Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 2:35 PM
To: Public Hearing
Subject: FW: San Fransisco's full medical cannabis act.
Attachments: MCD-Article_33.pdf; ATT00001.txt

-----Original Message-----
From: Jamie Shaw s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 1:57 PM
To: Correspondence Group, City Clerk's Office
Subject: San Fransisco's full medical cannabis act.

https://www.sfdph.org/dph/files/EHSdocs/MedCannabis/MCD-Article_33.pdf

ARTICLE 33: MEDICAL CANNABIS ACT

SEC. 3301. DEFINITIONS.

For the purposes of this Article:

(a) "Cannabis" means marijuana and all parts of the plant Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It includes marijuana infused in foodstuff. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seeds of the plant are incapable of germination.

(b) "City" means the City and County of San Francisco.

(c) "Convicted" means having pled guilty or having received a verdict of guilty, including a verdict following a plea of nolo contendere, to a crime.

(d) "Director" means the Director of Public Health or any individual designated by the Director to act on his or her behalf, including but not limited to inspectors.

(e) [*Reserved.*]

(f) "Medical cannabis dispensary" means a cooperative or collective of ten or more qualified patients or primary caregivers that facilitates the lawful cultivation and distribution of cannabis for medical purposes and operates not for profit, consistent with California Health & Safety Code Sections 11362.5 et seq., with the Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use issued by the California Attorney General in August 2008, and with this ordinance. A cooperative must be organized and registered as a Consumer Cooperative Corporation under the Corporations Code, Sections 12300, et seq., or a Nonprofit Cooperative Association under the Food and Agricultural Code, Sections 54002, et seq. A collective may be organized as a corporation, partnership or other legal entity under state law but must be jointly owned and operated by its members. As set forth in Section 3308(q), a medical cannabis dispensary may purchase or obtain cannabis only from members of the cooperative or collective and may sell or distribute cannabis only to members of the cooperative or collective. As set forth in Section 3308(c), a medical cannabis dispensary

may operate only on a not for profit basis and pay only reasonable compensation to itself and its members and pay only reasonable out-of-pocket expenses.
(g) "Medical Cannabis Identification Card" or "Identification Card" means a document issued by the State Department of Health Services pursuant to California Health and Safety Code Sections 11362.7 et seq. or the City pursuant to Health Code Article 28 that identifies a person authorized to engage in the medical use of cannabis and the person's designated primary caregiver, if any, or identifies a person as a primary caregiver for a medical cannabis patient.
(h) "Permittee" means the owner, proprietor, manager, or operator of a medical cannabis dispensary or other individual, corporation, or partnership who obtains a permit pursuant to this Article.
(i) "Primary caregiver" shall have the same definition as California Health and Safety Code Section 11362.7 et seq., and as may be amended, and which defines "primary caregiver" as an individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include a licensed clinic, a licensed health care facility, a residential care facility, a hospice, or a home health agency as allowed by California Health and Safety Code Section 11362.7(d)(1-3).
(j) "Qualified patient" shall have the same definition as California Health and Safety Code Section 11362.7 et seq., and as may be amended, and which states that a "qualified patient" means a person who is entitled to the protections of California Health and Safety Code Section 11362.5, but who does not have a valid medical cannabis identification card. For the purposes of this Article, a "qualified patient who has a valid identification card" shall mean a person who fulfills all of the requirements to be a "qualified patient" under California Health and Safety Code Section 11362.7 et seq. and also has a valid medical cannabis identification card
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-07, File No. 070667, App. 10/2/2007; Ord. 25-09, File No. 081199, App. 2/13/2009)

SEC. 3302. MEDICAL CANNABIS GUIDELINES.

Pursuant to the authority granted under Health and Safety Code section 11362.77, the City and County of San Francisco enacts the following medical cannabis guidelines:
(a) A qualified patient, person with a valid identification card, or primary caregiver may possess no more than eight ounces of dried cannabis per qualified patient. In addition, a qualified patient, person with a valid identification card, or primary caregiver may also maintain no more than twenty-four (24) cannabis plants par qualified patient or up to 25 square feet of total garden canopy measured by the combined vegetative growth area.
(b) If a qualified patient, person with an identification card, or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient, person with an identification card, or primary caregiver may possess an amount of cannabis consistent with the patient's needs.
(c) Only the dried mature processed flowers of female cannabis plant or the plant conversion shall be considered when determining allowable quantities of cannabis under this section.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3303. PERMIT REQUIRED FOR MEDICAL CANNABIS DISPENSARY.

