuana will not fall into its hands as manna from heaven. It must be obtained either directly from growers, as is now the case, or through a middleman, such as Mr. Richardson, as was the case in November of 1998."

In the Media

B.C. Compassion Club provides more than pot

By Matthew Burrows,
February 4, 2010
Georgia Straight

Jeet-Kei Leung admits that the B.C. Compassion Club Society is better known for the "medicinal-marijuana side of things" than for its adjoining Wellness Centre, which provides a number of subsidized treatment services on a sliding scale.

"It's been part of our core mission and part of our nonprofit model, which has been to use the revenue from our cannabis sales to create this affordable natural health care and to make it accessible to our members," Leung, communications coordinator for the Commercial Drive–based society, told the Georgia Straight by phone. "We've been doing that for over a decade, so it's something to be really proud of, I think. Over that decade, we've served over 5,000 members with serious or terminal illnesses. There have been a lot of benefits that have come through the additional therapies that have been offered on the wellness side."

The society generates approximately $3 million annually, Leung said. In 2008, he said, BCCCS subsidized 89 percent of a total of 2,524 treatments. He said there are 46 staff in total at the two addresses, with about half working full-time and half working a day or more a week. They provide herbs, massage, nutritional advice, reiki treatments, clinical counselling, craniosacral therapy, and, more recently, yoga.

"We can all see the problematic aspects of the allopathic side of things," Leung said of traditional medicine. "People want to find remedies that have less impacts on their bodies and that are more in line with its natural processes."

The sliding scale for treatments ranges from $5 to $30, according to 34-year-old Meredith Burney, who has been a clinical herbalist at the society for almost 10 years. Her products are not covered under provincial health plans.

"We won't turn anyone away, so if they are having difficulty accessing the services because they can't even afford that $5, then we have a bit of a process, but we will [waive it], if we agree," Burney said by phone. "As a herbalist, when I see a client I am generally recommending supplements, herbal teas, herbal tinctures, and things like that. And again, most of our members are impoverished and they can't afford it. So we will part-donate or completely donate, depending on their situation, those products to them."

In a notable case in her early days there, Burney may have saved the life of one woman who had hepatitis C. Doctors had said that her viral load indicated she would die without interferon treatments, which the woman was against taking.

"She came to see me and she had ceased drinking, which was a huge, huge piece of it," Burney said. "Then she went on a herbal tea, and her viral load dropped to almost nothing. She no longer was being pressured by her medical practitioners to go on treatment. So she was pretty pleased."

Burney recently saw the woman in a store and said she was "doing all right".

"But her life is hard," Burney said. "She was one of my first clients here. It's nice to have known her now for almost 10 years and...to see her kids grow up."

Asked about her take on prescription drugs, Burney said everything has its place but that she is a "herbs first" person. "It is a symptomatic release," she noted of the cannabis dispensed next door.

"We want to look at the cause for what's going on with them," she said of the medicinal-marijuana users. "That can be physical, emotional, and so we want to look at the same person. Not everyone decides they want to do natural therapies, and we're very much client-centred. So we want to help each person to heal themselves. We're just agents in trying to make that happen."

The downside to helping so many people so cheaply is the waiting lists, Burney said. It takes more than a year to see a herbalist like her, she added.

In the Media

California vote on marijuana legalization could make waves in B.C., compassion club says

By Carlito Pablo, August 11, 2010
Georgia Straight

Jeet-Kei Leung has high hopes about a statewide vote to be held in California on November 2.

That's when residents of the Golden State decide whether or not they want to legalize recreational marijuana use.

Leung's interest in this matter shouldn't be surprising. He's the spokesperson for the Vancouver-based B.C. Compassion Club, which is the oldest and biggest of its kind in Canada.

According to him, the California referendum holds a lot of promise.

"If the whole context changes with California being the first to adopt a legalization stance on marijuana, then definitely we could see a lot of social ripples that would hit here soon enough," Leung told the Straight in a phone interview on August 10.

Known as Proposition 19, the proposal formally called the Regulate, Control and Tax Cannabis Act seeks to allow persons over 21 years of age to possess one ounce (28 grams) of marijuana for personal use.

If passed, the law will also allow Californians to cultivate 25 square feet of marijuana plants in their gardens.

"We would that see marijuana is something that can easily integrated and managed within society," Leung said. "And I think that would certainly make the arguments for the continued prohibition more hollow than they are now."

Leung doesn't see Canadian compassion clubs being affected by the legalization of marijuana in California.

There are suggestions that legalization will encourage marijuana tourism, drawing clients from outside the state.

Leung has also heard about speculation that even B.C.'s own marijuana grow industry might be adversely impacted.

But what's more important for Leung at this time is that California has an historic opportunity to effect a sea change regarding cannabis use.

BC Compassion Club Society

In the Media

A step ahead of the law, "Compassion Club" sells marijuana to patients referred by MDs

By Heather Kent
CMAJ • October 19, 1999; 161 (8)

When Hilary Black, founder of Vancouver's Compassion Club Society, worked at a hemp-product retail store a few years ago, customers with AIDS, cancer and multiple sclerosis frequently asked about finding marijuana to help relieve their pain. Convinced that there was a need for medicinal marijuana, Black went to Holland and California to learn how buyers' clubs for cannabis operated in those places. In May 1997 she opened an office and began supplying medicinal marijuana herself.

"By the end of the summer I had 100 members, with prescriptions from their doctors," she says. Initially, rental space for the operation was hard to find, but a year ago the club, a registered provincial charity, moved to its present location in East Vancouver.

The club now has 700 members, ranging in age from 18 to 92, who have been referred by about 100 doctors. Three-quarters of the members have AIDS, around 15% have multiple sclerosis or experience chronic pain, and the remainder are cancer patients. Some of the AIDS patients are newly diagnosed, while others have had the disease for 13 years. New members attend a registration session, during which they sign a contract promising not to redistribute the marijuana. They pay $15 a year for the club's services, which include a wellness centre with counsellors and herbalists, and treatments such as acupuncture and yoga. A 30% markup on the cost of the cannabis covers the club's expenses. The marijuana costs between $5-$10 per gram, with each gram providing enough of the drug to make 4 joints.

Who refers patients to the club? "It is mostly oncologists and HIV/AIDS specialists who are willing to write the recommendations," says Black. "I suppose that is where the benefits of [medicinal marijuana] are the most well known, so they probably face the least amount of criticism from their peers."

The club gives prospective members a package of information for their doctors, which includes a referral form, academic papers supporting the medical use of marijuana and a copy of a letter to Black from the club's lawyer, which details his opinion that prescribing medicinal marijuana is lawful. The club uses between 10 and 15 suppliers; only a day's supply is kept on the premises.

How hard was it for the first members to obtain prescriptions? "For some it was very hard," says Black. "Doctors have a way of putting their words together very care-fully. Rather than saying, 'I prescribe cannabis for my patient,' they might say, 'John Smith is HIV positive and he tells me that cannabis helps relieve his symptoms,' or 'my patient would like access to the services at the Compassion Club.' Other doctors are more direct: 'My patient needs medicinal marijuana.'"

Dr. Morris Van Andel, deputy registrar of the College of Physicians and Surgeons of British Columbia, advises doctors to write a "confirmation" of a patient's medical condition, which suggests that the condition may be improved by marijuana, rather than an illegal prescription. "If I were a [practising] doctor, I would say, 'I am writing to confirm that Mr. Smith is HIV positive and that he has indicated that his chronic pain is helped by marijuana and therefore should such a substance be available to him, that on the basis of my knowledge of him, he should be eligible for that type of help.' Whether the Compassion Club has a way of making this substance available to that person is a decision between the patient and them. But that's quite different from the physician saying, 'Please give this patient marijuana.'"

Black says doctors like the Compassion Club because it offers recovering drug addicts a refuge from street dealers. "This is a safe place where they are not going to be asked if they want other drugs."

What do the police think of the Compassion Club? "It has not been one of our priorities, in terms of our drug investigations," says Constable Anne Drennan of the Vancouver Police. "There are some things we won't tolerate, such as when it becomes evident that the drug being sold is not strictly for medicinal purposes, but if the club abides by certain rules and regulations, they are not a priority for us. We are very much aware of the organization and what is going on there."

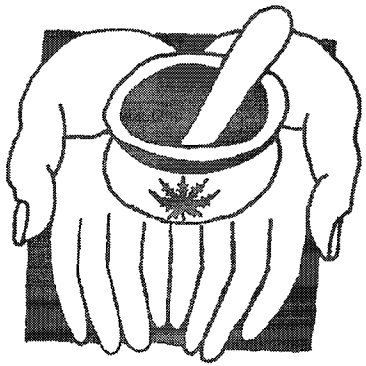
British Columbia Compassion Club Society

Response to Health Canada's Proposed Medical Marijuana Access Regulations

Published in the Canada Gazette, Part I, April 7th, 2001

Medicinal Cannabis Cultivation Recommendations and Information

Dated: May 4th, 2001



British Columbia Compassion Club Society

Response to Health Canada's Prosposed Medical Marijuana Access Regulations

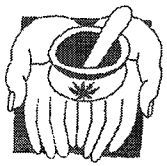
Dated: May 4th, 2001

Introduction

The British Columbia Compassion Club Society (BCCCS) greatly values this opportunity to offer input into the future regulations of medicinal cannabis. In our four years of experience with the practical application of medicinal cannabis distribution, we have gathered much information regarding all aspects of cannabis. We are pleased to share our experience and knowledge toward the creation of a compassionate and rational regulatory framework.

We support and echo the recommendations of The Vancouver Island Compassion Society. This document will go beyond critiquing the draft regulations. Our recommendations are based on a consideration of the fundamental premises and goals of the proposed regulations.

The BCCCS recognizes that many facets of society and branches of government will need to be involved in the legal transition of medicinal cannabis and have taken this into consideration in the development of these recommendations.



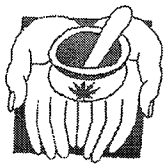
Recommendations

Medicinal cannabis should be accessible and available in a similar manner to other medicinal herbs. Cannabis is a non-toxic and highly effective medicinal herb that can be safely self-prescribed, and its dosage safely self-titrated. Cannabis does not require the same precautions that other potentially toxic and harmful pharmaceutical medications require.

The draft regulations propose to highly regulate medicinal cannabis, requiring the creation and maintenance of an unnecessary bureaucracy. The bureaucratic authorization process proposed is far more extensive, expensive, and difficult to administer and enforce than regulations for any other drugs or natural medicines. Cannabis simply does not warrant the restrictive and invasive procedures being proposed. The proposed regulations are akin to shooting a fly with a cannon, the cannon will do far more damage than the fly ever could. For example a person with Epilepsy would have to try or at least consider undergoing a lobotomy in order to comply with the proposed regulations.

Our membership and the broader medicinal cannabis community have informed us of what they are hoping for in terms of government involvement and the ultimate outcome of the legalization of medical marijuana within the healthcare system. Thus the goals of these recommendations are to develop a regulatory framework that will:

1) Allow those in medical need to access cannabis without fear of legal repercussion
2) Facilitate easy and timely access to cannabis
3) Financially support patients in accessing their supply of medicinal cannabis, as they are now supported in their access to other prescription medications
4) Remove the stigma and ignorance associated with cannabis use



1. Authorization to Possess:

Recommendation of Health Care Practitioners

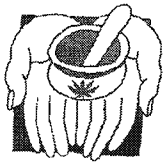
Cannabis is an herb; therefore the authorization to recommend access should be given to those health care practitioners most experienced with herbal medicines. Authorization to recommend cannabis use must not be limited to allopathic physicians. Other healthcare providers, such as clinical herbalists, naturopathic doctors, and doctors of traditional Chinese medicine, are trained in the clinical application of herbal medicines and must also have the authority to recommend access to cannabis.

The requirement to involve a medical specialist in the authorization of possession of medicinal cannabis is unjustified, unfounded, unrealistic and punitive. It negates timely and easy access, and places an unjustified burden on both the patient and the HealthCare system. Many patients already wait from nine months to a year to see a specialist. This means that those waiting for authorization to access medicinal cannabis may be on hold for upwards of a year. This is an inhumane wait to force upon those in dire medical need. In addition, it will unnecessarily exacerbate already extensive waiting lists for specialists, meaning those in genuine need of the specialists will unduly suffer.

Confirmation of Diagnosis

There are many conditions and symptoms for which the efficacy of cannabis use has been proven through copious amounts of anecdotal evidence and historical use. Recently, a limited amount of unbiased research has been conducted to determine the efficacy of cannabis use for specific conditions and symptoms.

Many healthcare practitioners will continue to be hesitant to recommend cannabis due to the legal and social stigma surrounding it. This reluctance will unduly restrict access to medicinal cannabis.



Therefore any patient who has confirmation of any condition or symptom for which there is sufficient anecdotal or scientific evidence for cannabis as an effective treatment should have the right to choose to utilize medicinal cannabis within the health care system without requiring further authorization. These conditions and symptoms include, but are not limited to:

- HIV/AIDS
- Cancer
- Fibromyalgia
- Multiple Sclerosis
- Seizure Disorders
- Chronic fatigue
- Chronic pain
- Severe weight loss
- Raised intra-ocular pressure
- Severe nausea
- Migraines
- Hepatitis C
- Crohn's Disease
- Anorexia and other eating disorders
- Stress and Anxiety Disorders

There are several treatments that may require access to cannabis, regardless of the condition for which the treatment is being applied, as a complement or to deal with their side effects. For example:

- Chemotherapy
- Radiation
- Morphine prescription

There are many conditions and symptoms for which there are over-the-counter medications available to Canadians for self-prescription and self-titration. If these regulations are to meet the criteria set forth by The Ontario Court of Appeals, specifically that they do not unduly restrict the availability of marijuana to persons which may receive health benefits from its use, a person should have the right to choose cannabis as a safe and reliable alternative to, and as their first treatment choice for conditions and symptoms treatable with over-the-counter medications, such as:

- Headache medications
- Sleeping Pills
- Appetite medications
- PMS medications
- Muscle Relaxants
- Anxiety medications
- Digestive Aids
- Stimulants (e.g. caffeine pills)

Cannabis is an herbal medicine that meets the criteria for over-the-counter medicine. It is up to the public to decide for what purpose they will use it. If there is a need for healthcare provider input during this transition phase it is up to the patient, on the recommendation or confirmation of diagnosis from her healthcare provider, as to whether or not she will use if for any particular illness. In other words, if cannabis is to be regulated within the healthcare system, it is a healthcare decision and it is inappropriate for the government to limit its use. A more suitable role for the government is to investigate its benefits and risks and to provide appropriate information to consumers and healthcare providers

2. Access and Production

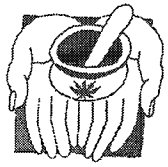
Once a patient has obtained a recommendation from their Health Care Practitioner, or has obtained a confirmation of diagnosis for an approved condition or symptom, they may obtain their medicine from the source of their choice without the additional unnecessary delay and proposed cost of government approval.

Self-Production

Those who are physically able, and choose to grow for them selves may require financial support for the acquisition of the necessary equipment. People who grow for them selves can grow within the approved production guidelines (see Cultivations Recommendations) without further authorization.

Third Party Production

The majority of patients are not able to grow for themselves, due to physical disadvantages, lack of financial resources, or shortage of appropriate space. Therefore many will be forced to rely on a third party grower.



The proposed inspections would be extremely invasive and infringe on personal rights, as inspectors will be authorized to:

- Have total access to one's home
- Open any container that could contain cannabis
- Examine and copy computer systems and records
- Seize and retain any substance found

These factors will dissuade many producers from consenting to an inspection, or even agreeing to produce for a patient. Many more growers will consent to inspections and be willing to support those in medical need if Health Canada focuses on safety and health issues rather than invasive, costly, and unnecessary policing.

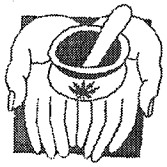
As with people growing their own medicine, anyone appointed as a third party grower should be able to grow within the production guidelines without further authorization.

Criminal Background Check

The draft regulations propose to exclude any person who has a criminal record of a cannabis-related offence from being a licensed grower. The exclusion of those Canadians who have experience with cannabis is extremely counter-productive. A novice cannabis grower will go through an expensive and time-consuming learning curve before she is able to produce cannabis efficiently. This learning curve will result in a financial burden to the patient, and will extend the period of time until harvest. Those who have been convicted and have served their sentences have already received their punishment. There is no need for them to be further discriminated against. The production of medicinal cannabis is an opportunity to contribute to society, the economy, and to create meaningful employment for Canadians.

Economy of scale

Restricting one address to grow for only three patients creates unnecessary limitations on the potential for economies of scale. A cannabis grower with some experience is in the position to cultivate a consistent, high quality supply. Production is more affordable if the costs are spread between a greater numbers of patients.



Safety and Knowledge

All producers, users and distributors of medicinal cannabis must have access to a laboratory that can test for molds, mildews, fungi and spores, harmful bacteria, yeasts, chemical residue, pesticides, fungicides, heavy metals, and cannabinoid profiles.

Many patient and third party growers will require the assistance of a resource person to ensure safety and to assist with cultivation techniques that will produce high quality medicinal cannabis.

3. Education

A well-funded and extensive education program would be an effective use of government resources. Education is an essential aspect of the legitimization of medicinal cannabis. Education will remove the stigma associated with cannabis and create an informed environment in which patients, healthcare providers, law enforcement personnel, government officials and the public, can make effective and informed decisions regarding cannabis. Educational content should include:

- Conditions and symptoms benefited by cannabis
- Cannabis' use as a harm reduction tool for addictions
- Recent court findings pertaining to the minimal harm of cannabis
- Harm reduction techniques
- Options for modes of ingestion
- Safe and effective cultivation techniques
- Effects of cannabis varieties
- History of cannabis prohibition
- Avenues available to access cannabis

4. The Role of the Police and Justice System

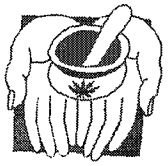
The role of the police in the new regulatory framework must be redefined. Presently the police conduct raids on production sites by obtaining a search warrant. Neither the investigating officers nor the Justice of the Peace who authorize the search warrant are empowered to determine medical necessity before conducting the raid. It is the responsibility of the judicial system to determine medical necessity after the fact. During this process the patients' medicine is seized, their expensive equipment destroyed, the respect of their neighbors replaced with judgment, and their livelihoods threatened. This happens to medical cannabis users

regularly. Even those holding a Section 56 Exemption are subject to a bust. Some patients will not grow at home, not for lack of ability or resources, but because they are afraid of the police. No one wants their children exposed to a war zone in their home.

Similarly, police confiscate cannabis from medicinal users. The cost of replacing confiscated medicine represents an intolerable financial burden to medical users, most of who live on a very low income.

During the transition period, while all concerned parties are becoming informed of the new regulatory framework, police discretion will be essential. The police and justice system need to be empowered to use their discretion to carefully establish if the production site or quantity of cannabis in question is intended for medical purposes, before conducting a raid or confiscating cannabis. This is the case particularly with small personal quantities or production sites. Larger medical supply operations that have obtained permits or licenses can also operate undisturbed. Such rational measures will greatly reduce the current burden on both the police and judicial system freeing resources to be utilized for the benefit of a safe society for all its members. Police must recognize that an absence of paperwork does not mean illegitimate cannabis use. It will take some time for all medicinal cannabis users and supportive healthcare practitioners to 'come out of the closet'.