Except for research facilities, it is unlawful to operate or maintain, or to participate therein, or to cause or to permit to be operated or maintained, any medical cannabis

dispensary without first obtaining a final permit pursuant to this Article. It is unlawful to operate or maintain, or to participate therein, or to cause or to permit to be operated or maintained, any medical cannabis dispensary with a provisional permit issued pursuant to this Article.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-06, File No. 060032, Effective without the signature of the Mayor)

SEC. 3304. APPLICATION FOR MEDICAL CANNABIS DISPENSARY PERMIT.

(a) Every applicant for a medical cannabis dispensary permit shall file an application with the Director upon a form provided by the Director and pay a non-refundable permit application fee of $8,459 to cover the costs to all City departments of investigating and processing the application and any applicable surcharges, exclusive of filing fees for appeals before the Board of Appeals. Beginning with fiscal year 2008-2009, fees set forth in this Section may be adjusted each year, without further action by the Board of Supervisors, as set forth in this Section.

Not later than April 1, the Director shall report to the Controller the revenues generated by the fees for the prior fiscal year and the prior fiscal year's costs of operation, as well as any other information that the Controller determines appropriate to the performance of the duties set forth in this Section.

Not later than May 15, the Controller shall determine whether the current fees have produced or are projected to produce revenues sufficient to support the costs of providing the services for which the fees are assessed and that the fees will not produce revenue which is significantly more than the costs of providing the services for which the fees are assessed.

The Controller shall if necessary, adjust the fees upward or downward for the upcoming fiscal year as appropriate to ensure that the program recovers the costs of operation without producing revenue which is significantly more than such costs. The adjusted rates shall become operative on July 1.

(b) The permit application form shall provide clear notice to applicants that the California Fire Code includes a requirement, among others that may apply, that an establishment obtain a place of assembly permit if it will accommodate 50 or more persons based on its square footage.

(c) The applicant for a medical cannabis dispensary permit shall set forth, under penalty of perjury, following on the permit application:

(1) The proposed location of the medical cannabis dispensary;

(2) The name and residence address of each person applying for the permit and any other person who will be engaged in the management of the medical cannabis dispensary;

(3) A unique identifying number from at least one government-issued form of identification, such as a social security card, a state driver's license or identification card, or a passport for of each person applying for the permit and any other person who will be engaged in the management of the medical cannabis dispensary;

(4) Written evidence that each person applying for the permit and any other person who will be engaged in the management of the medical cannabis dispensary is at least 18 years of age;

(5) All felony convictions of each person applying for the permit and any other person who will be engaged in the management of the medical cannabis dispensary;

(6) Whether cultivation of medical cannabis shall occur on the premises of the medical cannabis dispensary;

(7) Whether smoking of medical cannabis shall occur on the premises of the medical cannabis dispensary;
(8) Whether food will be prepared, dispensed or sold on the premises of the medical cannabis dispensary; and
(9) Proposed security measures for the medical cannabis dispensary, including lighting and alarms, to ensure the safety of persons and to protect the premises from theft.
(e) If the applicant is a corporation, the applicant shall set forth the name of the corporation exactly as shown in its articles of incorporation, and the names and residence addresses of each of the officers, directors and each stockholder owning more than 10 percent of the stock of the corporation. If the applicant is a partnership, the application shall set forth the name and residence address of each of the partners, including limited partners. If one or more of the partners is a corporation, the provisions of this Section pertaining to a corporation apply.
(f) The Director is hereby authorized to require in the permit application any other information including, but not limited to, any information necessary to discover the truth of the matters set forth in the application.
(g) The Department of Public Health shall make reasonable efforts to arrange with the Department of Justice and with DOJ-certified fingerprinting agencies for fingerprinting services and criminal background checks for the purposes of verifying the information provided under Section 3304(c)(5) and certifying the listed individuals as required by Section 3307(c)(4). The applicant or each person listed in Section 3304(c)(5) shall assume the cost of fingerprinting and background checks, and shall execute all forms and releases required by the DOJ and the DOJ-certified fingerprinting agency.
(Added by Ord. 271-05, File No. 051747, App. 11/30/2005; amended by Ord. 273-05, File No. 051748, App. 11/30/2005; Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-06, File No. 060032, Effective without the signature of the Mayor; Ord. 225-07, File No. 070667, App. 10/2/2007; Ord. 149-08, File No. 080744, App. 7/30/2008; Ord. 25-09, File No. 081199, App. 2/13/2009)

SEC. 3305. REFERRAL TO OTHER DEPARTMENTS.