5. Whole Plant Medicine versus Synthetic Pharmaceuticals



In the introduction to the proposed regulations, pharmaceutical products are mentioned several times as a final objective. While it is evident that synthetic cannabis is of great interest to the pharmaceutical industry, those interests cannot supercede the interests of the already existing and flourishing natural medicine industry that employs many Canadians.

It is crucial that medicinal users of cannabis continue to have the choice to use whole plant medicine, and are not forced to use isolated or synthetic versions of the medicinal ingredients in cannabis. The members of the BC Compassion Club Society and many of those holding Section 56 Exemptions have reported that when taking synthetic versions of the active ingredients of cannabis in pharmaceutical drugs, the negative side effects can be tremendous and the relief minimal. Many people simply prefer to use natural healthcare products. The right to choose whole plant medicine must be defended as an essential healthcare choice.

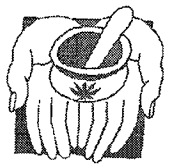
Future Considerations

Distribution Centers and their Supply

Many patients are not able to grow on their own, nor do they have a feasible option for a third party grower. Most patients require immediate access to medicinal cannabis, and others only require access for a limited period of time. Health Canada has begun to address these issues by developing a supply from the Prairie Plant System Inc.

The medical cannabis community is very concerned that the only consistent supply available will be limited to this one government approved producer. A free market with various producers licensed to supply distribution centers would most benefit the end consumer. Licensed production sites would be registered with the local police to ensure protection and inspected regularly to ensure they are growing within the safety standards. Competition will increase quality, broaden selection, and decrease the end cost of the medicine. Non-profit community-based distribution centers, supplied by a variety of producers, will ensure the medicine available to patients is competitively priced and has the wide variety of strains and strengths necessary. This is only possible through the utilization of the plethora of knowledge and genetics hidden within the medical cannabis community. Such a system will include many of the currently underground established growers, thus normalizing, legitimizing and protecting the livelihoods of many Canadians.

Conclusion



The BCCCS commends Health Canada for taking the first steps toward creating a functioning and effective regulatory framework. The first draft of the proposed recommendations requires the creation and maintenance of an unnecessary and expensive bureaucracy. Our aim is to assist in the development of regulations that will not only meet the requirements set forth by the Court of Appeals of Ontario, but will also empower patients and healthcare practitioners to utilize this effective herbal medicine in a supportive, safe and informed environment. Thank-you for considering our recommendations.

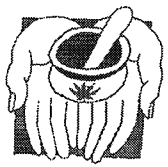
British Columbia
Compassion Club Society

Medicinal Cannabis Cultivation Recommendations and Information

Dated: May 4th, 2001

Introduction

The following information is intended to assist Health Canada with establishing an effective system to regulate medicinal cannabis cultivation. This information has been gathered through extensive consultation with medicinal cannabis growers.



Cultivation Recommendations

1. If a medicinal cannabis user is allowed to flower with twelve, 1000 watt lights once per year or four 1000 watt lights 3 crops per year (or any equivalent amount of wattage) they would have the ability to create a consistent personal supply of medicine, with an allowance for failure rates.

2. Restricting the amount of plants in vegetative growth is unrealistic, as patients will require an undeterminable number of seedlings and/or clones for their crop.Therefore the plants in this stage should be unregulated.

3. If a patient requires more cannabis than they can produce with four lights per crop, or one crop with twelve lights, they may apply to Health Canada to become registered.

4. Health Canada needs to have extensive information available to medicinal cannabis users on the following:

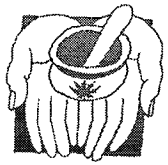
- Cultivation techniques
- Safety procedures
- Health concerns in cultivation and ingestion
- Detailed growing information on individual strains
- Strain-symptom correlations

The BC Compassion Club is able to provide much of this information.

5. Compassion Clubs should be licensed to produce and distribute clones and seeds to medicinal cannabis users. We have the capability to hold many varieties, learn their cannabinoid profiles, and amass anecdotal data regarding the symptom-strain correlation.

6. Compassion Clubs should be immediately empowered to select growers to be licensed to supply patient needs through Compassion Club. This that is the route through which those with exemptions and recommendations are presently obtaining their cannabis.

7. Compassion Clubs, their suppliers and members should be granted immediate immunity from arrest and prosecution.



8. Standards for testing at laboratories should include levels of:

a. Molds, fungi, mildews and bacteria
b. Chemical residue from pesticides and fungicides
c. Heavy metals

Cultivation Information

Terminology

Vegetative growth: 16-24 hours light

Flower growth: 12 hours of light

Indica: Broad short leaves, approximate height 2-4 ft, sedating effect

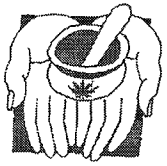
Sativa: Narrow long leaves, approximate height 5-10 ft, stimulating effect

Clone: Cutting taken from a mother plant creating an identical genetic copy

Brackets: Seed pod-create bulk of weight

Hermaphrodite plant: A plant containing both male and female flowers

Hermaphrodite seeds: A seed coming from a hermaphrodite plant which has fertilized itself from its male flower



Comparisons of Strains Produced Indoors

Creating a regulatory system based on limiting the number of plants allowed will prove to be near impossible. One could grow a higher number of smaller (lower producing) plants, or a lower number of larger (higher producing) plants, and the quantity of cannabis harvested will be equivalent.

These production estimates are based on:

- 1000watts / 4 square meters
- Light bulb has had no more then 4500 hours of previous use
- Weight is calculated only with dried manicured flower tops
- Soiless mix or hydroponic drip system feeding with a nutrient containing 550 ppm nitrogen
- High quality and clean growing conditions
- High production estimates are achievable only with an experienced, quality grower

Comparison of Indica and Sativa

- Purest Indicas have very few brackets and more foliage; therefore the buds they produce are larger and less dense then Sativa buds.
- Purest Sativas have many brackets and less foliage; therefore the buds they produce are smaller and denser then Indica buds.
- Comparing an equal size bud from a pure Indica and Sativa, the Sativa will weigh nearly twice as a result of the density.

Production Estimates for Indicas, Sativas and Crosses:

Pure Indica (66% Indica & higher):

Average flower time 6-8 weeks

High **340 grams**
Average **227 grams**
Low **180 grams**

Pure Sativa (66% Sativa & higher):

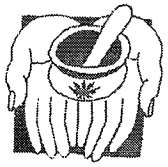
Average flower time 11-13 weeks

High **340 grams**
Average **227 grams**
Low **180 grams**

50% Indica - 50% Sativa:

Average flower time 9-11 week

High **700 grams**
Average **455 grams**
Low **355 grams**



Outdoor Production

Due to the short growing season in Canada, Indica or Indica/Sativa crosses are the preferable strains for outdoor cultivation. These plants should be started indoors and planted outdoors by mid-June; they can be harvested in late September.

The typical outdoor plant will produce approximately 250 grams. Production may increase or decrease due to environmental factors such as: sunlight, rain, fertilizers, temperature, molds and the variety being grown.

Seed vs. Clone

If one is using seeds, it takes 6 weeks to identify the males; the remaining females can then begin the flowering period.

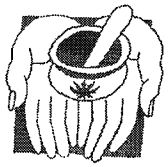
A clone only needs to have 2 weeks in vegetative growth; therefore growing from seed will increase the time until harvest by 4 weeks.

One growing from seed will require twice as many plants in order to end up with the desired number of female plants; therefore the growing space required will be double for the vegetative stage of growth.

Failure Rates

In a hydroponic or aeroponic system the water must be kept clean or bacteria, fungus, mold or algae can wipe out an entire crop overnight, or cause the plants to be so weak that harvest will be minimal.

In a soiless mix or healthy organic soil, the risk of algae, bacteria, or fungus affecting the whole crop is far lower; as the plants are separate from one another and the grow medium does not support the growth of algae, bacteria, or fungus.



Based on 100 seeds

Seed Germination rates: 5-10% failure = 90 seeds
Sprouted seeds surviving transplanting: 20% failure = 72 seedlings
After sexing normal seed: 50% will be female = 36 female seedlings
If the room does not have a plague of mold, fungus, bugs, a failure rate of 1-2% is realistic.

Based on 100 clones

Some strains will have a 100% success rate, while others will have only a 50% success rate, even in ideal conditions, the average failure rate is 25% during rooting.

During transplanting and through growth cycle a failure rate of 1-2% is realistic.

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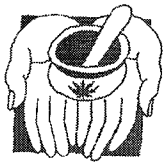
During transplanting and through growth cycle a failure rate of 1-2% is realistic.



A Review of the Cannabis Cultivation Contract between Health Canada and Prairie Plant Systems

Prepared by: Rielle Capler
British Columbia Compassion Club Society
Revised October 2007

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A Review of the Cannabis Cultivation Contract between Health Canada and Prairie Plant Systems

October 2007

The following is a review of the contract terms and negotiations between Health Canada and Prairie Plant Systems for the three contract extensions beginning January 2006 and ending September 2007. It is intended to inform stakeholders (i.e. medical cannabis users, Canadian taxpayers, and political representatives) of the costs of the federal government's medical cannabis program and to highlight areas of concern in order to ensure transparency and accountability. It does not address the quality of the cannabis produced by PPS.[1]

Background

Several medical cannabis court cases have called into question the validity of the federal medical cannabis program. It remains an open question whether the program provides a constitutionally adequate means for Canadians to access medical cannabis. The last court case offered specific remedies to the program which have not been implemented, and a new constitutional challenge is currently taking place in British Columbia.[2] Concerns over the cost of the program, to both taxpayers and those accessing the program, has precipitated a call for a federal audit of the program. The Auditor General of Canada has recently undertaken such an audit.

One of the major areas of concern about the program is the supply of legal cannabis. Currently the sole contractor for cannabis is Prairie Plant Systems (PPS). The original contract between Health Canada and PPS began in December 2000. The first quantity of the product was supposed to be available for distribution within one year of the contract award.[3] Those with Authorization to Possess (ATP) licenses began to have access to the PPS cannabis in August 2003. As of April 2007, only 351 out of the 1742 ATP license holders were accessing this cannabis. The cost of the contract with PPS now totals $10,278,276.

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[1] Concerns over the quality of the PPS product have been raised by medical cannabis consumers and such as Canadians For Safe Access (CSA) in their Open Letter of Concern, accessed on July 5, 2007 from http://safeaccess.ca/research/flinflon/opnltr0105.htm#qandp. In response, PPS threatened legal action against CSA. Although Health Canada claimed it could not direct PPS in these matter, information retrieved through an ATI request reveals that Health Canada was actively involved in the lawsuit. Accessed on July 10, 2007 from http://safeaccess.ca/research/flinflon/bccla_ltr2.htm and http://safeaccess.ca/research/pdf/pps_lawyer.pdf.

[2] Hitgiz vs. Her Majesty the Queen. Accessed on June 15, 2007 from http://www.johnconroy.com/library/lederman.pdf and VICS press release: *B.C. Supreme Court to Hear Constitutional Challenge of Federal Medical Cannabis Program.* Accessed on June 15, 2007 from http://thevics.com/legal/const_chall_pr.htm

[3] *Government Marijuana Growing Contract Terms and Conditions.* Accessed on June 15, 2007 from http://www.medicalmarihuana.ca/growcontractfaq.html

Number of Persons Accessing PPS Cannabis

The cost of the contract must be regarded in the context of the number of people to whom Health Canada is providing cannabis. [4]

- By the end of the initial 5-year contract (on or about December 31, 2005), 209 ATP license holders were accessing dried marihuana for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes.*
- By the end of the 6-month contract extension (on or about June 30, 2006), 296 ATP license holders were accessing dried marihuana for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes.*
- At the end of the 3-month extension (on or about September 30, 2006), 301 ATP license holders were accessing dried marihuana for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes.*
- The latest statistics for April 2007 show 351 ATP license holders accessing dried marihuana for medical purposes under the *Policy on Supply of Marihuana Seeds and Dried Marihuana for Medical Purposes.*
- PPS is also providing cannabis to 350 participants in the Cannabis for the Management of Pain: Assessment of Safety Study (COMPASS). The 3-year study began December 31, 2004 and its end date is December 31, 2007.[5]

Cost of Contract

Since 2005, while the number of people accessing the cannabis from PPS has not risen substantially, the cost of the contract has been growing exponentially.

- The initial 5-year contract for the cultivation of medical cannabis, ending December 31, 2005, was awarded to PPS for $5,751,250[6]. Several contract amendments totaling $317,355 [7] brought the total for the 5-year contract up to $6,068,605.
- A six-month contract extension beginning January 2006 was awarded to PPS at a cost of $771,224.[8] An amendment for $63,421 brought the cost of the 6-month extension up to $834,645 [9], and the entire contract for five and a half years to a total of $6,903,250.
- A 3-month extension was awarded to PPS for the period of July to September 2006 for $465,024. [10] Two contract amendments during this period were made for $187,359 [11], bringing the total of the 3-month contract to $652,383. The contract total for five years and 9 months was $7,555,633.

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[4] MMAR Stakeholder Statistics. Accessed on June 15, 2007 from http://www.hc-sc.gc.ca/dhp-mps/marihuana/stat/index_e.html
[5] Current Controlled Trials. Accessed on June 15, 2007 from http://www.controlled-trials.com/ISRCTN19449752/
[6] Government Marijuana Growing Contract Terms and Conditions. Accessed on June 15, 2007 from http://www.medicalmarihuana.ca/growcontractfaq.html
[7] Amendments 9-12 to contract number H1021-9-9012/001/SS with Prairie Plant Systems Inc. Accessed on June 15, 2007 from Contracts Canada at: http://csi.contractscanada.gc.ca/csi/prod/en/applctrl.cfm?cmd=simplist&rqst_levl=0
[8] Amendment 14
[9] Amendment 15
[10] Amendment 16
[11] Amendments 17 and 18

- Another one-year contract was awarded to PPS beginning October 2006 to September 2007 for $2,288,518, and with an amendment for $434,125 it is currently valued at $2,722,643. [12]
- The total cost of the contract, at this point in time, for six years and 9 months is $10,278,276.

Cost of Reports

Health Canada appears to be paying Prairie Plant Systems a considerable sum for their reports. It is questionable as to the extent these reports change from month to month to warrant these costs.

- For the contract ending December 31, 2005, Health Canada paid PPS $63,120 each for 54 monthly reports and $78,000 each for 4 yearly reports totaling $3,802,980.[13] This represents 62% of the cost of the 5-year contract.
- In the January to June 2006 contract, reports cost $64,067/month and $39,000 for a final report for a total of $423,402. [14] This represents 51% of the cost of this 6-month contract extension.
- For the July to September 2006 contract, reports cost $64,067/month and the final 3-month report was valued at $19,500 for a total of $211,701.[15] This represents 32% of the cost of this three-month contract extension.
- In the current contract, October 2006 to September 2007, reports are costing $86,740/month and the final report $78,000 for a total of $1,118,880.[16] This represents 41% of the cost of this one-year contract extension.
- Reports to date have cost taxpayers $5,556,963 representing 54% of the entire contract cost to date.

Cost of Cannabis

There has been a fair amount of negotiating around options for additional production, in terms of both quantity and dollars/kg. Additional cannabis production is valued at extremely elevated prices.

- The contract stipulates the cost of cannabis at $328.75/kg for 420 kg each year starting in January 2003.
- There are options for production above 420 kg: Option 3 paid $452/kg for amounts above the 420 kg in the initial 5-year contract.[17]
- In the negotiations prior to the final contract there is mention of an option for $3000/kg for additional qualified bulk flowering head.[18]

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[12] Amendments 19 and 20
[13] ATI request pg. 000112. Accessed on June 15, 2007 from http://safeaccess.ca/research/pdf/pps_contract_communication.pdf
[14] ATI request pg. 000112-000113
[15] ATI request pg. 000139-000140
[16] ATI request pg. 000152
[17] ATI request pg. 000018
[18] ATI request pg. 000052

- In the last contract extension, Option 9 was added to allow for the production of an additional 240-358 kg at $1144/kg.[19]
- As such, the first 420 kg will cost $138,075, and the next 358 would cost $409,552, for a total of $547,627.
- This represents 20% of the contract cost for the one-year period ending September 30, 2007.
- It is noteworthy that Health Canada pays PPS the same amount for all cannabis plant components, both usable and unusable. By PPS estimates, only 63%[20] of the bulk product are flowering heads, of which only some portion is actually usable for distribution to patients. [21]

Estimates for Increased Production

Over the period of three contract extensions starting January 2006 until the one-year contract extension starting in October 2006, the production quantity estimates rose considerably. The extent of anticipated increase in demand seems unwarranted.

- The contract with PPS stipulates the production of 420 kg of cannabis plant component parts per year. There are options to produce quantities above this amount at increased costs (see above section).
- For the 6-month contract extension, in anticipation of increased demand, PPS was contracted to produce 290 kg of bulk product in order to meet an anticipated need of 150 kg of finished product flowering heads for clinical trials as well as ATP license holders. [22]
- For the next contract extension, 100 kg of bulk products was to be produced over 3-months. It was anticipated that 85 kg of finished product would be needed for distribution, and any balance could come from a supply of usable inventory.[23]
- The third contract extension anticipated that 400 kg of finished product would be needed over the 12-month period, for which it would be necessary to produce at least 660 kg of bulk product.[24] To fulfill this quantity, the contract gave PPS an option for producing 240-358 kg above the 420 kg limit under Option 9 for $1144/kg.[25]
- Earlier estimates were for 600 kg, and for the production of the additional cannabis under Option 3 at $452/kg.[26] PPS proposed to produce 888 kg.[27]
- The numbers of plants per harvest was to increase from 800 to 1100 by May 2007. [28]

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[19] ATI request pg. 000159
[20] 63% of bulk product is flowering heads, however PPS estimates 880 kg of bulk material is necessary for 400 kg of flowering head finished product, or 45%. ATI request pg. 000064
[21] Accessed on June 15, 2007 from.000007, 000064 and 000087
[22] ATI request pg. 000015
[23] ATI request pg. 000034 and 000040
[24] ATI request pg. 000064
[25] ATI request pg. 000159. Note only 210 kg additional cannabis was required to fulfill 660 kg, since there was 30 kg remaining from the 2006 calendar year. ATI request pg. 000052
[26] ATI request pg.000040, 000051 and 000052
[27] ATI request pg. 000064
[28] ATI request pg. 000058 and 000072

- The increase in production was based on projections of a 75% annual increase in the number of ATP license holders. [29]
- In fact, the number of ATP licenses has increased from 1468 to 1742 during the period between October 2006 and April 2007 representing an 18.66% increase in ATP licenses.

Packaging Costs

Costs for packaging have been inexplicably high and seemingly arbitrary.

- Packaging costs have decreased dramatically since the time the PPS product was first being distributed.
- Packaging for ATP license holders cost $162.18/kg from August 1, 2003 to July 31, 2004; from August 1, 2004 to December 31, 2005 the cost dropped to $12.20/kg;
- Packaging costs for research participants during the period of January 2004 to December 31, 2005 remained at $162.18/kg.
- Starting January 2006, packaging costs for both ATP license holders and researchers dropped to $8/kg.[30]
- PPS estimated that packaging costs would come to about $144,000 for the contract ending September 30, 2007.[31]

Shipping and Distribution Costs

The complexity and security measures of the PPS program creates excessive shipping and distribution costs.

- Costs for shipping the cannabis between various sites for storage, irradiation and distribution are estimated at $215,101 for the contract ending September 30, 2007.[32]
- Health Canada also pays PPS for ongoing order processing and distribution for APT license holders and Researchers– at an estimate of $81,000 for the one-year contract ending September 30, 2007.