(a) Upon receiving a completed medical cannabis dispensary permit application and permit application fee, the Director shall immediately refer the permit application to the City's Planning Department, Department of Building Inspection, Mayor's Office on Disability, and Fire Department.
(b) Said departments shall inspect the premises proposed to be operated as a medical cannabis dispensary and confirm the information provided in the application and shall make separate written recommendations to the Director concerning compliance with the codes that they administer.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-06, File No. 060032, Effective without the signature of the Mayor; Ord. 225-07, File No. 070667, App. 10/2/2007)

SEC. 3306. NOTICE OF HEARING ON PERMIT APPLICATION.

(a) After receiving written approval of the permit application from other City Departments as set out in Section 3305, and notice from the Department of Building Inspection that it has approved a building permit, the Director shall fix a time and place for a public hearing on the application, which date shall not be more than 45 days after the Director's receipt of the written approval of the permit application from other City Departments.

(b) No fewer than 10 days before the date of the hearing, the permit applicant shall cause to be posted a notice of such hearing in a conspicuous place on the property at which the proposed medical cannabis dispensary is to be operated. The applicant shall comply with any requirements regarding the size and type of notice specified by the Director. The applicant shall maintain the notice as posted the required number of days. (Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-06, File No. 060032, Effective without the signature of the Mayor)

SEC. 3307. ISSUANCE OF MEDICAL CANNABIS DISPENSARY PERMIT.

(a) Within 14 days following a hearing, the Director shall either issue a provisional permit or mail a written statement of his or her reasons for denial thereof to the applicant.

(b) In recommending the granting or denying of a provisional permit and in granting or denying the same, the Director shall give particular consideration to the capacity, capitalization, complaint history of the applicant and any other factors that in their discretion he or she deems necessary to the peace and order and welfare of the public. In addition, prior to granting a provisional permit, the Director shall review criminal history information provided by the Department of Justice for the purpose of certifying that each person applying for the permit and any other person who will be engaged in the management of the medical cannabis dispensary has not been convicted of a violent felony within the State of California, as defined in Penal Code section 667.5(c), or a crime that would have constituted a violent felony as defined in Penal Code section 667.5(c) if committed within the State of California. However, the Director may certify and issue a medical cannabis dispensary provisional permit to any individual convicted of such a crime if the Director finds that the conviction occurred at least five years prior to the date of the permit application or more than three years have passed from the date of the termination of a penalty for such conviction to the date of the permit application and, that no subsequent felony convictions of any nature have occurred.

(c) No medical cannabis dispensary provisional permit shall be issued if the Director finds:

(1) That the applicant has provided materially false documents or testimony; or

(2) That the applicant has not complied fully with the provisions of this Article; or

(3) That the operation as proposed by the applicant, if permitted, would not have complied will all applicable laws, including, but not limited to, the Building, Planning, Housing, Police, Fire, and Health Codes of the City, including the provisions of this Article and regulations issued by the Director pursuant to this Article; or

(4) That the permit applicant or any other person who will be engaged in the management of the medical cannabis dispensary has been convicted of a violent felony as defined in Penal Code section 667.5(c) within the State of California or a crime that would have constituted a violent felony as defined in Penal Code section 667.5(c) if committed within the State of California. However, the Director may issue a medical cannabis dispensary provisional permit to any individual convicted of such a crime if the Director finds that the conviction occurred at least five years prior to the date of the permit application or more than three years have passed from the date of the termination of a penalty for such conviction to the date of the permit application and, that no subsequent felony convictions of any nature have occurred; or

(5) That a permit for the operation of a medical cannabis dispensary, which permit had been issued to the applicant or to any other person who will be engaged in the management of the medical cannabis dispensary, has been revoked, unless more than five years have passed from the date of the revocation to the date of the application; or

(6) That the City has revoked a permit for the operation of a business in the City which permit had been issued to the applicant or to any other person who will be engaged in the management of the medical cannabis dispensary unless more than five years have passed from the date of the application to the date of the revocation.
(d) Applicants with provisional permits shall secure a Certificate of Final Completion and Occupancy as defined in San Francisco Building Code Section 307 and present it to the Director, and the Director shall issue the applicant a final permit.
(e) The Director shall notify the Police Department of all approved permit applications.
(f) The final permit shall contain the following language: "Issuance of this permit by the City and County of San Francisco is not intended to and does not authorize the violation of State or Federal law."
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-06, File No. 060032, Effective without the signature of the Mayor; Ord. 225-07, File No. 070667, App. 10/2/2007)

SEC. 3308. OPERATING REQUIREMENTS FOR MEDICAL CANNABIS DISPENSARY.