Laboratory Costs

Health Canada appears to have paid for PPS's laboratory equipment associated with cannabinoid testing and subsequently paid for the use of that equipment as well for the space to house it.

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[29] ATI request pg. 000040 and 000041
[30] ATI request pg. 000158
[31] ATI request pg. 000090
[32] ATI request pg. 000091

- The cost for the establishment of a laboratory at PPS, including equipment, up to June 2006, was $59,272.[33] PPS also estimated a cost of monthly charge of $6,965 for the following three-month contract extension, for a total of $80,167.
- In the following contract extension, the allowable cost associated with PPS's new in-house laboratory was estimated at $80,168 over the 9-month period. $19,485 was allotted for the rental of equipment and the space to store it.[34]
- Laboratory costs for 12 months ending September 2007 were estimated at a total of $81,770, or $6,814/month.[35]

Costs of Maintenance, Capital Upgrades and Equipment

Health Canada is paying PPS to grow the product, paying for the necessary equipment, and also paying for the product. Health Canada appears to be making a large financial investment in PPS.

- In the January to June 2006 contract Health Canada paid $26,000 for inventory and distribution software development and implementation, equipment and software, security system upgrades.[36]
- In the October 2006 to September 2007 contract Health Canada agreed to pay for capital upgrades including maintenance for the growth chamber at $41,504 and equipment and facility improvements worth $457, 500.[37]
- These costs total $525,004 for the period of contract extensions from January 2006 to September 2007.
- Including the original start-up costs of $536,520, the total of capital investments is over 1 million dollars for the entire contract to date.
- Shortly after being awarded the last contract extension, PPS announced the opening of a new 1,500 square foot head office and laboratory facility.[38]

Cost of Cannabis to Patients

Health Canada is passing on the inflated cost of the contract to patients.

- Health Canada pays PPS $328.75/kg and charges patients $5000/kg. This constitutes a 1500% mark-up.
- By PPS estimates, Health Canada would receive approximately $330,000 from ATP license holders over the six-month contract extension.[39]
- Health Canada has sent collection agencies after those who cannot afford to pay for their medicine. The total debt for registered users now exceeds $300,000.[40]

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[33] ATI request pg. 000082
[34] ATI request pg. 000145
[35] ATI request pg. 000158
[36] ATI request pg. 000131
[37] ATI request pg. 000158 and 000159
[38] Media Release from PPS. Accessed on June 15, 2007 from http://www.prairieplant.com/documents/Oct-20-2006-Press-Release.pdf
[39] ATI request pg. 000123
[40] Article in Globe on Mail: *Unpaid bills mount over Ottawa's pot.* Accessed on July 5,2007 from http://www.theglobeandmail.com/servlet/story/LAC.20070703.BCPOT03/TPStory/?query=UNPAID+BILLS+MOUNT+OVER+OTTAWA%27S+POT+

Options for Cost-Effective Production and Distribution

Compassion clubs across Canada provide medical cannabis to over 10,000 people at no cost to taxpayers. These community-based medical cannabis dispensaries provide a cost-effective alternative to Health Canada's centralized monopoly for cultivation and distribution.[41]

Cost Comparison of PPS Contract Extension for Oct 2006-Sept 2007 to BCCCS Costs for Fiscal year of November 2005-October 2006

Program Variables	Health Canada	BCCCS
Number of Persons Accessing Product	700[42]	3000
Cost of Program	$2,722,643	$2,217,772[43]
Total Cost/Person	$3,889.49	$739.25
Cost of Cannabis	$547,627[44]	$1,299,409[45]
Quantity of Cannabis	778 kg[46]	262 kg
Cost of Cannabis/kg	$328.75/$1144[47]	$4959.57
Cost of Cannabis/Person	$782.32[48]	$433.13
Usable Percent of Cannabis	63%[49]	97% [50]
Cost of Unusable Cannabis	$202,622[51]	$43,345
Price to Patients/kg	$5000	$8000
Mark-Up on Price	1500%	66%
Operating Costs[52]	$2,175,016	$718,948[53]
Operating Cost/Person	$3,107.17	$239.34
Operations as Percent of Total Cost	80%	32%
Ratio of Operating Cost to Cannabis	4:1	1:2

- As a non-profit society, the British Columbia Compassion Club Society (BCCCS) is able to provide a wide variety of high quality cannabis strains, edible products and tinctures to approximately 3,000 clients at the cost of $2,217,772/year.[54]

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[41] For more information about compassion clubs, see Guidelines for the Community-Based Distribution of Medical Cannabis in Canada http://www.thecompassionclub.org/resources/guidelines%20for%20distribution.pdf and www.thecompassionclub.org accessed on July 5, 2007.
[42] 350 license holders and 350 COMPASS study participants. Compass study ending Dec 31, 2007.
[43] Includes all costs directly related to provision of cannabis as well other cannabis products (i.e. hashish, tinctures and baked goods), and smoking implements. Does not include costs directly related to provision of other natural health care services also provided by the BCCCS.
[44] $138,075 for 420 kg plus $409,552 for 358 kg.
[45] Does not include costs of hashish or other cannabis products.
[46] Bulk product.
[47] $328.75/kg for 420 kg and $1144/kg for amounts of 240-358 kg above 420 kg.
[48] $197.25 for the 420 kg, and $585.07 for the 358 kg.
[49] According to PPS, 45% of bulk product is usable (see footnote 20)
[50] Loss of usable product purchased by the BCCCS is due to moisture loss and stems. Product must meet our manicuring standards as a condition of purchase.
[51] Using the conservative number of 37% unusable cannabis. At 55%, this would total $310,195.
[52] For these purposes, defined as all costs above cost of cannabis, including packaging and processing orders.
[53] Does not include wages related to provision of other natural health care services, however does include rent and utilities related to those services.
[54] Based on 2006 financial statements of the BCCCS.

- The BCCCS typically charges a 66% mark-up on the cannabis purchased from contracted cultivators. This covers: cost of cannabis; rent; wages (for purchasing, packaging, distribution, administration, processing of applications, etc.); the provision of free and subsidized cannabis to those in need; provision of subsidized natural health care services; one-hour intake sessions with an educational component for each new member (about 400/year); cost-sharing of laboratory testing with suppliers.
- Compassion clubs must pay 'black market' prices for their product. If compassion clubs were permitted to legally cultivate their own supply, these organizations would be able to supply cannabis to their clients at substantially lower prices. Typically, compassion club cannabis prices are at or below 'street' prices.
- The biggest security risk to the BCCCS' cultivators and supply of cannabis comes from law enforcement officials.
- Other options for production facilities, such as greenhouses, could greatly reduce cultivation costs.

Discussion

In light of the federal government's decision to cut funding for the research component of the medical cannabis program, which affects millions of Canadians and the integrity of the program itself, Health Canada's decisions to invest substantially in a private production facility that supplies only 350 Canadians merits close scrutiny.[55] [56]

The 1500% mark-up on the cannabis charged to patients highlights the risk of Health Canada creating a monopoly over supply. Health Canada is requiring taxpayers and medical cannabis patients to fund inefficient practices, capital upgrades, and equipment for a private contractor. Instead of providing affordable medicine to those in need, Health Canada has chosen a policy and program that seemingly creates a windfall for one monopoly supplier to the detriment of patients and taxpayers.[57]

While community-based medical cannabis dispensaries provide a cost-effective alternative to Health Canada's centralized monopoly for cultivation and distribution, the end-cost to patients still remains problematic. The cost of cannabis for those in medical need must be covered under Canada's universal health care system as it is for other medicine. Canada's critically and chronically ill deserve the most affordable and highest quality care.

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A Roadmap to Compassion

The Implementation of a Working Medicinal Cannabis Program in Canada

By the Canadians for Safe Access,
the B.C. Compassion Club Society, and the
Victoria Island Compassion Society:
Philippe Lucas, Hilary Black, and Rielle Capler

02/18/04

The Implementation of a Working Medicinal Cannabis Program in Canada:

A Roadmap to Compassion

02/18/04

By Philippe Lucas, Hilary Black, and Rielle Capler

For over five years, the Canadian federal government has been struggling with the development and implementation of a national medicinal marijuana program. Although Health Canada has taken some progressive policy steps, many improvements are still needed.

This document identifies many of the roadblocks Canadians have been facing with the MMAR program, and proposes solutions to overcoming them. These solutions focus on the already existing and successful medical cannabis distribution system in Canada, the compassion societies.

The courts have acknowledged that compassion societies have been filling in the holes left by Health Canada's inadequate program. Many government bodies, including the Senate Special Committee on Illegal Drugs, the Ontario Court of Appeals and the BC Provincial Court have also recognized the key role of the Compassion Societies in a viable national program.

Senate Special Committee on Illegal Drugs

Conclusions of Chapter 9:

- People who smoke marijuana for therapeutic purposes prefer to have a choice as to methods of use;
- Measures should be taken to support and encourage the development of alternative practices, such as the establishment of compassion clubs;
- The practices of these organizations are in line with the therapeutic indications arising from clinical studies and meet the strict rules on quality and safety;
- The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards;
- The studies should focus on applications and the specific doses for various medical conditions;
- Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs.

From the Ontario Court of Appeal in regards to the Hitzig Decision:

"A central component of the Government's case is that there is an established part of the black market, which has historically provided a safe source of marihuana to those with the medical need for it, and that there is therefore no supply issue. The Government says that these "unlicensed suppliers" should continue to serve as the source of supply for those with a medical exemption. Since our remedy in effect simply clears the way for a licensing of these suppliers, the Government cannot be heard to argue that our remedy is unworkable."

Problems with the MMAR

The Canadian government was ordered by the courts to amend the cannabis prohibition laws to allow Canadians in medical need to access cannabis without fear of legal repercussion. The response was the creation of the MMAR. Since its implementation over 5 years ago, Health Canada's medicinal cannabis program has completely failed to live up to its mandate. Numerous courts have found both the MMAR and its predecessor, the Section 56 Exemption, unconstitutional. More tellingly, the critically and chronically ill Canadians who have been diligent and determined enough to join the MMAR have also been its most vocal and vociferous critics.

Obstacles to Access

While Health Canada's own polls suggest that over 400,000 Canadians currently claim to use cannabis for medicinal purposes, its program has registered a mere 700 applicants over 4 years. Unjustified bureaucratic obstacles to accessing the program, such as yearly renewals and the requirements of support from a medical specialist, have created an oxymoron out of Health Canada's Office of Cannabis Medical Access.

Both the Canadian Medical Association and the Canadian Medical Protection Association have issued notices to the medical community instructing them not to participate in the federal medicinal cannabis program for fear of potential legal liability. This has effectively stymied the proper implementation of the MMAR.

A centralized approval and registration system is in itself an unnecessary obstacle to access. Such a system is far more extensive, expensive, and difficult to administer and enforce than regulations for any other medicine. Cannabis simply does not warrant such restrictive and invasive measures.

Supply and Distribution

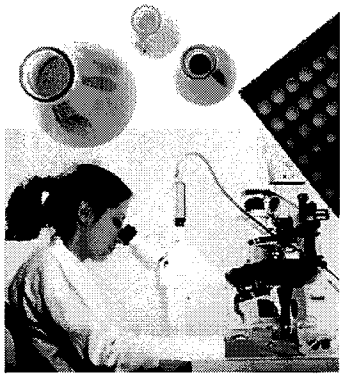
Once a patient has obtained an MMAR license, their choices for accessing a legal supply are severely limited. They may either produce it themselves or apply to have a third party grow for them. Many patients are not able to produce their own medicine nor do they have feasible options for a third party-grower.

A more recent court-ordered option provides for license holders to apply to receive their cannabis directly from Prairie Plant System. This half-hazard option is problematic for several reasons:

- Health Canada's attempts to produce medicinal grade cannabis have been an embarrassing and expensive ($5 million +) failure, resulting in a non-organic product that is of poor quality and potentially dangerous to medicinal users. The product may be unsafe due to heavy metal contamination and the use of gamma irradiation. Even those who so desperately need this herb have rejected the product;
- The undeniable importance of making a variety of different strains of cannabis products available in many different forms has been ignored;
- A monopoly on production prevents the potential benefit to medicinal cannabis users from the reduced cost, increased quality and wider range of varieties that would prevail with free-market competition;
- Current distribution possibilities completely ignore the educational component necessary for the safe and successful use of cannabis products.

Most importantly, the costs of this medicine are not yet covered. The price of medicinal cannabis is artificially inflated due to its illegal status. As with other prescribed medicines, cannabis should be covered through the provincial health insurance system.

Research



Although Health Canada claims to be promoting research into this area of medicine, it has only approved and fully funded one clinical protocol since the implementation of this program. Experts in the field of medicinal cannabis are concerned about skewed research outcomes resulting from the government's crop, which is below average quality cannabis.

In addition, Health Canada has inexplicably ignored the recommendations of the Special Senate Committee to undertake research in collaboration with the compassion societies.

Recommendations: A Roadmap for Change

What is readily apparent to all is that for a cost of over $3 million a year, Canadians who could benefit from the use of medicinal cannabis are being drastically underserved by the OCMA.

The following recommendations are based on the experience and expertise of medicinal cannabis users and distributors, and are intended to:

- Help Health Canada finally address its many court obligations as well its responsibilities to Canada's critically and chronically ill;
- Put in place a community-based system for the safe and effective non-profit cultivation and distribution of medicinal cannabis.
- Create a system that is easier to understand and implement - for both patients and physicians - than the current system.;
- Allow Health Canada to use its resources more effectively and thus reduce costs;
- Financially support patients in accessing their supply of medicine;
- Create a program that is both in line with Canada's Constitution, Canada's international obligations that merits the support of the Canadian courts, press, and public;
- Create a well funded research program using high quality cannabis;.
- And address concerns about black-market re-distribution.

The Role of Health Canada

Health Canada must abandon its role in the approval process of potential medicinal cannabis users. This role creates a burden of wasted time and unnecessary bureaucracy for applicants; and of expense and wasted resources for Health Canada.

Health Canada should allow access to medicinal cannabis solely with a confirmation of diagnosis from an appropriate health practitioner Physicians are currently able to prescribe many controlled substances that are addictive and potentially dangerous without onerous government oversight; there simply is no logical or scientific reason to place cannabis under a stricter regulatory regime. Although the effectiveness of cannabis in treating certain ailments may not yet be fully conclusive, its remarkable safety profile is well established and accepted within the scientific community.

In order to ensure the success of this program, The OCMA's role should more closely resemble the Dutch Office of Medicinal Cannabis. Its roles would include:

- Working with provincial health care programs to ensure cost coverage of medicinal cannabis and harm reduction devices such as vaporizers, and for cultivation equipment where applicable;
- Creating national standards in collaboration with the existing Compassion Societies for the operation and licensing of community-based cannabis distribution centres;
- Establishing guidelines for site inspections and the testing of cannabis for strength and safety;
- Creating system to ensure protection of medicinal cannabis users from police interference;
- Providing appropriate information to consumers, healthcare providers, and law enforcement.

The Role of Physicians and other Health Care Practitioners

The involvement of physicians in the process is not questioned – what must be determined is their proper role with respect to use of cannabis for therapeutic purposes.

Health Canada should reconsider the role of the physician in the context of this program. The Senate Special Committee on Illegal Drugs recognized some of the concerns with prescribing an illegal herbal medication, but concluded that these can be addressed by replacing the role of the physician as gatekeeper with that of diagnostician:

" The involvement of physicians in the process is not questioned – what must be determined is their proper role with respect to use of cannabis for therapeutic purposes. Physicians are trained to provide a diagnosis of a person's medical conditions and symptoms and to determine how to treat these conditions and symptoms medically. Most do not have, however, adequate knowledge of the therapeutic benefits of cannabis and are reluctant to associate themselves with this product for a variety of reasons, including its illegality.

In these circumstances, the proper role of the physician should be to make a diagnosis of the patient's medical conditions or symptoms. If the condition or symptom is one where cannabis has potential therapeutic applications, the patient would be authorized to use the therapeutic product of his or her choice, including cannabis. This would also mean eliminating the current requirement that all other ""conventional treatments" have been tried or considered before the use of cannabis is authorized. There is no justification for making cannabis an option of "last resort."

These recommendations mirror the procedures already being carried out by physicians in order to register their patients at Compassion Societies. Compassion Societies require health care practitioners to confirm their patients' diagnoses and symptoms, and to "recommend" rather than prescribe cannabis. Any patient who has a confirmation of any condition or symptom for which cannabis is an effective treatment should have the right to choose to utilize this medicine within the health care system without further authorization. The decision to use medicinal cannabis should be between a patient and their healthcare practitioner, as it is with all pharmaceutical and natural health products.

Cannabis is an herb; therefore the authorization to recommend access must be given to those health care practitioners most experienced with herbal medicine and should not be limited to allopathic physicians. The BC Compassion Club Society currently accepts confirmations of diagnosis and recommendations from physicians (GP or specialist), Naturopathic Doctors, or Doctors of Traditional Chinese Medicine. Clinical Herbalists will be added to this list once they have the licensing bodies and associations necessary to be legally regulated.

The Role of the Compassion Societies

In the state of California, where over 70,000 registered users gain legal access solely through compassion clubs, a recent Field poll suggests that support for the program has grown from about 56% in 1996, to 74% today.

The compassion societies have been successfully meeting the needs of medicinal cannabis users across the country for seven years. These not-for-profit compassion societies currently supply over 6000 critically and chronically ill Canadians with a safe supply of cannabis at no cost to Health Canada or the taxpayers. They have been risking arrest, criminal records and imprisonment for this important work.

Compassion societies have long ago recognized that different conditions respond better to different varieties of cannabis and modes of administration. They therefore stock numerous strains and offer this medicine as loose-leaf product, or in the form of tinctures, oral sprays, edible oils, concentrates and baked goods.

Similar to Health Canada's program, compassion societies oversee membership requirements, confirm diagnoses and recommedations with approved health care practitioners and keep careful files on each member, tracking their use of cannabis.

There are many additional services provided which are outside of Health Canada's mandate:

- Education regarding harm reduction strategies and information on strains, proper dosages and methods of ingestion;
- A community environment, providing valuable social support and safe space;
- Low cost complimentary healthcare, such as herbalism, counselling, acupuncture, nutritional counselling, massage and yoga;
- Outreach designed to address the questions and concerns of physicians and of law enforcement officials;

Under a new regulatory and licensing regime, the role of Compassion Societies would remain much the same. Compassion Societies would continue to be responsible for maintaining transparency and for accurate and accountable record keeping. The Vancouver Island Compassion Society and the BC Compassion Society are successful socially accepted and integrated models of such organizations.

The Role of Private Cultivators

Sensibly regulated, not-for-profit organic cultivation of cannabis would allow a safe and steady supply of medicine. Community based cultivation would take advantage of the extensive genetic pool and knowledge residing within those currently engaged in the grey-market production and distribution of therapeutic cannabis. This would significantly improve the quality, expand the selection and lower the cost of the supply.

Furthermore, it would relieve the federal government of the onerous and clearly unwanted responsibility cultivating a Canadian supply of therapeutic cannabis.

Criteria for the licensing of compassion societies and community-based cultivators:

An excellent guidance document for the regulation of the services provided by compassion societies titled "Operational Standards for the Distribution of Medicinal Cannabis" has been drafted by the British Columbia Compassion Club Society - Canada's oldest and largest compassion club - and should be used as the basis for the development and implementation of further regulations[1].

Some recommended standards are:

- Non-profit incorporation to guarantee financial transparency and ensure responsibility to the consumer;
- A minimum level of production and distribution standards based on Good Lab Practices (GLP) and Good Agricultural Practices (GMP) guidelines;
- The exclusive use of organic cultivation practices;
- Participation in inspections to ensure standards are being met.

Compassion Society-Based Research

Compassion societies are uniquely suited to participate in research projects. They have extensive experience in the application of cannabis as a medicine, and their collective national membership are an untapped resource of potential study participants.

Over the last 2 years, compassion societies have been at the forefront of research into the safety and effectiveness of medicinal cannabis. They have conducted research protocols regarding the effects of cannabis on Hep-C with the University of California San Francisco and regarding nausea and pregnancy with UBC. The VICS has received independent funding to study the effects of smoked cannabis on chronic pain. All of this research is peer-reviewed and publishable, and is being conducted at no cost to the taxpayer.

Health Canada must expanded its research agenda and funding to include compassion societies and university partnerships.

Potential Concerns With a Decentralized Program

There have been some concerns vocalized by various government and enforcement agencies regarding a decentralized program.

International Treaties: In the past, Health Canada has implied that the decentralization of this program is restricted by our international treaty obligations, the most significant of which are the Single Convention on Narcotic Drugs [(1961)], the Convention on Psychotropic Substances [(1971)] and the relevant portions of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances [(1988)].

According to section (c) of the original 1961 treaty, a signing country has the right to produce any drug or substance so long as its use and distribution is: "Subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs." In other words, there should be no doubt that the trade, use and possession of drugs for medical or scientific purposes is permitted by the terms of this Convention.

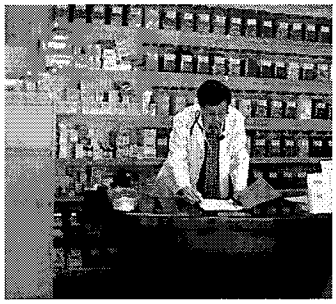
Re-distribution: The fear of illicit re-distribution has been cited as a main reason to maintain centralized federal control over the cultivation and distribution of cannabis. No scientific data has ever been presented to suggest that the re-distribution of cannabis would increase or be more of a concern than it is under the current system. The same measures can be taken as are currently in place for alcohol, cigarettes, or prescription and over-the-counter pharmaceuticals.

The responsibility to dissuade the re-distribution of cannabis should fall on the individual compassion societies. Currently the practice of compassion societies includes clear and firm rules against diversion or re-distribution; memberships have been revoked for the re-distribution of cannabis.

Increased Use: There may be a concern that legitimizing the compassion societies would increase or promote the use of cannabis. Evidence from other jurisdictions with medicinal cannabis programs would appear to counter this claim. After the state of California passed medicinal cannabis legislation in 1996, high school drug use surveys (conducted by the state every 2 years) have shown that the rate of cannabis use has remained steady or has decreased[2].
Increased use is not necessarily a problem. Many people who need medicinal cannabis are currently prevented from accessing the medicine they require. What would undoubtedly result from the decentralization of this program would be a visible shift by medicinal users away from black-market sources to licensed distributors.

Timeline for Implementation

The relationship between Health Canada and the nation's medicinal cannabis users, cultivators and distributors has unfortunately suffered as a result of broken promises, lengthy litigation, and a lack of cooperation and trust. We are compelled to suggest a timeline for the implementation of these necessary changes with the hope of allowing the government to fulfill its obligation in a timely manner and to restore good faith between all parties.



3 months - The MMAR is changed to allow for the legal use of medicinal cannabis with the diagnosis and recommendation of either a physician or other qualified health care practitioner such as a Doctor of Traditional Chinese Medicine or Naturopathic Doctor. Consultations with compassion societies and medicinal users are initiated to produce a regulatory scheme for the community based, not-for profit distribution of medicinal cannabis.

6 months - Licensing scheme is in place for compassion societies. Private cultivators can bid for local, small-scale non-profit cultivation contracts from Compassion Societies. Physician or health care practitioner diagnosis and recommendation allows legal access to medicinal cannabis through compassion societies.

9 months - Health Canada has expanded its research agenda and funding to include compassion societies and university partnerships.
12 months - The program is fully decentralized. National standards in have been collaboratively established for site inspections and the testing of cannabis for strength and safety. Compassion societies are licensed.

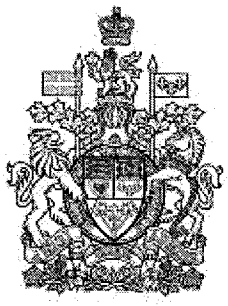
Conclusion:

The future of a successful medicinal cannabis program in this country should focus on the distribution model that has already proven itself to be safe and successful: not-for profit distribution by community-based compassion societies.

For over seven years, national compassion clubs and societies have been risking arrest and prosecution in order to address the pressing medicinal needs of Canada's critically and chronically ill, all at no cost to the taxpayer. This vital work has been recognized by numerous Canadian courts, as well as governmental bodies such as the Senate Special Committee on Illegal Drugs. Compassion societies serve a clear and necessary purpose, and benefit from the support of their local communities and of the Canadian public as a whole.

The decentralization of the Office of Cannabis Medical Access program and the legitimization of these compassionate organizations will not only save Health Canada both time and money, it will also address many of the concerns expressed by those who could benefit from medicinal access to this herb. For the thousands of Canadians who could alleviate their chronic and debilitating symptoms, while staying productive and maintaining a level of hope and happiness despite their serious condition, decentralization is simply the right thing for Health Canada to do.

1 http://thecompassionclub.org/club/standardsapr30.pdf
2 http://www.safestate.org/index.cfm?navID=254



Sénat Senate

CANADA

CANNABIS:

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

SUMMARY REPORT

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DEPUTY CHAIR

COLIN KENNY

SEPTEMBER 2002

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GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see Chapter 7). In the Report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence.

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators as THC increases, the liberation of dopamine in nucleus accumbens and in the cerebral cortex.

At-risk use
Use behaviour which makes users at risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly Delta 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marijuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is

the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure* decriminalization, which entails an amendment to criminal legislation, and *de facto* decriminalization, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard. Other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalization
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see Chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects. Also used to refer to illicit rather than licit (such as nicotine, alcohol or medicines) substances.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states within the EU objective, reliable and comparable information on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate the tissues quickly. THC is highly fat-soluble.

Gateway / Gateway Theory
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then to "hard" drugs. In regard to cannabis, the theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular users than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half-life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate it from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces of inactive THC metabolites can be detected as long as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant transformed into a paste.

International conventions
Various international conventions have been adopted by the international community since 1912, first under the League of Nations, then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions in force are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organization responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems through substance use. Pharmacology generally distinguishes four levels of intoxication: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC in their use are more difficult, especially to determine the therapeutic benefits of cannabis and to examine its effects on driving.

League of Nations
International organisation organization of Sstates until in existence until 1938; now the United Nations.

Legalization
Legislating under a regulatory system the culture, production, marketing, sale and use of substances. Although no such provision currently exist in relation to "street-drugs" (as opposed to alcohol or tobacco which are regulated products), a legalization system could take two forms: free of state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become a synonym for cannabis in popular language usage.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of National Drug Control Policy (ONDCP) USA
Created in 1984 under the Reagan administration, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term most often refers to the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. We prefer to use this term as it is more neutral than the term "drug" and does not refer to the legal status of the substance.

Psychotropic substance (see also psychoactive)
Used synonymously with psychoactive substance, however the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytics, sedatives, neuroleptics, etc. More specifically,the term refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
System of control specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is highly fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, lead to higher levels of THC concentration.

Tolerance
Reduced response of an organism and increased capacity to support the effects of a substance after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs,including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Program works to educate the world about the dangers of drug abuse. The Program aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programs. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO) The World Health Organization, the United Nations' specialized agency for health, was established on April 7, 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

INTRODUCTION

The **Senate Special Committee on Illegal Drugs** addressed the question of drugs just as everyone else does, with the same preconceptions, attitudes, fears and anxieties we all share. Of course, we had at our disposal the 1996 study our colleagues conducted on government legislation dealing with illegal drugs, which had enabled them to hear a number of witnesses over several months. We also knew at the outset that research expertise would be available to us, but it is still difficult to overcome attitudes and opinions that we have long taken for granted. Whether one is in favour of enhanced enforcement or, on the contrary, greater liberalization, opinions often resist the facts and in a field such as this the production of facts, even through scientific research, is not necessarily a neutral undertaking. We, like you, have our prejudices and preconceptions. Together we must make the effort to go beyond such predispositions. That is one of the objectives of this report.

The public policy regime we propose expresses the fundamental premise underlying our report: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy as far as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equality of others.***

We are aware, as much now as we were at the start of our work, that there is no pre-established consensus in Canadian society on public policy choices in the area of drugs. In fact, our research has shown us that there are few societies where there is a broadly shared consensus among the general public, let alone between the public and experts. We are well aware, perhaps more so than at the outset, that the question of illegal drugs, viewed from the standpoint of public policy, has a broad international context and that we cannot think or act in isolation. We know our proposals are provocative, that they will meet with resistance. However, we are also convinced that Canadian society has the maturity and openness to welcome an informed debate.

PART I – GENERAL ORIENTATION

CHAPTER 1 – OUR MANDATE

"That a special committee of the Senate be struck to examine:

- *the approach taken by Canada to cannabis, its preparations, derivatives and similar synthetic preparations, in context;*
- *the effectiveness of this approach, the means used to implement it and the monitoring of its application;*
- *the related official policies adopted by other countries;*
- *Canada's international role and obligations under United Nations agreements and conventions on narcotics, in connection with cannabis, the Universal Declaration of Human Rights and other related treaties; and*
- *the social and health impacts of cannabis and the possible consequences of different policies;*

That the special committee consist of five senators, three of whom shall constitute a quorum;
That the Honourable Senators Banks, Kenny, Nolin, Rossiter and (a fifth Senator to be named by the Chief Government Whip) be named to the committee;
That the committee be authorized to send for persons, papers and records, to hear witnesses, to report from time to time, and to print from day to day such papers and evidence as may be ordered by it;
That the briefs and evidence heard during consideration of Bill C-8, An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof, by the Standing Senate Committee on Legal and Constitutional Affairs during the 2nd Session of the 35th Parliament be referred to the committee;
That the documents and evidence compiled on this matter and the work accomplished by the Special Senate Committee on Illegal Drugs during the 2nd Session of the 36th Parliament be referred to the committee;
That the committee be empowered to authorize, if deemed appropriate, the broadcasting on radio and/or television and the coverage via electronic media of all or part of its proceedings and the information it holds;
That the committee present its final report no later than August 31, 2002; and that the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 30 days after the tabling of that report;
That the committee be authorized, notwithstanding customary practice, to table its report to the Clerk of the Senate if the Senate is not sitting, and that a report so tabled be deemed to have been tabled in the Senate."

The Committee's mandate is a continuation of the evolution of drug legislation passed by the Parliament of Canada in 1996, the *Controlled Drugs and Substances Act.* While this legislation was being studied by the Sub-Committee on Bill C-7 of the Standing Committee on Health of the House of Commons in 1994 and 1995, the vast majority of witnesses were highly critical of the bill. The most common criticisms concerned three points: first, the lack of basic principles or an expressed statement as to the purpose of the act; second, the fact that the bill perpetuated the prohibition system of the 1920s, and third, the absence of any emphasis on harm reduction and prevention criteria. Despite the amendments made by the Sub-Committee of the House, the testimony heard by the Senate Committee was equally critical. Witnesses noted that the Act did not categorize drugs on the basis of the dangers they represented, that it did not contain any specific, rational criteria and that it was impossible, particularly in view of the Act's complexity, to determine how it would be implemented in practice. All of these criticisms led that Senate Committee to "*propose energetically*" the creation of a Joint Committee of the House of Commons and the Senate that would review all Canadian drug legislation, policies and programs. However, the 1997 federal election intervened. Senator Nolin, convinced of the need for action and faced with the inaction of the House of Commons, tabled his first motion in 1999 - that a Senate Committee be struck and given a mandate to examine the legislation, policies and programs on illegal drugs in Canada. The motion was adopted by the Senate in April 2000.

However, that Committee was dissolved by general election of October 2000, and was restruck on March 15, 2001, with an amended mandate: the scope of its work was now restricted to cannabis "in its context". We chose to interpret this sentence broadly.

CHAPTER 2 – OUR WORK

At the Committee's public hearings, the Chair presented the research program as follows:

> *"In order to fully satisfy the mandate conferred upon the committee, the committee has adopted an action plan. This plan centres around three challenges. The first challenge is that of knowledge. We will be hearing from a wide variety of experts, both from Canada and afar, from academic settings, the police, legal specialists, medical specialists, the government sector and social workers. (...)*
> *The second challenge, surely the most noble challenge, is that of sharing knowledge. The committee hopes that Canadians from coast to coast will be able to learn and share the information that we will have collected. In order to meet this challenge, we will work to distribute this knowledge and make it accessible to all. We would also like to hear the opinions of Canadians on this topic and in order to do so, we will be holding public hearings in the spring of 2000 throughout Canada.*
> *And finally, the third challenge for this committee will be to examine and identify the guiding principles on which Canada's public policy on drugs should be based."*

In view of our mandate, including an obligation to provide Canadians with objective and rigorous information, we have emphasized rigour and openness throughout the entire process, an approach that was all the more important as opinions on all sides of the illegal drugs issue are strong and often categorical. But rigour is not enough. For the information to reach Canadians, we could not reserve it for our exclusive use, hence the second principle that guided us: openness. From the outset, we insisted that all our work be made available as soon as possible on our Web site and we entered into direct dialogue with our fellow citizens as well as with experts.

The Committee approved a research program divided into five major axes of knowledge, sub-dividing each one into specific issues:

- the socio-historical, geopolitical, anthropological, criminological and economic issues of the use and regulation of cannabis;
- the medical and pharmacological aspects of the consumption, use and regulation of cannabis;
- the legal aspects from a national perspective;
- the legal and political issues in an international perspective; and
- the ethical issues and Canadians' moral and behavioural standards.

In an attempt to answer these questions in the most effective and economical manner possible, the Committee agreed to perform two tasks concurrently: conduct a research program and hear expert witnesses–complementary activities. We asked the Parliamentary Research Branch and other researchers to produce syntheses and analyses of the relevant literature. In all, the Committee received 23 reports and benefited from summaries of work conducted in other countries, including attendance at international conferences. In all, the Committee held more than 40 days of public hearings in Ottawa and 10 other Canadian communities, hearing more than 100 witnesses from all backgrounds, from across Canada and abroad.

The second component of our program of work was to examine public opinion. That meant we had two closely related responsibilities. The first was a duty to inform, indeed, to educate. We hope those who are offended by that term will pardon our presumption, but we are convinced that on public policy topics that are societal issues, it is the duty of political leaders to transmit information that educates, not merely convinces. The level of knowledge about drugs, even about cannabis, perhaps the best known drug, is often limited and clouded by myth. Our second responsibility in taking public opinion into account was to go out and discover it. We did so in three ways. We publicized our work as widely and as openly as possible to enable everyone to learn about it and react to it. Many chose to write us, although they were relatively few compared with the number of people in this country. We commissioned a qualitative public opinion study. The focus groups conducted across the country as part of that study are described in detail in Chapter 10. We also held public hearings in eight

communities across the country, enabling citizens to come and tell us what they thought, what they knew and what they had experienced.

In order to be able to interpret all this knowledge and come to conclusions and recommendations, the third component of our work focussed on guiding principles.

CHAPTER 3 – GUIDING PRINCIPLES

It has now been thirty years since the Royal Commission of Inquiry on the Non-Medical Use of Drugs, the Le Dain Commission, studied issues similar to those we are studying today. Its report on cannabis, whose scientific conclusions on the effects of the drug were generally accepted by all members of the Commission, led to three reports: a majority report by three of the members, and two minority reports. Each expressed a different concept of the role of the State and of criminal law, and the roles of science and ethics in the choices that had to be made. Having examined each of these subjects, we have elected to set down the guiding principles that clarify the concept we have of the roles that the state, criminal law, science and ethics must play in the development of a public policy on cannabis.

Ethical considerations take us through what is, that is the realm of facts, to the realm of what should be, what would be desirable, moving from recognized facts to standards, then more importantly to values and finally to the means of passing on and above all implementing these values. This is why ethics was our first subject. As a guideline, we have adopted the principle that an ethical public policy on illegal drugs, and on cannabis in particular, must **promote reciprocal autonomy built through a constant exchange of dialogue within the community.**

We always find ourselves in paradoxical situations where, to a certain degree, each person has the free will to make decisions and makes free decisions for himself, while at the same time rules are established in order to regulate interaction with others, a complex and more or less formal, but appropriate approach. The goal of governance is freedom, and not control. It is a question of defining the goals of society through policies and programs of action that are then implemented through systems and processes and upheld by those who govern that permits the encouragement and affirmation of those goals for human action. The law, as a vehicle of choice of governance, does not merely express rules or limitations passed for the benefit of and on behalf of citizens, but seeks a reciprocal process of building social relationships through which people, citizens and governments, can constantly adjust their expectations of behaviour. We therefore accept as a guiding principle for governance that **all of the means the State has at its disposal must work towards facilitating human action, particularly the processes allowing for the building of arrangements between government of the citizenry and governance of the self.**

On the whole, the legal basis of the criminal law is weak where the prescribed standard first, does not concern a relationship with others and where the characteristics of the relationship do not establish a victim and a perpetrator able to recognize his/her

actions; second, has to find its justification outside fundamental social relationships; and third, results in the form of enforcement, the harmful effects of which undermine and challenge the very legitimacy of the law. Where criminal law is involved in these issues, the very standard prescribed by the law turns the perpetrator into the victim and tries to protect him from himself, something it can do only by producing a never-ending stream of knowledge that remains constantly out of his reach. In this context **only offences involving significant direct danger to others should be matters of criminal law.**

The Committee's Report - especially the second part - puts great emphasis on research-based knowledge. This focus is an attempt to do justice to the knowledge that has been developed over the past few decades. We considered it important and indeed necessary to give it detailed consideration. Indeed, the Committee recommends that the drive to acquire knowledge on specific issues we deem important be continued. We do not claim, however, to have answered the fundamental question of why people consume psychoactive substances, such as alcohol, drugs or medication. We were indeed surprised, given the quantity of studies conducted each year on drugs, that this area has not been covered. It is almost as if the quest for answers to technical questions has caused science to lose sight of the basic issue!

Scientific knowledge cannot replace either personal reflection or the political decision-making process. It supports those processes, science's greatest contribution to public drug policy. Our guiding principle is that **science, which must continue to explore specific areas of key issues and reflect on overarching questions, supports the public policy development process.**

These principles have guided our interpretation of the available information as well as our choice of recommendations; the reader should always keep them in mind when reading our report.

CHAPTER 4 – A CHANGING CONTEXT

This chapter puts the Committee's work in context. In recent years, in fact, in the past few months, events of some significance have taken place; some directly linked to illegal drugs, others far removed from them. Obviously, September 11 comes to mind. In social and political terms, the claims of medical users, of recreational users, within the changing context of drug use and, more generally, inter-generational conflict, have to be taken into account. Legislation passed in the aftermath of September 11, some provisions of which could affect police drug investigations, the fight against organized crime and the trial of the Hells Angels in Quebec, must also be taken into account. In legal terms, court decisions have had a direct effect on medical use and a decision will be rendered in the next few months by the Supreme Court on recreational use. In international terms, the fragility of the UNDCP and the development of a continental drug policy for the Americas are relevant to an understanding of certain issues that may even overdetermine national policy. Finally, globalization and the more extreme forms

of economic liberalism have been factors too, primarily in western societies but worldwide as well, in the increase of addictive behaviours, be they the use of drugs or other substitutes for social life.