(a) Medical cannabis dispensaries shall meet all the operating criteria for the dispensing of medical cannabis as is required pursuant to California Health and Safety Code Section 11362.7 et seq., by this Article, by the Director's administrative regulations for the permitting and operation of medical cannabis dispensaries and by the AG's Guidelines.
(b) Medical cannabis dispensaries shall be operated only as collectives or cooperatives in accordance this ordinance. All patients or caregivers served by a medical cannabis dispensary shall be members of that medical cannabis dispensary's collective or cooperative. Medical cannabis dispensaries shall maintain membership records on-site or have them reasonably available.
(c) The medical cannabis dispensary shall operate on a not for profit basis. It shall receive only compensation for the reasonable costs of operating the dispensary, including reasonable compensation incurred for services provided to qualified patients or primary caregivers to enable that person to use or transport cannabis pursuant to California Health and Safety Code Section 11362.7 et seq., or for payment for reasonable out-of-pocket expenses incurred in providing those services, or both. Reasonable out-of-pocket expenses may include reasonable expenses for patient services, rent or mortgage, utilities, employee costs, furniture, maintenance and reserves. Sale of medical cannabis to cover anything other than reasonable compensation and reasonable out-of-pocket expenses is explicitly prohibited. Once a year, commencing in March 2008, each medical cannabis dispensary shall provide to the Department a written statement by the dispensary's permittee made under penalty of perjury attesting to the dispensary's compliance with this paragraph. Upon request by the Department, based on reasonable suspicion of noncompliance, the medical cannabis dispensary shall provide the Department copies of, or access to, such financial records as the Department determines are necessary to show compliance with this paragraph. Reasonable suspicion is defined as possession of specific and articulate facts warranting a reasonable belief that the dispensary is not complying with the requirement that it be not for profit. Financial records are records of revenues and expenses for the organization, including but not limited to Board of Equalization returns, payroll records, business expense records and income tax returns. The Director only shall disclose these financial records to those City and County departments necessary to support the Director's review of the records. Upon completion of the Director's review,

and provided that the Director no longer has any need for the records, the Director shall return any financial records, and copies thereof, to the medical cannabis dispensary.

(d) Medical cannabis dispensaries shall sell or distribute only cannabis manufactured and processed in the State of California that has not left the State before arriving at the medical cannabis dispensary.

(e) It is unlawful for any person or association operating a medical cannabis dispensary under the provisions of this Article to permit any breach of peace therein or any disturbance of public order or decorum by any tumultuous, riotous or disorderly conduct, or otherwise, or to permit such dispensary to remain open, or patrons to remain upon the premises, between the hours of 10 p.m. and 8 a.m. the next day. However, the Department shall issue permits to two medical cannabis dispensaries permitting them to remain open 24 hours per day. These medical cannabis dispensaries shall be located in order to provide services to the population most in need of 24 hour access to medical cannabis. These medical cannabis dispensaries shall be located at least one mile from each other and shall be accessible by late night public transportation services. However, in no event shall a medical cannabis dispensary located in a Small-Scale Neighborhood Commercial District, a Moderate Scale Neighborhood Commercial District, or a Neighborhood Commercial Shopping Center District as defined in Sections 711, 712 and 713 of the Planning Code, be one of the two medical cannabis dispensaries permitted to remain open 24 hours per day.

(f) Medical cannabis dispensaries may not dispense more than one ounce of dried cannabis per qualified patient to a qualified patient or primary caregiver per visit to the medical cannabis dispensary. Medical cannabis dispensaries may not maintain more than ninety-nine (99) cannabis plants in up to 100 square feet of total garden canopy measured by the combined vegetative growth area. Medical cannabis dispensaries shall use medical cannabis identification card numbers to ensure compliance with this provision. If a qualified patient or a primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or the primary caregiver may possess and the medical cannabis dispensary may dispense an amount of dried cannabis and maintain a number cannabis plants consistent with those needs. Only the dried mature processed flowers of female cannabis plant or the plant conversion shall be considered when determining allowable quantities of cannabis under this Section.