PART II – CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES

CHAPTER 5 – CANNABIS: FROM PLANT TO JOINT

This chapter first describes the cannabis plant and the various forms in which it becomes a consumer drug. We then take a brief look at the geographical origin of the cannabis plant and the routes along which it circulates in the modern world, noting at the same time current modes of production (soil-based and hydroponic) that have developed in certain regions of Canada. We then describe the pharmacokinetics of the cannabis plant, in particular its main active ingredients, and their metabolism in the body.

Available information on cannabis markets is weak and contradictory. Since 1997, the RCMP's annual reports on drugs suggest that 800 tons of cannabis circulate in Canada each year. Yet, many people told us that cannabis production has increased significantly and that cannabis has become more available than ever in this country. Data on the economic value of the cannabis market are no more reliable. We noted that:

- The size of the national production has significantly increased, and it is estimated that 50% of cannabis available in Canada is now produced in the country;
- The main producer provinces are British Columbia, Ontario and Quebec;
- Estimates of the monetary value of the cannabis market are unreliable. For example, if 400 tons are grown yearly in Canada, at a street value of $225 per ounce, the total value of the Canadian production would be less than $6 billion per year, less than the often quoted value of the BC market alone;
- An unknown proportion of national production is exported to the United States; and
- A portion of production is controlled by organized crime elements.

We heard many alarmist comments on the increased level of active ingredient (THC) in cannabis, however, it is currently impossible to estimate the average content of cannabis available in the market. More sophisticated growing methods have likely contributed to increasing the THC concentration. We observed that:

- In its natural state, cannabis contains between 0.5% and 3% THC. Sophisticated growing methods and genetic progress have made it possible to increase THC content in recent years, but it is impossible to estimate the average content of cannabis available in the market; it is reasonable to consider that content varies between 6% and 31%.

- THC is fat soluble and readily spreads in the innervated tissues of the brain; it reaches a peak in the blood plasma in less than nine minutes and falls to approximately 5% after one hour.
- The body is slow to eliminate THC and inactive THC metabolites can be detected in urine up to 27 days after use in the case of regular users.
- Psychoactive effects generally last two to three hours and may last as many as five to seven hours after use.

CHAPTER 6 – USERS AND USES: FORM, PRACTICE, CONTEXT

Who uses cannabis? How do the patterns of use in Canada compare to those in other countries? In what context is cannabis used? Why? What populations are most vulnerable? What are the social consequences of cannabis, specifically on delinquency and criminal behaviour? Most important, what trajectories do cannabis users follow, specifically with respect to consumption of other drugs?

At the very least, partial answers to these questions are prerequisite to establishing policy on a substance. In Canada, knowledge of patterns and contexts of cannabis use verges on the abysmal. In the early 1980s, the USA, the United Kingdom, and Australia introduced monitoring systems for the general population and the student population. In the last five years, a number of European countries have introduced data collection systems as part of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Canada, by contrast, has carried out only two epidemiological general population surveys specific to drugs (in 1989 and 1994), and only some provinces conduct surveys of the student population, using different methods and instruments that preclude data comparison. Furthermore, few sociological or anthropological studies are conducted on the circumstances or context of illegal drug use, specifically for cannabis. The result is that our pool of knowledge on users and characteristics of use is sorely lacking.

We have no explanation for this situation, at least no satisfactory explanation. In the 1970s, following up on the work done by the Le Dain Commission, Canada could have set up a trend monitoring system. In the 1980s, when Canada's Anti-Drug Strategy was adopted, to which the federal government allocated $210M over five years, a data collection system could well have been created. The fact that it was not could be due to an absence of leadership or vision, a fear of knowing, the division of powers among levels of government, or the absence of a socio-legal research tradition within the departments responsible for justice and health. In fact, all of the above are probable factors. Whatever the case, it is our contention that this situation, unacceptable by definition, requires timely remedial action. We must resign ourselves to working with the scarce Canadian data available, and, more significantly, the virtually non-existent comparable data. We will also look at studies and data from other countries.

The chapter is divided into four sections. The first covers consumption patterns in the population as a whole, then specifically in the 12-18 year age group and compares the patterns in various countries. In the adult population we observed that:

- The epidemiological data available indicates that close to 30% of the population (12 to 64 years old) has used cannabis at least once;
- Approximately 2 million Canadians over age 18 have used cannabis during the previous 12 months, approximately 600,000 have used it during the past month, and approximately 100,000 use it daily. Approximately 10% used cannabis during the previous year; and
- Use is highest between the ages of 16 and 24.

For youth in the 12-17 age group, we observed that:

- Canada would appear to have one of the highest rates of cannabis use among youths;
- Approximately 1 million would appear to have used cannabis in the previous 12 months, 750,000 in the last month and 225,000 would appear make daily use; and
- The average age of introduction to cannabis is 15.

The second section looks at what we know about reasons for and details on use, including origins and cultural differences. The third section deals specifically with cannabis user trajectories, including escalation. We have observed the following:

- Most experimenters stop using cannabis;
- Regular users were generally introduced to cannabis at a younger age. Long-term users most often have a trajectory in which use rises and falls;
- Long-term regular users experience a period of heavy use in their early 20s;
- Most long-term users integrate their use into their family, social and occupational activities; and
- Cannabis itself is not a cause of other drug use. In this sense, we reject the gateway theory.

The fourth and last section covers the relationship between cannabis use and delinquency and crime. Based on research evidence, we concluded that:

- Cannabis itself is not a cause of delinquency and crime; and
- Cannabis is not a cause of violence.

CHAPTER 7 – CANNABIS: EFFECTS AND CONSEQUENCES

When it comes to cannabis, one hears anything and its opposite. While in some areas more research is needed and in others research results are contradictory, there exists nevertheless a strong basis of information contradicting many of the myths that continue to be perpetuated.

This chapter is divided into five sections. The first is a collection of statements on the presumed effects of marijuana that the Committee heard or became aware of through its research. The following three sections examine the acute effects of cannabis, followed in turn by the physiological and neurological consequences, the psychological consequences and the social consequences. Then, because of its significance and the central place it holds in social and political concerns, we turn our attention specifically to the question of any possible dependence arising from prolonged use of cannabis.

With respect to the effects of cannabis, the Committee observed that:

- The immediate effects of cannabis are characterized by feelings of euphoria, relaxation and sociability; they are accompanied by impairment of short-term memory, concentration and some psychomotor skills; and
- Long term effects on cognitive functions have not been established in research.

The Committee has distinguished between use, at-risk use and excessive use. Quantities used, psychosocial characteristics of the users and factors related to use contexts and quality of the substance all come into play to explain the passage from one category to the other. On at-risk use, the Committee observed that:

- Most users are not at-risk users insofar as their use is regulated, irregular and temporary, rarely beyond 30 years of age;
- For users above 16, at-risk use is defined as using between 0.1 to 1 gram per day; and
- Available epidemiological data suggests that approximately 100,000 Canadians might be at-risk users.
- The Committee feels that, because of its potential effects on the endogenous cannabinoid system and cognitive and psychosocial functions, any use in those under age 16 is at-risk use.

With respect to excessive use we observed that:

- More than one gram per day over a long period of time is heavy use, which can have certain negative consequences on the physical, psychological and social well-being of the user. According to the epidemiological data available, there is reason to believe that approximately 80,000 Canadians above age 16 could be excessive users;
- For those between the ages of 16 and 18, heavy use is not necessarily daily use but use in the morning, alone or during school activities;
- Heavy use can have negative consequences for physical health, in particular for the respiratory system (chronic bronchitis, cancer of the upper respiratory tract);
- Heavy use of cannabis can result in negative psychological consequences for users, in particular impaired concentration and learning and, in rare cases and with people already predisposed, psychotic and schizophrenic episodes;
- Heavy use of cannabis can result in consequences for a user's social well-being, in particular their occupational and social situation and their ability to perform tasks; and

- Heavy use of cannabis can result in dependence requiring treatment; however, dependence caused by cannabis is less severe and less frequent than dependence on other psychotropic substances, including alcohol and tobacco.

CHAPTER 8 – DRIVING UNDER THE INFLUENCE OF CANNABIS

If there is one issue, other than the effects of cannabis use on young people or the effects of substance abuse, that is likely to be of concern to society and governments, then it is certainly the effect of the use of cannabis on the ability to drive a vehicle. We are already familiar with the effects of alcohol on driving and the many accidents involving injuries or deaths to young people. In spite of the decreases in use noted in recent years, one fatal accident caused by the use of a substance is one accident too many.

Next to alcohol, cannabis is the most widely used psychoactive substance, particularly among young people in the 16-25 age group. Casual use occurs most often in a festive setting, at weekend parties, often accompanied by alcohol. People in this age group are also the most likely to have a car accident and are also susceptible to having an accident while impaired.

Cannabis affects psychomotor skills for up to five hours after use. The psychoactive effects of cannabis are also dependent on the amount used, the concentration of THC and the morphology, experience and expectations of users. But what are the specific effects of cannabis on the ability to drive motor vehicles? What are the effects of alcohol and cannabis combined? And what tools are available to detect the presence of a concentration of THC that is likely to significantly affect the psychomotor skills involved in vehicle operation?

This chapter is divided into three sections. The first considers the ways of testing for the presence of cannabinoids in the body. The second analyzes studies on the known prevalence of impaired driving, in both accident and non-accident contexts. The third and last summarizes what is known about the effects of cannabis on driving based on both laboratory and field studies. As in the other chapters, the Committee then draw its own conclusions.

The Committee feels it is quite likely that cannabis makes users more cautious, partly because they are aware of their deficiencies and compensate by reducing speed and taking fewer risks. However, because what we are dealing with is no longer the consequences on the users themselves, but the possible consequences of their behaviour on others, the Committee feels that it is important to **opt for the greatest possible caution** with respect to the issue of driving under the influence of cannabis.

Given what we have seen, we conclude the following:

- Between 5% and 12% of drivers may drive under the influence of cannabis; this percentage increases to over 20% for young men under 25 years of age;
- Cannabis alone, particularly in low doses, has little effect on the skills involved in automobile driving. Cannabis leads to a more cautious style of driving. However it has a negative impact on decision time and trajectory. This in itself does not mean that drivers under the influence of cannabis represent a traffic safety risk;
- A significant percentage of impaired drivers test positive for cannabis and alcohol together. The effects of cannabis when combined with alcohol are more significant than is the case for alcohol alone;
- Despite recent progress, there does not yet exist a reliable and non intrusive rapid roadside testing method;
- Blood remains the best medium for detecting the presence of cannabinoids;
- Urine cannot screen for recent use;
- Saliva is promising, but rapid commercial tests are not yet reliable enough;
- The visual recognition method used by police officers has yielded satisfactory results; and
- It is essential to conduct studies in order to develop a rapid testing tool and learn more about the driving habits of cannabis users.

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES

There has been renewed interest in the issue of the use of marijuana for therapeutic purposes in recent years, particularly in Canada. In the wake of an Ontario Court of Appeal ruling which found the provisions of the *Controlled Drugs and Substances Act* to be unconstitutional pertaining to the therapeutic use of marijuana, the federal Minister of Health made new regulations in July 2001 that give people with specified medical problems access to marijuana under certain conditions.

However, the scientific community, the medical community in particular, is divided on the real therapeutic effectiveness of marijuana. Some are quick to say that opening the door to medical marijuana would be a step toward outright legalization of the substance.

But none of that should matter to physicians or scientists. It is not a question of defending general public policy on marijuana or even all illegal drugs. It is not a question of sending a symbolic message about "drugs". It is not a question of being afraid that young people will use marijuana if it is approved as a medicine. The question, and the only question, for physicians as professionals is whether, to what extent and in what circumstances, marijuana serves a therapeutic purpose. Physicians should have to determine whether people with certain diseases would benefit from marijuana use and weigh the side effects against the benefits. If they do decide the patient should use marijuana, they then have to consider how he or she might get it.

This chapter is devoted to the history of the use of marijuana for therapeutic purposes and the status of contemporary knowledge of marijuana and synthetic cannabinoids. We then give a brief account of compassion clubs and other organizations that supply marijuana for therapeutic use, as well as various public policy regimes. We conclude with our views on medical use of marijuana. In a later chapter, we discuss which public policy regime would be most appropriate given the status of medical use of marijuana

We observed that:

- There are clear, though non-definitive indications of the therapeutic benefits of marijuana in the following conditions: analgesic for chronic pain, antispasm for multiple sclerosis, anticonvulsive for epilepsy, antiemetic for chemotherapy and appetite stimulant for cachexi;
- There are less clear indications regarding the effect of marijuana on glaucoma and other medical conditions;
- Marijuana has not been established as a drug through rigorous, controlled studies;
- The quality and effectiveness of marijuana, primarily smoked marijuana, have not been determined in clinical studies;
- There have been some studies of synthetic compounds, but the knowledge base is still too small to determine effectiveness and safety;
- Generally, the effects of smoked marijuana are more specific and occur faster than the effects of synthetic compounds;
- The absence of certain cannabinoids in synthetic compounds can lead to harmful side effects, such as panic attacks and cannabinoid psychoses;
- Smoked marijuana is potentially harmful to the respiratory system;
- People who smoke marijuana for therapeutic purposes self-regulate their use depending on their physical condition and do not really seek the psychoactive effect;
- People who smoke marijuana for therapeutic purposes prefer to have a choice as to methods of use;
- Measures should be taken to support and encourage the development of alternative practices, such as the establishment of compassion clubs;
- The practices of these organizations are in line with the therapeutic indications arising from clinical studies and meet the strict rules on quality and safety;
- The studies that have already been approved by Health Canada must be conducted as quickly as possible;
- The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards;
- The studies should focus on applications and the specific doses for various medical conditions; and
- Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs.

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES

It is always difficult to gauge the public's opinions, attitudes and concerns. The traditional method of surveying a representative sample of the population was too expensive for our resources. Surveys also have limits that we discuss in more detail. However, we did commission a qualitative study using focus groups, the results of which are presented in this chapter. We also report the results of other surveys that we researched and considered. As well, many Canadians wrote to us or sent us e-mails, and others came out to our public hearings to participate. Obviously we cannot draw solid conclusions from this. The people who wrote to us were probably those to whom the issue is very important, regardless of which way they may lean. Some are cited in our Report but we must reiterate that no conclusion should be drawn from these opinions in terms of representativeness. No account of Canadians' opinions on and attitudes toward drugs in general would be complete without an examination of the role of the media in shaping those opinions and attitudes. In recent years, as a result of this Committee's work and other initiatives, various Canadian newspapers and magazines have run stories or have written editorials on the issue. These are the focus of the first part of the chapter. The next part presents the results of surveys and polls, including the survey we commissioned and surveys conducted in different provinces. The last part covers our understanding of what Canadians told us.

We observed the following:

- Public opinion on marijuana is more liberal than it was 10 years ago;
- There is a tendency to think that marijuana use is more widespread and that marijuana is more available than it used to be;
- There is a tendency to think that marijuana is not a dangerous drug;
- The concern about organized crime is significant;
- Support for medical use of marijuana is strong;
- There is a tendency to favour decriminalization or, to a lesser degree, legalization;
- People criticize enforcement of the legislation in regards to simple possession of marijuana; and
- There is a concern for youth and children.

PART III -- POLICIES AND PRACTICES IN CANADA

CHAPTER 11 - A NATIONAL DRUG STRATEGY?

Based on the importance of the subject, it would probably surprise many Canadians to learn that only from 1987 to 1993 did Canada have a fully funded national drug strategy. It is true that Canada has had legislation dealing with the use of psychoactive substances since the passage of the *Opium Act* in 1908. This Act was followed by several pieces of criminal legislation over the years that increased federal

enforcement powers over psychoactive substances and expanded the list of illicit substances. These pieces of legislation have historically focused on the supply of psychoactive substances, adopting a prohibitionist approach to use. It is widely acknowledged now, however, that a more balanced approach is required if one is to deal effectively with those who abuse psychoactive substances.

This chapter recounts the development and implementation of the 1987 National Drug Strategy, which had as an objective the promotion of a balanced approach to the problem of psychoactive substance abuse. This is followed by a discussion of what became of the national strategy and what goals have been achieved.

We observed the following:

- Canada urgently needs a comprehensive and coordinated national drug strategy for which the federal government provides sound leadership;
- Any future national drug strategy should incorporate all psychoactive substances, including alcohol and tobacco;
- To be successful, a national drug strategy must involve true partnerships with all levels of government and with non-governmental organizations;
- Over the years, the intermittency of funding has diminished the ability to coordinate and implement the strategy; adequate resources and a long-term commitment to funding are needed if the strategy is to be successful;
- Clear objectives for the strategy must be set out, and comprehensive evaluations of these objectives and the results are required;
- At the developmental stage, there is a need to identify clear and shared criteria for "success";
- The core funding for the Canadian Centre on Substance Abuse (CCSA) has been insufficient for it to carry out its mandate; proper funding for the CCSA is essential;
- There is a need for an independent organization – the CCSA – to conduct national surveys at least every second year; there is also a need to achieve some level of consistency, comparability and similar time frames for provincially-based school surveys;
- Coordination at the federal level should be given to a body that is not an integral part of one of the partner departments; and
- Canada's Drug Strategy's should adopt a balanced approach – 90% of federal expenditures are currently allocated to the supply reduction.

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT

Drugs have been prohibited for fewer than a hundred years; cannabis for slightly more than 75 years. It is tempting to think that the decisions made over the years to use criminal law to fight the production and use of certain drugs are in keeping with social progress and the advancement of scientific knowledge about drugs. But is this really the case? The history of legislation governing illegal drugs in Canada, like the analysis in Chapter 19 of the structure of international conventions, suggests that it is highly

doubtful. To what extent is such reasoning really rational? Is the rationale of the system of controls acceptable in the eyes of civil society, users as well as abstainers? What criteria motivated legislator decisions? Indeed, were there criteria? What motivated parliamentarians from Canada and elsewhere to prohibit certain substances, to control access to certain others, and to permit still others to be sold over the counter?

Knowing where we have been helps in understanding where we are going. That is the goal of this chapter, retracing the evolution of Canadian drug laws from 1908 to the present day. We have identified three legislative periods. The first, and longest, spans 1908 to 1960, the period of hysteria. We were told that drugs were made criminal because they are dangerous. Analysis of debates in Parliament and in media accounts clearly shows how far this is from truth. When cannabis was introduced in the legislation on narcotics in 1923, there was no debate, no justification, in fact many members did not even know what cannabis was.

The second period, much shorter, runs from 1961 to 1975, the search for lost reason. Following the explosion in drug use in the early 1960s and demands for reform from various sectors of society, governments appointed a commission of inquiry in Canada, the Le Dain Commission. Last comes the contemporary period at the beginning of the 1980s. Reform is not on the policy agenda any more and anti-drug policies have forged ahead.

In summary, we observed that:

- Early drug legislation was largely based on a moral panic, racist sentiment and a notorious absence of debate;
- Drug legislation often contained particularly severe provisions, such as reverse onus and cruel and unusual sentences; and
- The work of the Le Dain Commission laid the foundation for a more rational approach to illegal drug policy by attempting to rely on research data. The Le Dain Commission's work had no legislative outcome until 1996 in certain provisions of the *Controlled Drugs and Substances Act*, particularly with regard to cannabis.