(g) No medical cannabis shall be smoked, ingested or otherwise consumed in the public right-of-way within fifty (50) feet of a medical cannabis dispensary. Any person violating this provision shall be deemed guilty of an infraction and upon the conviction thereof shall be punished by a fine of $100. Medical cannabis dispensaries shall post a sign near their entrances and exits providing notice of this policy.

(h) Any cultivation of medical cannabis on the premises of a medical cannabis dispensary must be conducted indoors.

(i) All sales and dispensing of medical cannabis shall be conducted on the premises of the medical cannabis dispensary. However, delivery of cannabis to qualified patients with valid identification cards or a verifiable, written recommendation from a physician for medical cannabis and primary caregivers with a valid identification card outside the premises of the medical cannabis dispensary is permitted if the person delivering the cannabis is a qualified patient with a valid identification card or a verifiable, written recommendation from a physician for medical cannabis or a primary caregiver with a valid identification card who is a member of the medical cannabis dispensary.

(j) The medical cannabis dispensary shall not hold or maintain a license from the State Department of Alcohol Beverage Control to sell alcoholic beverages, or operate a business that sells alcoholic beverages. Nor shall alcoholic beverages be consumed on

the premises or on in the public right-of-way within fifty feet of a medical cannabis dispensary.
(k) In order to protect confidentiality, the medical cannabis dispensary shall maintain records of all qualified patients with a valid identification card and primary caregivers with a valid identification card using only the identification card number issued by the State or City pursuant to California Health and Safety Code Section 11362.7 et seq. and City Health Code Article 28.
(l) The medical cannabis dispensary shall provide litter removal services twice each day of operation on and in front of the premises and, if necessary, on public sidewalks within hundred (100) feet of the premises.
(m) The medical cannabis dispensary shall provide and maintain adequate security on the premises, including lighting and alarms reasonably designed to ensure the safety of persons and to protect the premises from theft.
(n) Signage for the medical cannabis dispensary shall be limited to one wall sign not to exceed ten square feet in area, and one identifying sign not to exceed two square feet in area; such signs shall not be directly illuminated. Any wall sign, or the identifying sign if the medical cannabis dispensary has no exterior wall sign, shall include the following language: "Only individuals with legally recognized Medical Cannabis Identification Cards or a verifiable, written recommendation from a physician for medical cannabis may obtain cannabis from medical cannabis dispensaries." The required text shall be a minimum of two inches in height. This requirement shall remain in effect so long as the system for distributing or assigning medical cannabis identification cards preserves the anonymity of the qualified patient or primary caregiver.
(o) All print and electronic advertisements for medical cannabis dispensaries, including but not limited to flyers, general advertising signs, and newspaper and magazine advertisements, shall include the following language: "Only individuals with legally recognized Medical Cannabis Identification Cards or a verifiable, written recommendation from a physician for medical cannabis may obtain cannabis from medical cannabis dispensaries." The required text shall be a minimum of two inches in height except in the case of general advertising signs where it shall be a minimum of six inches in height. Oral advertisements for medical cannabis dispensaries, including but not limited to radio and television advertisements shall include the same language. This requirement shall remain in effect so long as the system for distributing or assigning medical cannabis identification cards preserves the anonymity of the qualified patient or primary carver.
(p) The medical cannabis dispensary shall provide the Director and all neighbors located within 50 feet of the establishment with the name phone number and facsimile number of an on-site community relations staff person to whom one can provide notice if there are operating problems associated with the establishment. The medical cannabis dispensary shall make every good faith effort to encourage neighbors to call this person to try to solve operating problems, if any, before any calls or complaints are made to the Police Department or other City officials.
(q) Medical cannabis dispensaries may purchase or obtain cannabis only from members of the medical cannabis dispensary's cooperative or collective and may sell or distribute cannabis only to members of the medical cannabis dispensary's cooperative or collective.
(r) Medical cannabis dispensaries may sell or distribute cannabis only to those members with a medical cannabis identification card or a verifiable, written recommendation from a physician for medical cannabis. This requirement shall remain in effect so long as the system for distributing or assigning medical cannabis identification cards preserves the anonymity of the qualified patient or primary caregiver.

(s) It shall be unlawful for any medical cannabis dispensary to employ any person who is not at least 18 years of age.
(t) It shall be unlawful for any medical cannabis dispensary to allow any person who is not at least 18 years of age on the premises during hours of operation unless that person is a qualified patient with a valid identification card or primary caregiver with a valid identification card or a verifiable, written recommendation from a physician for medical cannabis.
(u) Medical cannabis dispensaries that display or sell drug paraphernalia must do so in compliance with California Health and Safety Code §§ 11364.5 and 11364.7.
(v) Medical cannabis dispensaries shall maintain all scales and weighing mechanisms on the premises in good working order. Scales and weighing mechanisms used by medical cannabis dispensaries are subject to inspection and certification by the Director.
(w) Medical cannabis dispensaries that prepare, dispense or sell food must comply with and are subject to the provisions of all relevant State and local laws regarding the preparation, distribution and sale of food.
(x) The medical cannabis dispensary shall meet any specific, additional operating procedures and measures as may be imposed as conditions of approval by the Director in order to insure that the operation of the medical cannabis dispensary is consistent with the protection of the health, safety and welfare of the community, qualified patients and primary caregivers, and will not adversely affect surrounding uses.
(y) Medical cannabis dispensaries shall be accessible as required under the California Building Code. Notwithstanding the foregoing, if a medical cannabis dispensary cannot show that it will be able to meet the disabled access standard for new construction, it shall meet the following minimum standards:
(1) An accessible entrance;
(2) Any ground floor service area must be accessible, including an accessible reception counter and access aisle to the employee workspace behind; and,
(3) An accessible bathroom, with a toilet and sink, if a bathroom is provided, except where an unreasonable hardship exemption is granted.
(4) A "limited use/limited access" (LULA) elevator that complies with ASME A17.1 Part XXV, an Article 15 elevator may be used on any accessible path of travel. A vertical or inclined platform lift may be used if an elevator is not feasible and the ramp would require more than thirty percent (30%) of the available floor space.
(5) Any medical cannabis dispensary that distributes medical cannabis solely through delivery to qualified patients or primary caregivers and does not engage in on-site distribution or sales of medical cannabis shall be exempt from the requirements of this subsection 3308(y).
(z) Any medical cannabis dispensary in a building that began the Landmark Initiation process (as codified by Article 10 of the San Francisco Planning Code) by August 13, 2007 is exempt from the requirements set forth in section 3308(y) of this legislation until September 1, 2008.
(aa) Prior to submission of a building permit application, the applicant shall submit its application to the Mayor's Office on Disability. The Mayor's Office on Disability shall review the application for access compliance and forward recommendations to the Department of Building Inspection.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-07, File No. 070667, App. 10/2/2007; Ord. 318-08, File No. 081230, 12/19/2008; Ord. 25-09, File No. 081199, App. 2/13/2009)

SEC. 3309. PROHIBITED OPERATIONS.

All medical cannabis dispensaries operating in violation of California Health and Safety Code Sections 11362.5 and 11326.7 et seq., or this Article are expressly prohibited. No entity that distributed medical cannabis prior to the enactment of this Article shall be deemed to have been a legally established use under the provisions of this Article, and such use shall not be entitled to claim legal nonconforming status for the purposes of permitting,
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3310. DISPLAY OF PERMIT.

Every permit to operate a medical cannabis dispensary shall be displayed in a conspicuous place within the establishment so that the permit may be readily seen by individuals entering the premises.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3311. SALE OR TRANSFER OF PERMITS.

(a) Upon sale, transfer or relocation of a medical cannabis dispensary, the permit and license for the establishment shall be null and void unless another permit has been issued pursuant to this Article; provided, however, that upon the death or incapacity of the permittee, the medical cannabis dispensary may continue in business for six months to allow for an orderly transfer of the permit.
(b) If the permittee is a corporation, a transfer of 25 percent of the stock ownership of the permittee will be deemed to be a sale or transfer and the permit and license for the establishment shall be null and void unless a permit has been issued pursuant to this Article; provided, however that this subsection shall not apply to a permittee corporation, the stock of which is listed on a stock exchange in this State or in the City of New York, State of New York, or which is required by law, to file periodic reports with the Securities and Exchange Commission.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3312. RULES AND REGULATIONS.

(a) The Director shall issue rules and regulations regarding the conduct of hearings concerning the denial, suspension or revocation of permits and the imposition of administrative penalties on medical cannabis dispensaries.
(b) The Director may issue regulations governing the operation of medical cannabis dispensaries. These regulations shall include, but need not be limited to:
(1) A requirement that the operator provide patients and customers with information regarding those activities that are prohibited on the premises;
(2) A requirement that the operator prohibit patrons from entering or remaining on the premises if they are in possession of or are consuming alcoholic beverages or are under the influence of alcohol;
(3) A requirement that the operator require employees to wash hands and use sanitary utensils when handling cannabis;
(4) A description of the size and type of notice of hearing to be posted in a conspicuous place on the property at which the proposed medical cannabis dispensary is to be operated and the number of days said notice shall remain posted; and
(5) A description of the size and type of sign posted near the entrances and exits of medical cannabis dispensaries providing notice that no medical cannabis shall be smoked, ingested or otherwise consumed in the public right of way within fifty (50) feet of a medical cannabis dispensary and that any person violating this policy shall be deemed

guilty of an infraction and upon the conviction thereof shall be punished by a fine of $100.