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS

Cannabis has an extremely long history of therapeutic use, going back several thousands of years. It was often used for the same medical conditions it is used for today. With the development of the pharmaceutical industry in the last century, the medical community has gradually discontinued its use. Various factors may explain this. Developments in the pharmaceutical industry provided the medical community with more stable and better tested medication. The practice of medicine itself has changed and so has our conception of health. Then, at the turn of the 20th century, the plants from which opium, cocaine and cannabis are derived were banned by the international community, except for medical and scientific purposes. In the case of cannabis, no rigorous study had been done until recently.

Further to the social rediscovery of cannabis and the identification of its molecular composition and chemical elements in the 1960s, renewed interest in the therapeutic applications of cannabis grew in the early 1970s. More people began using the plant for its therapeutic benefits and many demanded a relaxation of the prohibitionist rules governing cannabis.

Partly because its safety and effectiveness have yet to be reviewed in clinical trials, cannabis has not been approved for sale in Canada as a medical product. Despite this lack of approval, many use cannabis for its therapeutic purposes without legal authorization. In addition, because of the many claims regarding its therapeutic benefit, a growing number of people have called for a less restrictive approach and are demanding access to cannabis for people who could benefit from its use.

This chapter reviews the events that prompted the recent enactment of the *Marihuana Medical Access Regulations*. One of the objectives of the regulations is to provide a compassionate framework of access to marijuana for seriously ill Canadians while research regarding its therapeutic application continues. Also discussed is the implementation of these regulations, which came into force on 30 July 2001.

We have observed the following:

- The MMAR are not providing a compassionate framework for access to marijuana for therapeutic purposes and are unduly restricting the availability of marijuana to patients who may receive health benefits from its use;
- The refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an "illusory" legislative exemption and raises serious Charter implications;
- In almost one year, only 255 people have been authorized to possess marijuana for therapeutic purposes under the MMAR and only 498 applications have been received – this low participation rate is of concern;
- Changes are urgently needed with regard to who is eligible to use cannabis for therapeutic purposes and how such people gain access to cannabis;
- Research on the safety and efficacy of cannabis has not commenced in Canada because researchers are unable to obtain the product needed to conduct their trials;
- No attempt has been made in Health Canada's current research plan to acknowledge the considerable expertise currently residing in the compassion clubs;
- The development of a Canadian source of research-grade marijuana has been a failure.

CHAPTER 14 - POLICE PRACTICES

Views on police priorities regarding enforcement of laws on illicit drugs are, at the very least, inconsistent, if not contradictory. Some believe that too much police time, effort and resources are spent in investigating illicit drug offences and, more specifically, possession offences, even more specifically, cannabis possession offences. Others, including the police themselves, claim that police priorities are already focused

on traffickers and producers, and that possession charges are laid as a result of police presence to deal with other criminal activity. Thus, they maintain that the vast majority of cannabis possession charges are incidental to other police responsibilities.

This chapter reviews the key organizations that are responsible for enforcing Canada's current illicit drugs legislation, the *Controlled Drugs and Substances Act* (CDSA). It includes a discussion of the powers they have been granted, and the investigative techniques used, in relation to illicit drug investigations. Finally, key police-related statistics are explored. This information should help clarify some of the misconceptions related to enforcement of laws on illicit drugs.

The Committee found that:

- The annual cost of drug enforcement in Canada is estimated to be between $700 million and $1 billion;
- Reduced law enforcement activities resulting from amendments to the drug legislation on cannabis could produce substantial savings or a significant reallocation of funds by police forces to other priorities;
- Due to the consensual nature of drug offences, police have been granted substantial enforcement powers and have adopted highly intrusive investigative techniques; these powers are not unlimited, however, and are subject to review by Canadian courts;
- Over 90,000 drug-related incidents are reported annually by police; more than three-quarters of these incidents relate to cannabis and over 50% of all drug-related incidents involve possession of cannabis;
- From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5 – thus, the rate of reported cannabis-related offences has almost doubled in the past decade;
- The number of reported incidents related to the cultivation of cannabis increased dramatically in the past decade;
- Reported incident rates vary widely from province to province;
- Cannabis was involved in 70% of the approximately 50,000 drug-related charges in 1999. In 43% of cases (21,381), the charge was for possession of cannabis.;
- The rate of charges laid for drug offences vary significantly from province to province;
- The uneven application of the law is of great concern and may lead to discriminatory enforcement, alienation of certain groups within society, and creation of an atmosphere of disrespect for the law; in general, it raises the issue of fairness and justice; and
- Statistics on seizure seem to confirm an increase in cannabis cultivation in Canada and also a shift in police priorities regarding this offence.

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM

The previous chapter examined how people first come into contact with the criminal justice system through the enforcement of criminal legislation. Several questions remain, however. What happens once a person has been charged with a drug offence? Who is responsible for prosecuting drug cases? What type of punishment do people receive? Who ends up with a criminal record? Have there been any challenges to the constitutional validity of drug legislation? These issues and others related to the criminal justice system are reviewed in this chapter

We have observed the following:

- The cost of prosecuting drug offences in 2000-2001 was $57 million with approximately $5 million or roughly 10% of the total budget relating to prosecuting cannabis possession offences;
- In 1999, it was estimated that Canadian criminal courts heard 34,000 drug cases, which involved more than 400,000 court appearances;
- The Drug Treatment Court initiatives seem very encouraging, although comprehensive evaluations are needed to ensure such programs are effective;
- Disposition and sentencing data with respect to drug-related offences are incomplete and there is an urgent need to correct this situation;
- Correctional Service Canada spends an estimated $169 million annually to address illicit drugs through incarceration, substance abuse programs, treatment programs and security measures; expenditures on substance abuse programs are unreasonably low, given the number of inmates who have substance-abuse dependence problems;
- A criminal conviction can negatively affect a person's financial situation, career opportunities and restrict travel. In addition, it can be an important factor in future dealings with the criminal justice system; and
- Provincial courts of appeal have so far maintained the constitutionality of cannabis prohibition. They have found that because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to act as it has done, and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7 of the Charter. These decisions have been appealed, and the Supreme Court of Canada will soon decide whether cannabis prohibition is constitutionally sound.

CHAPTER 16 - PREVENTION

Viewed in theory, at least, as a public health issue, a policy on illegal drugs should call for a strong prevention strategy. Nothing, however, is more fluid, vague, or even controversial, than prevention. When it comes to illegal drugs, the legal and political context makes the issue of prevention even harder to clarify and actions even harder to define. The national legal context surrounding illegal drugs and the interpretation of international drug policies are such that because they are defined *a priori* as harmful

substances, illegal drugs must not be used. Another way of putting it is that any use is abuse. If use is abuse, if individuals or organizations involved in prevention are unable to make distinctions that are essential in setting objectives and devising preventive measures, what hope is there of establishing successful prevention programs? There are, as this chapter will show, many prevention programs that are not aimed solely or even particularly at the prevention of use, but rather the prevention of at-risk behaviour. Harm reduction, for example, is not only a general strategy for dealing with psychoactive substances, but is also a preventive approach that seeks to lower the risks associated with drugs and drug control without requiring abstinence. However, harm reduction is the subject of much controversy and criticism because it is based on the premise that use of drugs is a social reality. Addressing the issue of prevention means considering at the same time government policies on illegal drugs. Any discussion of prevention entails discussion of the limits of government intervention and of how one conceives of human action. How far should government interventions go in identifying groups at risk without further stigmatizing groups already at risk? To what extent are humans rational beings who act in their best interest provided they are given the right information?

This chapter on prevention begins with a statement that will come as no surprise to health or justice experts: when it comes to prevention, there is lots of talk, but the resources allocated are small and the initiatives weak. The second section asks the question: what prevention? We look at current knowledge of the factors underlying prevention initiatives and the effectiveness of some preventive measures, with special emphasis on one of the most important weapons in the war on drugs, the DARE program. The third section looks at the harm reduction approach to prevention. As in the other chapters, our conclusions are in the form of observations that may serve to guide future actions.

The Committee found that:

- Prevention is not designed to control but rather to empower individuals to make informed decisions and acquire tools to avoid at-risk behaviour;
- A national drug strategy should include a strong prevention component;
- Prevention strategies must be able to take into account contemporary knowledge about drugs;
- Prevention messages must be credible, verifiable and neutral;
- Prevention strategies must be comprehensive, cover many different factors and involve the community;
- Prevention strategies in schools should not be led by police services or delivered by police officers;
- The RCMP should reconsider its choice of the DARE program that many evaluation studies have shown to be ineffective;
- Prevention strategies must include comprehensive evaluation of a number of key elements;

- A national drug strategy should include mechanisms for widely disseminating the results of research and evaluations;
- Evaluations must avoid reductionism, involve stakeholders in prevention, be part of the program, and include longitudinal impact assessment;
- Harm reduction strategies related to cannabis should be developed in coordination with educators and the social services sector; and
- Harm reduction strategies related to cannabis should include information on the risks associated with heavy chronic use, tools for detecting at-risk and heavy users and measures to discourage people from driving under the influence of marijuana.

CHAPTER 17 - TREATMENT PRACTICES

With the exception of the treatment given to offenders imprisoned in federal institutions and Aboriginals, the care available to individuals who are substance-dependent is essentially the responsibility of the provinces and territories. This chapter is therefore brief since we received only a few submissions and heard few witnesses on this question.

In Chapter 7 we determined that physical dependency on cannabis was rare and insignificant. Some symptoms of addiction and tolerance can be identified in habitual users but most of them have no problem in quitting and do not generally require a period of withdrawal. As far as forms of psychological dependency are concerned, the studies are still incomplete but the international data tend to suggest that between 5% and 10% of regular users (using at least in the past month) are at risk of becoming dependent on cannabis. We estimated that approximately 3% or 600,000 adult Canadians have consumed cannabis in the past month and that approximately 0.5% or 100,000 use it on a daily basis. This indicates that somewhere between 30,000 and 40,000 people might be at-risk and 5,000 to 10,000 might make excessive use. For those aged 16 and 17, the numbers were between 50,000 and 70,000 at-risk and 8,000 to 17,000 potentially excessive users. The data also indicated that the peak period for intensive use is between the ages of 17 and 25 years. These broad parameters indicate where to look to prevent dependency and offer treatment services for those in need.

What form does cannabis dependency take? Most authors agree that psychological dependency on cannabis is relatively minor. In fact, it cannot be compared in any way with tobacco or alcohol dependency and is even less common than dependency on certain psychotropic medications.

We have observed that:

- The expression 'drug addiction' should no longer be used and we should talk instead of substance abuse and dependency;
- Between 5% and 10% of regular cannabis users are at risk of developing a dependency;
- Physical dependency on cannabis is virtually non-existent;

- Psychological dependency is moderate and is certainly lower than for nicotine or alcohol;
- Most regular users of cannabis are able to diverge from a trajectory of dependency without requiring treatment;
- There are many forms of treatment but nothing is known about the effectiveness of the different forms of treatment for cannabis dependency specifically;
- As a rule, treatment is more effective and less costly than incarceration;
- Studies of the treatment programs should be conducted, including treatments programs for people with cannabis dependency; and
- Studies should be conducted on the interaction of the cannabinoid and the opioid systems.

CHAPTER 18 - OBSERVATIONS ON PRACTICES

Previous chapters have described public action by dividing it into the major sectors of involvement. Before closing the third part of this report, we make some general observations that cut across the individual areas we have examined. The first concerns difficulties in harmonizing the various levels and sectors of involvement; the second, the difficulty in co-ordinating their various approaches; and the third, the costs of drugs and public policy.

A study published by CCSA in 1996 but based on 1992 data had identified the following costs of substance abuse:

- The costs associated with all illegal drugs were $1.4 billion, compared with $7.5 billion in the case of alcohol and $9.6 billion in the case of tobacco.
- Expressed as a percentage of the gross domestic product, the total costs for all substances was 2.67%. Of this, 0.2% was for illegal drugs, 1.09% for alcohol and 1.39% for tobacco.
- The principal costs of illegal drugs are externalities, that is, loss of productivity - $823 million, health care - $88 million, and losses in the workplace - $5.5 million, for a total of about 67% of all costs related to illegal drugs.
- The cost of public policies, or opportunity costs, represent about 33%.
- The cost of enforcing the law represents about 29.2% of all costs, or about 88% of all policy costs. The balance goes to prevention, research and administration.

Previous studies conducted in British Columbia in 1991, in Ontario in 1988 and in Quebec in 1988, using different methodologies, established costs of $388 million, $1.2 billion and $2 billion respectively, for a total cost of $3.5 billion in these three provinces alone. These figures demonstrate the extent to which such estimates can vary, according to the methodology selected and the availability of data.

Nevertheless, with the CCSA study taken as the standard, two comments must be made. First, loss of productivity – the major cost – is measured in mortality - $547 million and morbidity - $275 million. Except in the case of traffic fatalities, cannabis is not a cause of death and involves none of this type of social cost. Morbidity corresponds to losses attributed to problems caused by drug use as measured by the difference between the average annual income of users and of the population in general. Here, two further observations about cannabis should be noted. A large proportion of cannabis users are young people who are not yet part of the workforce and cannabis use involves none of the addiction and attendant problems that follow from heroin or cocaine use. Therefore, the costs that can be attributed to cannabis in this regard are likely minimal. If one accepts the methodology of the authors, **cannabis in itself entails few externalities**, which are the main measures of the social cost of illegal drugs.

However, it should also be noted that the study did not calculate the costs of substance-related crime. Alcohol is well known for its frequent association with crimes of violence (at least 30% of all cases), as well as with impaired driving, which results in major social and economic losses. Crime related to illegal drugs is of several types: organized crime, crimes against property committed in order to pay for drugs, true mainly in the case of heroin and cocaine, and crimes of violence committed under the influence of drugs. With the exception of organized crime and driving under the influence, cannabis involves few of the factors that generate criminal behaviour.

Secondly, according to the CCSA's study, the main cost of illegal drugs, after loss of productivity, is the cost of law enforcement, which the study estimates at approximately $400 million. In Chapters 14 and 15, we note that police and court costs are certainly much higher than this figure, and probably total between $1 and $1.5 billion. The proportion of these costs attributable to cannabis is impossible to determine for certain. But, insofar as 77% of all drug-related offences involve cannabis, and of these 50% simple possession, and given that about 60% of incidents result in a charge, of which some 10% to 15% of cases the accused receives a prison sentence, it is clear that a considerable proportion of the drug-related activity addressed by the penal justice system is concerned with cannabis. While admitting this to be a very rough estimate, we suggest that about 30% of the activity of the justice system is tied up with cannabis. On the basis of our estimates and the lowest cost of law enforcement, or $1 billion, it costs about $300 million annually to enforce the cannabis laws.

In effect, the main social costs of cannabis are a result of public policy choices, primarily its continued criminalization, while the consequences of its use represent a small fraction of the social costs attributable to the use of illegal drugs.

Overall, we observed the following:

- The lack of any real national platform for discussion and debate on illegal drugs prevents the development of clear objectives and measurement indicators;
- The absence of a national platform makes exchange of information and best practices impossible;
- Practices and approaches vary considerably between and within provinces and territories;
- The conflicting approaches of the various players in the field are a source of confusion;
- The resources and powers of enforcement are greatly out of balance compared with those of the health and education fields and the civil society;
- The costs of all illegal drugs had risen to close to $1.4 billion in 1992;
- Of the total costs of illegal drugs in 1992, externalities (social costs) represented 67% and public policy costs 33%;
- The social costs of illegal drugs and the public policy costs are underestimated ;
- The cost of enforcing the drug laws is more likely to be closer to $1 billion to $1.5 billion per annum;
- The principal public policy cost relative to cannabis is that of law enforcement and the justice system; which may be estimated to represent a total of $300 to $500 million per annum;
- The costs of externalities attributable to cannabis are probably minimal - no deaths, few hospitalizations, and little loss of productivity;
- The costs of public policy on cannabis are disproportionately high given the drug's social and health consequences; and
- The Canadian Centre on Substance Abuse is seriously under-funded; its annual budget amounts to barely 0.1% of the social costs of illegal drugs alone (alcohol not included). Its budget should be increased to at least 1%; that is, approximately $15 million per annum.

PART IV-PUBLIC POLICY OPTIONS

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT

This chapter could begin and end with the same words: The international drug control conventions are, at least with respect to cannabis, an utterly irrational restraint that has nothing to do with scientific or public health considerations.

Three points bear making concerning the substance of the current conventions.

The first has to do with the absence of definitions. The terms drugs, narcotics and psychotropics are not defined in any way except as lists of products included in schedules. It follows that any natural or synthetic substance on the list of narcotics is, for the purposes of international law, a narcotic, and that a psychotropic is defined in

international law by its inclusion in the list of psychotropics. The only thing that the 1961 Convention tells us about the substances to which it applies is that they can be abused. The 1971 Psychotropics Convention, which reversed the roles in that the synthetic drug producing countries wanted narrower criteria, indicates that the substances concerned may cause dependence or central nervous system stimulation or depression and may give rise to such abuse as to "constitute a public health problem or a social problem that warrants international control."

The second point, following from the first, relates to the arbitrary nature of the classifications. While cannabis is included, along with heroin and cocaine, in Schedules I and IV of the 1961 Convention, which carry the most stringent controls, it is not even mentioned by name in the 1971 Convention, though THC is listed as a Schedule I psychotropic along with mescaline, LSD and so on. The only apparent criterion is medical and scientific use, which explains why barbiturates are in Schedule III of the 1971 Convention and therefore subject to less stringent controls than natural hallucinogens. These classifications are not just arbitrary, but inconsistent with the substances' pharmacological classifications and their danger to society.

Third, if there was so much concern about public health based on how dangerous "drugs" are, one has to wonder why tobacco and alcohol are not on the list of controlled substances.

We conclude from these observations that the international regime for the control of psychoactive substances, beyond any moral or even racist roots it may initially have had, **is first and foremost a system that reflects the geopolitics of North-South relations in the 20th century**. Indeed, the strictest controls were placed on organic substances – the coca bush, the poppy and the cannabis plant – which are often part of the ancestral traditions of the countries where these plants originate, whereas the North's cultural products, tobacco and alcohol, were ignored and the synthetic substances produced by the North's pharmaceutical industry were subject to regulation rather than prohibition. It is in this context that the demand made by Mexico on behalf of a group of Latin American countries during the negotiations leading up to the 1988 Convention, that their use be banned, must be understood. It was a demand that restored the balance to a degree, as the countries of the South had been forced to bear the full brunt of the controls and their effects on **their own people** since the inception of drug prohibition. The result may be unfortunate, since it reinforces a prohibitionist regime that history has been shown to be a failure, but it may have been the only way, given the mood of the major Western powers, to demonstrate the irrationality of the entire system in the longer term. In any case, it is a short step from there to question the legitimacy of instruments that help to maintain the North-South disparity yet fail miserably to reduce drug supply and demand.

We make the following observations:

- The series of international agreements concluded since 1912 have failed to achieve their ostensible aim of reducing the supply of drugs;
- The international conventions constitute a two-tier system that regulates the synthetic substances produced by the North and prohibits the organic substances produced by the South, while ignoring the real danger the substances represent for public health;
- When cannabis was included in the international conventions in 1925, there was no knowledge of its effects;
- The international classifications of drugs are arbitrary and do not reflect the level of danger they represent to health or to society;
- Canada should inform the international community of the conclusions of our report and officially request the declassification of cannabis and its derivatives.

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES

The vast majority of Canadians have heard about the "war on drugs" which the USA is conducting and about its prohibitionist approach, but many would be surprised to see the major variations between states, indeed between cities, within that country. Even fewer know that Sweden enforces a prohibitionist policy at least as strict as that of the US, but through other means. Many of us have, in one way or another, heard about the "liberal" approach introduced in the Netherlands in 1976. Fewer people know of the Spanish, Italian, Luxembourg or Swiss approaches, which are even more liberal in certain respects. More recently, Canadians learned of the decision by the UK's Minister of the Interior to reclassify cannabis as a Class C drugs, but it is not clear that we know precisely what that means. In view of the preconceptions that many may have in relation to France with regard to wine, many may be surprised to learn that its policy on cannabis appears more "conservative" than that of neighbouring Belgium, for example. As may be seen, after the overall framework of the puzzle has been established by the international community, the ways the pieces are put together vary widely among states, and at times among the regions of a single state.

That is why, in order to learn about the experience and approaches of other countries, the Committee commissioned a number of research reports on the situations in other countries and heard representatives of some of those countries in person. We of course had to make some choices, such as limiting ourselves to the western countries of the northern hemisphere. This is a weak point in our Report, we agree, but our resources were limited. In addition, as we wanted to compare public policies with data on use trends and judicial practices, we were forced to choose countries with an information base. In our hearings with representatives of those countries, we were mainly limited by time and cost.

In this chapter, we describe the situations in five European countries — France, the Netherlands, the United Kingdom, Sweden and Switzerland — and in Australia and the United States.

CHAPTER 21 - PUBLIC POLICY OPTIONS

Public policy is not just a matter of enabling legislation, in this case criminal legislation. Nonetheless, when it comes to illegal drugs, criminal legislation occupies a symbolic and determinative place. It is as if this legislation is the backbone of our public policy. Public discussions of cannabis do not deal so much with such matters as public health, user health, prevention of at-risk or excessive use, but with such questions as the pros and cons of decriminalization, establishing a civil offence or maintaining a criminal offence, or possible legalization and the extent thereof.

In respect of illegal drugs, where the key issues are, first and foremost, matters of public health and culture (including education and research), and where criminal law should be used only as a last resort, public policy must be based primarily on clear principles and objectives. For this to come about, public policy must be equipped with a set of tools designed to deal with the various issues that drugs represent to societies. Legislation is only one such tool. The social and economic costs of illegal drugs affect many aspects of society through lower productivity and business loss, hours of hospitalization and medical treatment of all kinds, police time and prison time, and broken or lost lives. Even if no one can pinpoint the exact figures, a portion of these costs arise, not from the substances themselves, but from the fact that they are criminalized. In fact, more than for any other illegal drug, its criminalization is the principal source of social and economic costs. However, in spite of the fact that the principal social costs of drugs affect business, health and family, the emphasis on the legal debate tips the scales of public action in favour of law enforcement agencies. No one can deny that their work is necessary to ensure public order and peace and fight organized crime. At the same time, over 90% of resources are spent on enforcing the law, the most visible actions with respect to drugs in the public sphere are police operations and court decisions and, at least with respect to cannabis, the law lags behind individual attitudes and opinions, thus creating a huge gap between needs and practice.

Most national strategies display a similar imbalance. The national strategies that appear to have the greatest chance of success, however, are those that strive to correct the imbalance. These strategies have introduced knowledge and observation tools, identified indicators of success with respect to their objectives, and established a veritable nerve centre for implementing and monitoring public policy. The law, criminal law especially, is put in its proper place as one method among many of reaching the defined objectives, not an aim in itself.

This chapter is divided into three sections. The first examines the effectiveness of legal measures for fighting drugs, and shows that legal systems have little effect on consumption or supply. The second section describes the various components of a public policy. The third considers the direction of criminal policy, and defines the main terms used: decriminalization, depenalization, diversion, legalization, and regulation.

In our view, it is clear that if the aim of public policy is to diminish consumption and supply of drugs, specifically cannabis, all signs indicate

complete failure. One might think the situation would be worse if not for current anti-drug action. This may be so. Conversely, one might also think that the negative impact of anti-drug programs that are currently centre stage are greater than the positive effect, specifically non-compliance with laws that are inconsistent with majority attitudes and behaviour. One of the reasons for this failure is the excessive emphasis placed on criminal law in a context where prohibition of use and a drug-free society appear to remain the omnipresent and determining direction of current public policies.

We think that a public policy **on psychoactive substances must be both integrated and adaptable, target at-risk uses and behaviours and abuses based on a public health approach that neither trivializes nor marginalizes users.** Implementation of such a policy must be multifaceted.

Some say that decriminalization is a step in the right direction, one that gives society time to become accustomed to cannabis, to convince opponents that chaos will not result, to adopt effective preventive measures. We believe however that **this approach is in fact the worst case scenario, depriving the State of a necessary regulatory tool for dealing with the entire production, distribution, and consumption network, and delivering hypocritical messages at the same time.**

In our opinion, the data we have collected on cannabis and its derivatives provide sufficient grounds for our general conclusion that the **regulation of the production, distribution and consumption of cannabis, inasmuch as it is part of an integrated and adaptable public policy, is best able to respond to the principles of autonomy, governance that fosters human responsibility and limitation of penal law to situations where there is demonstrable harm to others. A regulatory system for cannabis should permit, specifically:**

- ***more effective targeting of illegal traffic and a reduction in the role played by organized crime;***
- ***prevention programs better adapted to the real world and better able to prevent and detect at-risk behaviour;***
- ***enhanced monitoring of products, quality and properties;***
- ***better user information and education; and***
- ***respect for individual and collective freedoms, and legislation more in tune with the behaviour of Canadians.***

In our opinion, Canadian society is ready for a responsible policy of cannabis regulation that complies with these basic principles.

CONCLUSIONS AND RECOMMENDATIONS

The Senate Special Committee on Illegal Drugs' mandate was to examine Canada's public policy approach in relation to cannabis and assess its effectiveness and impact in light of the knowledge of the social and health-related effects of cannabis and the international context. Over the past two years, the Committee has heard from Canadian and foreign experts and reviewed an enormous amount of scientific research. The Committee has endeavoured to take the pulse of Canadian public opinion and attitudes and to consider the guiding principles that are likely to shape public policy on illegal drugs, particularly cannabis. Our report has attempted to provide an update on the state of knowledge and the key issues, and sets out a number of conclusions in each chapter.

This final section sets out the main conclusions drawn from all this information and presents the resulting recommendations derived from the thesis we have developed namely: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy as far as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equality of others.***

LE DAIN – THIRTY YEARS AGO ALREADY

Thirty years ago, the Le Dain Commission released its report on cannabis. This Commission had far greater resources than we did. However, we had the benefit of Le Dain's work, a much more highly developed knowledge base since then and of thirty years' historical perspective.

The Commission concluded that the criminalization of cannabis had no scientific basis. Thirty years later, we confirm this conclusion and add that continued criminalization of cannabis remains unjustified based on scientific data on the danger it poses.

The Commission heard and considered the same arguments on the dangers of using cannabis: apathy, loss of interest and concentration, learning difficulties. A majority of the Commissioners concluded that these concerns, while unsubstantiated, warranted a restrictive policy. Thirty years later, we assert that the studies done in the meantime have not confirmed the existence of the so-called amotivational syndrome

and add that most studies rule out this syndrome as a consequence of the use of cannabis.

The Commission concluded that not enough was known about the long-term and excessive use of cannabis. We assert that these types of use exist and may present some health risks; excessive use, however, is limited to a minority of users. Public policy, we would add, must provide ways to prevent and screen for at-risk behaviour, something our policies have yet to do.

The Commission concluded that the effects of long-term use of cannabis on brain function, while largely exaggerated, could affect adolescent development. We concur, but point out that the long-term effects of cannabis use appear reversible in most cases. We note also that adolescents who are excessive users or become long-term users are a tiny minority of all users of cannabis. Once again, we would add that a public policy must prevent use at an early age and at-risk behaviour.

The Commission was concerned that the use of cannabis would lead to the use of other drugs. Thirty years' experience in the Netherlands disproves this clearly, as do the liberal policies of Spain, Italy and Portugal. And here in Canada, despite the growing increase in cannabis users, we have not had a proportionate increase in users of hard drugs.

The Commission was also concerned that legalization would mean increased use, among the young in particular. We have not legalized cannabis, and we have one of the highest rates in the world. Countries adopting a more liberal policy have, for the most part, rates of usage lower than ours, which stabilized after a short period of growth.

Thirty years later, we note that:

- Billions of dollars have been sunk into enforcement without any greater effect. There are more consumers, more regular users and more regular adolescent users;
- Billions of dollars have been poured into enforcement in an effort to reduce supply, without any greater effect. Cannabis is more available than ever, it is cultivated on a large scale, even exported, swelling coffers and making organized crime more powerful; and
- There have been tens of thousands of arrests and convictions for the possession of cannabis and thousands of people have been incarcerated. However, use trends remain totally unaffected and the gap the Commission noted between the law and public compliance continues to widen.

It is time to recognize what is patently obvious: our policies have been ineffective, because they are poor policies.

INEFFECTIVENESS OF THE CURRENT APPROACH

No clearly defined federal or national strategy exists. Some provinces have developed strategies while others have not. There has been a lot of talk but little significant action. In the absence of clear indicators accepted by all stakeholders to assess Canadian public policy, it is difficult to determine whether action that has been taken is effective.

Given that policy is geared to reducing demand (i.e. drug-use rates) and supply (by reducing the availability of drugs and pushing up drug prices), both these indicators may be used. A look at trends in cannabis use, both among adults and young people, **forces us to admit that current policies are ineffective**. In Chapter 6, we saw that trends in drug-use are on the increase. If our estimates do indeed reflect reality, no fewer that 2million Canadians aged between 18 and 65 have used cannabis at least once over the past 12 months, while at least 750,000 young people between the ages of 14 and 17 use cannabis at least once per month, one third of them on a daily basis. This proportion appears, at least in the four most highly-populated provinces, to be increasing. Statistics suggest that both use and at-risk use is increasing.

Of course, we must clearly establish whether the ultimate objective is a drug-free society, at least one free of cannabis, or whether the goal is to reduce at-risk behaviour and abuse. This is an area of great confusion, since Canadian public policy continues to use vague terminology and has failed to establish whether it focuses on substance abuse as the English language terminology used in several documents seems to suggest or on drug-addiction as indicated by the French language terminology.

It is all very well to criticize the "trivialization" of cannabis in Canada, to "explain" increases in use, but it must also be established why, if this is indeed the case, this trivialization has occurred. It is also important to identify the root cause of this trivialization against a backdrop of mainly anti-drug statements. The courts and their lenient attitude might be blamed for this. Perhaps the judiciary is at the forefront of those responsible for cannabis policies and the enforcement of the law. It must also be determined whether sentences are really as lenient as some maintain. A major issue to be addressed is whether harsher sentences would indeed be an effective deterrent given that the possibility of being caught by the police is known to be a much greater deterrent. Every year, over 20,000 Canadians are arrested for cannabis possession. This figure might be as high as 50,000 depending on how the statistics are interpreted. No matter what the numbers, they are too high for this type of conduct. However, even those numbers are laughable number when compared to the three million people who have used cannabis over the past 12 months. We should not think that the number of arrests could be significantly increased even if billions more dollars were allocated to police enforcement. Indeed, such a move should not even be considered.

A look at the availability and price of drugs, **forces us to admit that supply-reduction policies are ineffective**. Throughout Canada, above all in British Columbia

and Quebec, the cannabis industry is growing, flooding local markets, irritating the United States and lining the pockets of criminal society. Drug prices have not fallen but quality has improved, especially in terms of THC content – even if we are sceptical of the reported scale of this improvement. Yet, police organizations already have greater powers and latitude – especially since the September 11, 2001 tragedy – in relation to drugs than in any other criminal matter. In addition, enforcement now accounts for over 90 % of all spending related to illegal drugs. To what extent do we want to go further down this road?

Clearly, current approaches are ineffective and inefficient. Ultimately, their effect amounts to throwing taxpayers' money down the drain in a crusade that is not warranted by the danger posed by the substance. It has been maintained that drugs, including cannabis, are not dangerous because they are illegal but rather are illegal because they are dangerous. This is perhaps true of other types of drugs, but not of cannabis. We should state this clearly once and for all, for public good: it is time to stop this crusade.

PUBLIC POLICY BASED ON GUIDING PRINCIPLES

However much we might wish good health and happiness for everyone, we all know how fragile they are. Above all, we realize that health and happiness cannot be forced on a person, especially not by criminal law based on a specific concept of what is morally 'right'. No matter how attractive calls for a drug-free society might be, and even if some people might want others to stop smoking, drinking alcohol, or smoking joints, we all realize that these activities are part of our social reality and the history of humankind.

Consequently, what role should the State play? It should neither abdicate responsibility and allow drug markets to run rife, nor should it impose a particular way of life on people. We have opted, instead, for a concept whereby public policy **promotes and supports freedom for individuals and society as a whole**. For some, this would undoubtedly mean avoiding drug use. However, for others, the road to freedom might be via drug use. For society as a whole, in practice, this concept means a State that does not dictate what should be consumed and under what form. Support for freedom necessarily means flexibility and adaptability. It is for this reason that public policy on cannabis has to be clear while at the same time tolerant, to serve as a guide while at the same time avoiding imposing a single standard. This concept of the role of the State is based on the **principle of autonomy and individual and societal responsibility.** Indeed, it is much more difficult to allow people to make their own decisions because there is less of an illusion of control. It is just that: an illusion. We are all aware of that. It is perhaps sometimes comforting, but is likely to lead to abuse and unnecessary suffering. An ethic of responsibility teaches social expectations, expectations not to use drugs in public or sell them to children and responsible

behaviour, recognizing at-risk behaviour and being able to use moderately, and supports people facing hardship by providing a range of treatment.

From this concept of government action ensues a limited role for criminal law. As far as cannabis is concerned, **only behaviour causing demonstrable harm to others should be prohibited**: illegal trafficking, selling to minors and impaired driving.

Public policy shall also draw on available knowledge and scientific research but without expecting science to provide the answers to political issues. Indeed, scientific knowledge does have a major role to play **in supporting decision-making,** at both the individual and government levels. But science should play no greater role. It is for this reason that the Committee considers that a drug and dependency monitoring agency and a research program should be set up to help future decision-makers.

A CLEAR AND COHERENT FEDERAL STRATEGY

Although the Committee has focused on cannabis, we have nevertheless observed inherent shortcomings in the federal drug strategy. Quite obviously, there is no real strategy or focused action. Behind the assumed leadership provided by Health Canada there emerges a lack of necessary tools for action, a patchwork of ad hoc approaches varying from one substance to another and piecemeal action by various departments. Of course, co-ordinating bodies do exist, but lack real tools and clear objectives, each focusing its action according to its own particular priorities. This state of affairs has resulted in a whole series of funded programs being developed without any tangible cohesion.

Many stakeholders have expressed their frustration to the Committee at the apparently vanishing pieces of the puzzle and at the whole gamut of incoherent decisions, that cause major friction on the front lines. Various foreign observers also expressed their surprise that a country as rich as Canada, which is not immune to psychoactive substance-related problems, did not have a "champion", a spokesperson or a figure of authority able to fully grasp the real issues and obtain genuine cooperation from all of the stakeholders.

It is for this reason that we are recommending the creation of the position of National Advisor on Psychoactive Substances and Dependency to be attached to the Privy Council. We do not envisage this as a superstructure responsible for managing budgets and action related to psychoactive substances. We favour an approach similar to that of the *Mission interministérielle à la drogue et à la toxicomanie* in France over one modelled on that of the United States' Office of National Drug Control Policy. The Advisor would have a small dedicated staff, the majority of whom would be on assignment from various federal departments and bodies involved in drug issues.

The Advisor would be responsible: for advising the Cabinet and the Prime Minister on national and international psychoactive substance-related issues; for ensuring coordination between federal departments and agencies; for overseeing the

development of federal government psychoactive substance-related objectives and ensuring these objectives are satisfied; and to serve as a Canadian government spokesperson on issues related to psychoactive substances at an international level.

Recommendation 1

The Committee recommends that the position of National Advisor on Psychoactive Substances and Dependency be created within the Privy Council Office; that the Advisor be supported by a small secretariat and that the necessary staff be assigned by federal departments and agencies involved with psychoactive substances on request.

NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESSOURCES AND TOOLS

A federal policy and strategy do not in themselves make a national strategy. Provinces, territories, municipalities, community organizations and even the private sector all have a role to play in accordance with their jurisdiction and priorities. This is necessary and this diversity is worth encouraging. However, some harmonization and meaningful discussion on practices and pitfalls, on progress and setbacks, and on knowledge are to be encouraged. Apart from those provided by the resource-starved piecemeal actions of the Canadian Centre on Substance Abuse, there are all too few opportunities and schemes to promote exchanges of this type. **The current and future scale of drug and dependency-related issues warrants that the Canadian government earmark the resources and establish the tools with which to develop fair, equitable and considered policies.**

Like the majority of Canadian and foreign observers of the drug situation, we were struck by the relative lack of tools and measures for determining and following up on the objectives of public psychoactive substance policy. One might not agree with the numbers-focused goals set out by the Office of National Drug Control Policy for the reduction of drug use or for the number of drug treatment programs set up and evaluated. However, we have to admit that at least these figures serve as guidelines for all stakeholders and as benchmarks against which to measure success.

Similarly, one might not feel totally comfortable with the complex Australian goal-definition process, whereby the whole range of partners from the various levels of government, organizations and associations meet at a conference every five years to review goals. However, at least those goals agreed upon by the various stakeholders constitute a clear reference framework and enable better harmonization of action.

The European monitoring system with its focal points in each country of the European Union under the European Monitoring Centre for Drugs and Drug Addiction umbrella might seem cumbersome; and the American system of conducting various annual epidemiological studies might appear expensive. We might even

acknowledge that there are problems with epidemiological studies, which are far from providing a perfect picture of the psychoactive substance use phenomena. However, at least these tools, referred to and used throughout the western world, permit the development of a solid information base with which to analyse historical trends, identify new drug-use phenomena and react rapidly. In addition, it allows for an assessment of the relevance and effectiveness of action taken. No system of this type exists in Canada, which is the only industrialized western country not to have such a knowledge structure.

It is for these reasons that the Committee recommends that the Government of Canada support various initiatives to develop a genuine national strategy. Firstly, the Government should call a national conference of the whole range of partners with a view to setting out goals and priorities for action over a five-year period. This conference should also identify indicators to be used in measuring progress at the end of the five-year period. Secondly, the Canadian Centre on Substance Abuse needs to be renewed. Not only does this body lack resources but it is also subject to the vagaries of political will of one Minister, the Minister of Health. The Centre should have a budget in proportion with the scale of the psychoactive substance problem and should have the independence required to address this issue. Lastly, a Canadian Monitoring Agency on Drugs and Dependency should be created within the Centre.

Recommendation 2

The Committee recommends that the Government of Canada mandate the National Advisor on Psychoactive Substances and Dependency to call a high-level conference of key stakeholders from the provinces, territories, municipalities and associations in 2003, to set goals and priorities for action on psychoactive substances over a five-year period.

Recommendation 3

The Committee recommends that the Government of Canada amend the enabling legislation of the Canadian Centre on Substance Abuse to change the Centre's name to the *Canadian Centre on Psychoactive Substances and Dependency*; make the Centre accountable to Parliament; provide the Centre with an annual basic operating budget of $15 million to be increased annually; require the Centre to table an annual report on actions taken, key issues, research and trends in Parliament and in the provincial and territorial legislatures; mandate the Centre to ensure national coordination of research on psychoactive substances and dependency and to conduct studies into

specific issues; and mandate the Centre to undertake an assessment of the national strategy on psychoactive substance and dependency every five years.