(c) Failure by an operator to do either of the following shall be grounds for suspension or revocation of a medical cannabis dispensary permit: (1) comply with any regulation adopted by the Director under this Article, or (2) give free access to areas of the establishment to which patrons have access during the hours the establishment is open to the public, and at all other reasonable times, at the direction of the Director, or at the direction of any City fire, planning, or building official or inspector for inspection with respect to the laws that they are responsible for enforcing.

(Added by Ord. 275-05, File No. 051250, App. 11/30/2005; Ord. 225-06, File No. 060032, Effective without the signature of the Mayor)

SEC. 3313. INSPECTION AND NOTICES OF VIOLATION.

(a) The Director may inspect each medical cannabis dispensary regularly and based on complaints, but in no event fewer than two times annually, for the purpose of determining compliance with the provisions of this Article and/or the rules and regulations adopted pursuant to this Article. If informal attempts by the Director to obtain compliance with the provisions of this Article fail, the Director may take the following steps:

(1) The Director may send written notice of noncompliance with the provisions of this Article to the operator of the medical cannabis dispensary. The notice shall specify the steps that must be taken to bring the establishment into compliance. The notice shall specify that the operator has 10 days in which to bring the establishment into compliance.

(2) If the Director inspector determines that the operator has corrected the problem and is in compliance with the provisions of this Article, the Director may so inform the operator.

(3) If the Director determines that the operator failed to make the necessary changes in order to come into compliance with the provisions of this Article, the Director may issue a notice of violation.

(b) The Director may not suspend or revoke a permit issued pursuant to this Article, impose an administrative penalty, or take other enforcement action against a medical cannabis dispensary until the Director has issued a notice of violation and provided the operator an opportunity to be heard and respond as provided in Section 3316.

(c) If the Director concludes that announced inspections are inadequate to ascertain compliance with this Article (based on public complaints or other relevant circumstances), the Director may use other appropriate means to inspect the areas of the establishment to which patrons have access. If such additional inspection shows noncompliance, the Director may issue either a notice of noncompliance or a notice of violation, as the Director deems appropriate.

(d) Every person to whom a permit shall have been granted pursuant to this Article shall post a sign in a conspicuous place in the medical cannabis dispensary. The sign shall state that it is unlawful to refuse to permit an inspection by the Department of Public Health, or any City peace, fire, planning, or building official or inspector, conducted during the hours the establishment is open to the public and at all other reasonable times, of the areas of the establishment to which patrons have access.

(e) Nothing in this Section shall limit or restrict the authority of a Police Officer to enter premises licensed or permitted under this Article (i) pursuant to a search warrant signed by a magistrate and issued upon a showing of probable cause to believe that a crime has been committed or attempted, (ii) without a warrant in the case of an emergency or other exigent circumstances, or (iii) as part of any other lawful entry in connection with a criminal investigation or enforcement action.

(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3314. VIOLATIONS AND PENALTIES.

(a) Any dispensary, dispensary operator or dispensary manager who violates any provision of this Article or any rule or regulation adopted pursuant to this Article may, after being provided notice and an opportunity to be heard, be subject to an administrative penalty not to exceed $1,000 for the first violation of a provision or regulation in a 12-month period, $2,500 for the second violation of the same provision or regulation in a 12-month period; and $5, 000 for the third and subsequent violations of the same provision or regulation in a 12-month period.

(b) The Director may not impose an administrative penalty or take other enforcement action under this Article against a medical cannabis dispensary until the Director has issued a notice of violation and provided the operator an opportunity to be heard and respond as provided in Section 3316.

(c) Nothing herein shall prohibit the District Attorney from exercising the sole discretion vested in that officer by law to charge an operator, employee, or any other person associated with a medical cannabis dispensary with violating this or any other local or State law.

(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3315. REVOCATION AND SUSPENSION OF PERMIT.