Recommendation 4
The Committee recommends that, in the legislation creating the Canadian Centre on Psychoactive Substances and Dependency, the Government of Canada specifically include provision for the setting up of a Monitoring Agency on Psychoactive Substances and Dependency within the Centre; provide that the Monitoring Agency be mandated to conduct studies every two years, in cooperation with relevant bodies, on drug-use trends and dependency problems in the adult population; work with the provinces and territories towards increased harmonization of studies of the student population and to ensure they are carried out every two years; conduct ad hoc studies on specific issues; and table a bi-annual report on drug-use trends and emerging problems.

A PUBLIC HEALTH POLICY

When cannabis was listed as a prohibited substance in 1923, no public debate or discussion was held on the known effects of the drug. In fact, opinions expressed were disproportionate to the dangers of the substance. Half a century later, the Le Dain Royal Commission of Inquiry on the Non-Medical Use of Drugs held a more rational debate on cannabis and took stock of what was known about the drug. Commissioners were divided not so much over the nature and effects of the drug but rather over the role to be played by the State and criminal law in addressing public health-related goals. Thirty years after the Le Dain Commission report, we are able to categorically state that, **used in moderation, cannabis in itself poses very little danger to users and to society as a whole, but specific types of use represent risks for users.**

In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed to discrimination by the police and the criminal justice system; society sees the power and wealth of organized crime enhanced as criminals benefit from prohibition; and governments see their ability to prevent at-risk use diminished.

We would add that, **even if cannabis were to have serious harmful effects, one would have to question the relevance of using the criminal law to limit these effects.** We have demonstrated that criminal law is not an appropriate governance tool for matters relating to personal choice and that prohibition is known to result in harm

which often outweighs the desired positive effects. However, current scientific knowledge on cannabis, its effects and consequences are such that this issue is not relevant to our discussion.

Indeed available data indicate that the scale of the cannabis use phenomenon can no longer be ignored. Chapter 6 indicated that no fewer than 30% of Canadians (12 to 64 years old) have experimented with cannabis at least once in their lifetime. In all probability, this is an underestimation. We have seen that approximately 50% of high school students have used cannabis within the past year. Nevertheless, a high percentage of them stop using, and the vast majority of those who experiment do not go on to become regular users. Even among regular users, only a small proportion develop problems related to excessive use, which may include some level of psychological dependency. Consumption patterns among cannabis users do not inevitably follow an upward curve but rather a series of peaks and valleys. Regular users also tend to have a high rate of consumption in their early twenties, which then either drops off or stabilizes, and in the vast majority of cases, most often ceasing altogether in their thirties.

All of this does not in any way mean, however, that cannabis use should be encouraged or left unregulated. Clearly, it is a psychoactive substance with some effects on cognitive and motor functions. When smoked, cannabis can have harmful effects on the respiratory airways and is potentially cancerous. Some vulnerable people should be prevented, as much as possible, from using cannabis. This is the case for young people under 16 years of age and those people with particular conditions that might make them vulnerable, for example those with psychotic predispositions. As with alcohol, adult users should be encouraged to use cannabis in moderation. Given that, as for any substance, at-risk use does exist, preventive measures and detection tools should be established and treatment initiatives must be developed for those who use the drug excessively. Lastly, it goes without saying that education initiatives and severe criminal penalties must be used to deter people from operating vehicles under the influence of cannabis.

As for any other substance, there is at-risk use and excessive use. There is no universally accepted criterion for determining the line between regular use, at-risk use and excessive use. The context in which use occurs, the age at which users were introduced to cannabis, substance quality and quantity are all factors that play a role in the passage from one type of use to another. Chapters 6 and 7 identified various criteria, which we have collated in table form below.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport...) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

Even if **cannabis itself poses very little danger to the user and to society as a whole, some types of use involve risks.** It is time for our public policy to recognize this and to **focus on preventing at-risk use and on providing treatment for excessive cannabis users.**

Recommendation 5

The Committee recommends that the Government of Canada adopt an integrated *policy on the risks and harmful effects of psychoactive substances* covering the whole range of substances (medication, alcohol, tobacco and illegal drugs). With respect to cannabis, this policy should focus on educating users, detecting and preventing at-risk use and treating excessive use.

A REGULATORY APPROACH TO CANNABIS

The **prohibition of cannabis does not bring about the desired reduction in cannabis consumption or problematic use.** However, this approach does have a whole series of harmful consequences. Users are marginalized, and over 20,000 Canadians are arrested each year for cannabis possession. Young people in

schools no longer enjoy the same constitutional and civil protection of their rights as others. Organized crime benefits from prohibition and the criminalization of cannabis enhances their power and wealth. Society will never be able to stamp out drug use – particularly cannabis use.

Some might believe that an alternative policy signifies abandoning ship and giving up on promoting well-being for Canadians. Others might maintain that a regulatory approach would fly in the face of the fundamental values of our society. We believe, however, that the continued prohibition of cannabis jeopardizes the health and well-being of Canadians much more than does the substance itself or the regulated marketing of the substance. In addition, we believe that the continued criminalization of cannabis undermines the fundamental values set out in the *Canadian Charter of Rights and Freedoms* and confirmed in the history of a country based on diversity and tolerance.

We do not want to see cannabis use increase, especially among young people. Of note, the data from other countries that we compared in Chapters 6 and 20 indicate that countries such as the Netherlands, Australia and Switzerland, which have put in place a more liberal approach, have not seen their long-term levels of cannabis use rise. The same data also clearly indicate that countries with a very restrictive approach, such as Sweden and the United States, are poles apart in terms of cannabis use levels and that countries with similar liberal approaches, such as the Netherlands and Portugal, are also at opposite ends of the spectrum, falling somewhere between Sweden and the United States. We have concluded that public policy itself has little effect on cannabis use trends and that other more complex and poorly understood factors play a greater role in explaining the variations.

An exemption regime making cannabis available to those over the age of 16 could probably lead to an increase in cannabis use for a certain period. Use rates would then level off as interest wanes and as effective prevention programs are set up. A roller coaster pattern of highs and lows would then follow, as has been the case in most other countries.

This approach is neither one of total abdication nor an indication of abandonment but rather a vision of the role of the State and criminal law as **developing and promoting but not controlling human action** and as **stipulating only necessary prohibitions** relating to the fundamental principle of respect for life, other persons and a harmonious community, and as **supporting and assisting others, not judging and condemning difference**.

We might wish for a drug-free world, fewer smokers or alcoholics or less prescription drug dependency, but we all know that we shall never be able to eliminate these problems. More importantly, we should not opt to criminalize them. The Committee believes that the same healthy and respectful approach and attitude should be applied to cannabis.

It is for this reason that the Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme, under which the production and sale of cannabis would be licensed. Licensing

and the production and sale of cannabis would be subject to specific conditions, which the Committee has endeavoured to specify. For clarity's sake, these conditions have been compiled at the end of this section. It should be noted at the outset that the Committee suggests cigarette manufacturers should be prohibited from producing and selling cannabis.

Recommendation 6
The Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme. This legislation should stipulate the conditions for obtaining licences as well as for producing and selling cannabis; criminal penalties for illegal trafficking and export; and the preservation of criminal penalties for all activities falling outside the scope of the exemption scheme.

Recommendation 7
The Committee recommends that the Government of Canada declare an amnesty for any person convicted of possession of cannabis under current or past legislation.

A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE

In Chapter 9, we noted that cannabis has not been approved as a medicinal drug in the pharmacological sense of the word. In addition to the inherent difficulties in conducting studies on the therapeutic applications of cannabis, there are issues arising from the current legal environment and the undoubtedly high cost to governments of conducting such clinical studies.

Nevertheless, we do not doubt that for some medical conditions and for certain people cannabis is indeed an effective and useful therapy. Is it more effective than other types of medication? Perhaps not. Can physicians currently prescribe cannabis at a known dosage? Undoubtedly not. Should persons suffering from certain physical conditions diagnosed by qualified practitioners be permitted to use cannabis if they wish to do so? Of this, we are convinced.

The regulations made in 2001 by Health Canada, even though they are a step in the right direction, are fundamentally unsatisfactory. They do not facilitate access to therapeutic cannabis. They do not consider the experience and expertise available in compassion clubs. These regulations only govern marijuana and do not include cannabis derivatives such as hashish and cannabis oils.

It is for these reasons that the Committee recommends that Health Canada amend the *Marihuana Medical Access Regulations* in order to allow compassionate access to cannabis and its derivatives. As in the previous chapter, proposed rules have been compiled at the end of this chapter.

Recommendation 8

The Committee recommends that the *Marijuana Medical Access Regulations* be amended to provide new rules regarding eligibility, production and distribution with respect to cannabis for therapeutic purposes. In addition, research on cannabis for therapeutic purposes is essential.

PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS

In Chapter 8, we discussed the fact that research has not clearly established the effects of cannabis when taken alone on a person's ability to operate a vehicle. Nevertheless, there is enough evidence to suggest that operating a vehicle while under the influence of cannabis alters motor functions and affects a person's ability to remain in his or her lane. We have also established that the combined effects of cannabis and alcohol impair faculties even more than does alcohol taken alone. Epidemiological studies have shown that a certain number of cannabis users do drive under the influence of the substance and that a large proportion of these people, mainly the young, appear to believe that cannabis does not impair their ability to drive.

This chapter also indicated that no reliable and non-intrusive roadside detection tools exist. Saliva-based equipment is a promising development but for the time being, provide random results. We have also established that a visual recognition system, which has mainly been developed and assessed in the United States, is a reliable way of detecting drug-induced impaired driving faculties.

Recommendation 9

The Committee recommends that the Criminal Code be amended to lower permitted alcohol levels to 40 milligrams of alcohol per 100 millilitres of blood, in the presence of other drugs, especially, but not exclusively cannabis; and to admit evidence from expert police officers trained in detecting persons operating vehicles under the influence of drugs.

RESEARCH

Research on psychoactive substances, and particularly on cannabis, has undergone a boom over the past 20 years. The Committee was able to fully grasp the actual extent of this increase since we faced the challenge of summarizing it. Not all research is of the same quality and the current political and legal climate governing cannabis hampers thorough and objective studies. Nevertheless, a solid fact base was available to the Committee, on which to establish its conclusions and recommendations.

However, more research needs to be done in a certain number of specific areas. In Chapter 6, we established that a lack of practical research on cannabis users has resulted in only a limited amount of information on contexts of use being available. It is also currently difficult to establish criteria on the various types of cannabis use in order to guide those responsible for prevention. The Committee suggests that cannabis use of over one gram per day constitutes excessive use and that between 0.1 and one gram per day equates to at-risk use. We also suggest that any use below 16 years of age is at-risk use. This is of course enlightened speculation, but speculation nevertheless, which remains to be explored.

In Chapters 16 and 17, we referred to the fact that we know very little about the most effective prevention practices and treatment. Here also, the current context hindered. As far as prevention is concerned, the more or less implicit *"just say no"* message and the focus on cannabis use prevention are strategies that have been dictated by the prohibition-based environment. In terms of treatment for problem users, abstinence-based models have long been the dominant approach and continue to sit very poorly with harm-reduction-based models. Thorough assessment studies are required.

The Canadian Centre on Psychoactive Substances and Dependency must play a key role in co-ordinating and publishing the results of studies. The Centre does not have to conduct research itself. This can and indeed must sometimes be carried out by academics. The Health Research Institutes are also natural players. However, it is important to clearly identify a single central body to collect research information. This will enable the information to be distributed as widely possible and, we hope, used.

Recommendation 10

The Committee recommends that the Government of Canada create a national fund for research on psychoactive substances and dependency to fund research on key issues, more particularly on various types of use, on the therapeutic applications of cannabis, on tools for detecting persons operating vehicles under the influence of drugs and on effective prevention and treatment programs; that the Government of Canada mandate the Canadian Centre on

Psychoactive Substances and Dependency to co-ordinate national research and serve as a resource centre.

CANADA'S INTERNATIONAL POSITION

The Committee is well aware that were Canada to choose the rational approach to regulating cannabis we have recommended, it would be in contravention of the provisions of the various international conventions and treaties governing drugs. We are also fully aware of the diplomatic implications of this approach, in particular in relation to the United States.

We are keen to avoid replicating, at the Canada - US border, the problems that marked relations between the Netherlands, France, Belgium and Germany over the issue of drug tourism between 1985 and 1995. This is one of the reasons that justifies restricting the distribution of cannabis for recreational purposes to Canadian residents.

We are aware of the fact that a proportion of the cannabis produced in Canada is exported, mainly to the United States. We are also aware that a considerable proportion of heroin and cocaine comes into Canada via the United States. We are particularly cognisant of the fact that Canadian cannabis does not explain the increase in cannabis use in the United States. It is up to each country to get its own house in order before criticizing its neighbour.

Internationally, Canada will either have to temporarily withdraw from the conventions and treaties or accept that it will be in temporary contravention until the international community accedes to its request to amend them. The Committee opts for the second approach, which seems to us to be more consistent with the tradition and spirit of Canadian foreign policy. In addition, we have seen that international treaties foster the imbalanced relationship between the northern and southern hemispheres by prohibiting access to plants, including cannabis, produced in the southern hemisphere, while at the same time developing a regulatory system for medication manufactured by the pharmaceutical industry in the northern hemisphere. Canada could use this imbalanced situation to urge the international community to review existing treaties and conventions on psychoactive substances.

Canada can and indeed should provide leadership on drug policy. Developing a national information and action infrastructure would undoubtedly be key to this. **Canada must also play a leading role in the Americas.** We believe that Canada enjoys a favourable international reputation and that it can promote the development of fairer and more rational drug, in particular cannabis policies. We also contend that Canada should strive for the creation of a European observatory style Drug and Dependency Monitoring Agency for the Americas within the Organization of American States.

Recommendation 11

The Committee recommends that the Government of Canada instruct the Minister of Foreign Affairs and International Trade to inform the appropriate United Nations authorities that Canada is requesting an amendment to the conventions and treaties governing illegal drugs; and that the development of a Drugs and Dependency Monitoring Agency for the Americas be supported by the Government of Canada.

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES

Amendments to the
Marijuana Medical Access Regulations
(Production and sale of cannabis for therapeutic purposes)

A. Eligible person

A person affected by one of the following: wasting syndrome; chemotherapy treatment; fibromyalgia; epilepsy; multiple sclerosis; accident-induced chronic pain; and some physical condition including migraines and chronic headaches, whose physical state has been certified by a physician or an individual duly authorized by the competent medical association of the province or territory in question, may choose to buy cannabis and its derivatives for therapeutic purposes. The person shall be registered with an accredited distribution centre or with Health Canada.

B. Licence to distribute

A Canadian resident may obtain a licence to distribute cannabis and its derivatives for therapeutic purposes. The resident must undertake to only sell cannabis and its derivatives to eligible persons; to only sell cannabis and its derivatives purchased from producers duly licensed for this purpose; to keep detailed records on the medical conditions and their development, consumption and the noted effects on patients; to take all measures needed to ensure the safety of the cannabis products and to submit to departmental inspections.

C. Licence to produce

A Canadian resident may obtain a licence to produce cannabis and its derivatives for therapeutic purposes. The resident must undertake: to not hold a licence to produce cannabis for non therapeutic purposes; to take the measures necessary to ensure the consistency, regularity and quality of crops; to take the measures necessary to ensure the security of production sites; to know and document the properties and concentrations of each harvest with respect to Delta 9 THC; to sell only to accredited distribution centres and to submit to departmental inspections.

D. Other proposals

- Ensure that expenses relating to the use of cannabis for therapeutic purposes will be eligible for a medical expenses tax credit;
- Establish a program of research into the therapeutic applications of cannabis, by providing sufficient funding; by mandating the Canadian Centre on Psychoactive Substances and Dependency to co-ordinate the research program; and by providing for the systematic study of clinical cases based on the documentation available in organizations currently distributing cannabis for therapeutic purposes and in future distribution centres; and
- Ensure that the advisory committee on the therapeutic use of cannabis represents all players, including distribution centres and users.

Amendment to the *Controlled Drugs and Substances Act* (CDSA) (Production and sale of cannabis for non therapeutic purposes)

A. General aims of the bill

- To reduce the injurious effects of the criminalization of the use and possession of cannabis and its derivatives;
- To permit persons over the age of 16 to procure cannabis and its derivatives at duly licensed distribution centres; and
- To recognize that cannabis and its derivatives are psychoactive substances that may present risks to physical and mental health and, to this end, to regulate the use and trade of these substances in order to prevent at-risk use and excessive use.

B. Licence to distribute

Amend the Act to create a scheme providing for exemption to the criminal offences provided in the CDSA with respect to the distribution of cannabis. A Canadian resident may obtain a licence to distribute cannabis. The resident must undertake **not to distribute to persons under the age of 16; must never have been sentenced for a criminal offence, with the exception of offences related to the possession of cannabis, for which an amnesty will be declared**; and must agree to procure cannabis only from duly licensed producers. In addition, in accordance with potential restrictions under the *Canadian Charter of Rights and Freedoms*, licensed distributors shall not display products explicitly and shall not advertise in any manner.

C. Licence to produce

Amend the Act to create an exemption to the criminal offences provided in the CDSA with respect to the production of cannabis. A Canadian resident may obtain a licence to produce cannabis. The resident must undertake to only sell to duly licensed distributors; to sell only marijuana and hashish with a THC content of 13% or less; to limit production to the quantity specified in the licence; to take the measures needed to ensure the security of production sites; to keep detailed records of quantities produced, crops, levels of THC concentration and production conditions; and to submit to departmental inspections. No person charged with and sentenced for criminal offences, with the exception of the possession of cannabis, for which an amnesty will be declared, shall be granted a licence. No person or legal entity, directly or indirectly associated with the production, manufacture, promotion, marketing or other activity connected with tobacco products and derivatives shall be granted a licence. In accordance with potential restrictions under the *Canadian Charter of Rights and Freedoms*, cannabis products and their derivatives shall not be advertised in any manner.

D. Production for personal use

Amend the Act to create an exemption to the criminal offences provided in the CDSA in order to permit the personal production of cannabis so long as it is not sold for consideration or exchange in kind or other and not advertised or promoted in any other way. In addition, quantities shall be limited to ensure production is truly for personal consumption.

E. Consumption in public

Consumption in public places frequented by young people under 16 years of age shall be prohibited.

F. International trade

All forms of international trade, except those explicitly permitted under the Act shall be subject to the penalties provided in the CDSA for illegal trafficking.

G. Other proposals

- Ensure the establishment of a National Cannabis Board with duly mandated representatives of the federal government and the governments of the provinces and territories. The Board would keep a national register on the production and sale of cannabis and its derivatives, set the amount and distribution of taxes taken on the sale of cannabis products and ensure the taxes collected on the production and sale of cannabis and derivatives are

directed solely to prevention of at-risk use, treatment of excessive users, research and observation of trends and the fight against illegal trafficking.

- The provinces and territories would continue to develop prevention measures that should be directed at at-risk use, as a priority. The Canadian Centre on Psychoactive Substances and Dependency should be mandated to collect best treatment practices and ensure an exchange of information on effective practices and their evaluation.
- The provinces and territories would continue to develop support and treatment measures that should be directed at excessive use, as a priority. The Canadian Centre on Psychoactive Substances and Dependency should be mandated to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.
- Resources available to police and customs to fight smuggling, export in all its forms and cross-border trafficking should be increased.