(a) Any permit issued for a medical cannabis dispensary may be revoked, or suspended for up to 30 days, by the Director if the Director determines that:

(1) the manager, operator or any employee has violated any provision of this Article or any regulation issued pursuant to this Article;

(2) the permittee has engaged in any conduct in connection with the operation of the medical cannabis dispensary that violates any State or local laws, or any employee of the permittee has engaged in any conduct that violates any State or local laws at permittee's medical cannabis dispensary, and the permittee had or should have had actual or constructive knowledge by due diligence that the illegal conduct was occurring;

(3) the permittee has engaged in any material misrepresentation when applying for a permit;

(4) the medical cannabis dispensary is being managed, conducted, or maintained without regard for the public health or the health of patrons;

(5) the manager, operator or any employee has refused to allow any duly authorized City official to inspect the premises or the operations of the medical cannabis dispensary;

(6) based on a determination by another City department, including the Department of Building Inspections, the Fire Department, the Police Department, and the Planning Department, that the medical cannabis dispensary is not in compliance with the laws under the jurisdiction of the Department.

(b) The Director may not suspend or revoke a permit issued pursuant to this Article or take other enforcement action against a medical cannabis dispensary until the Director has issued a notice of violation and provided the operator an opportunity to be heard and respond as provided in Section 3316.

(c) Notwithstanding paragraph (b), the Director may suspend summarily any medical cannabis dispensary permit issued under this Article pending a noticed hearing on revocation or suspension when in the opinion of the Director the public health or safety requires such summary suspension. Any affected permittee shall be given notice of such

summary suspension in writing delivered to said permittee in person or by registered letter.
(d) If a permit is revoked no application for a medical cannabis dispensary may be submitted by the same person for three years.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3316. NOTICE AND HEARING FOR ADMINISTRATIVE PENALTY AND/OR REVOCATION OR SUSPENSION.

(a) If the Director determines that a medical cannabis dispensary is operating in violation of this Article and/or the rules and regulations adopted pursuant to this Article, he or she shall issue a notice of violation to the operator of the medical cannabis dispensary.
(b) The notice of violation shall include a copy of this Section and the rules and regulations adopted pursuant to this Article regarding the conduct of hearings concerning the denial, suspension or revocation of permits and the imposition of administrative penalties on medical cannabis dispensaries. The notice of violation shall include a statement of any informal attempts by the Director to obtain compliance with the provisions of this Article pursuant to Section 3313(a). The notice of violation shall inform the operator that:
(1) The Director has made an initial determination that the medical cannabis dispensary is operating in violation of this Article and/or the rules and regulations adopted pursuant to this Article; and
(2) The alleged acts or failures to act that constitute the basis for the Directors initial determination; and
(3) That the Director intends to take enforcement action against the operator, and the nature of that action including the administrative penalty to be imposed, if any, and/or the suspension or revocation of the operator's permit; and
(4) That the operator has the right to request a hearing before the Director within fifteen (15) days of receipt of the notice of violation in order to allow the operator an opportunity to show that the medical cannabis dispensary is operating in compliance with this Article and/or the rules and regulations adopted pursuant to this Article.
(c) If no request for a hearing is. filed with the Director within the appropriate period, the initial determination shall be deemed final and shall be effective fifteen (15) days after the notice of initial determination was served on the alleged violator. The Director shall issue an Order imposing the enforcement action and serve it upon the party served with the notice of initial determination. Payment of any administrative penalty is due within 30 days of service of the Director's Order. Any administrative penalty assessed and received in an action brought under this Article shall be paid to the Treasurer of the City and County of San Francisco. The alleged violator against whom an administrative penalty is imposed also shall be liable for the costs and attorney's fees incurred by the City in bringing any civil action to enforce the provisions of this Section, including obtaining a court order requiring payment of the administrative penalty.
(d) If the alleged violator files a timely request for a hearing, within fifteen (15) days of receipt of the request, the Director shall notify the requestor of the date, time, and place of the hearing. The Director shall make available all documentary evidence against the medical cannabis dispensary no later than fifteen (15) days prior to the hearing. Such hearing shall be held no later than forty-five (45) days after the Director receives the request, unless time is extended by mutual agreement of the affected parties.

(e) At the hearing, the medical cannabis dispensary shall be provided an opportunity to refute all evidence against it. The Director shall conduct the hearing. The hearing shall be conducted pursuant to rules and regulations adopted by the Director.
(f) Within twenty (20) days of the conclusion of the hearing, the Director shall serve written notice of the Director's decision on the alleged violation. If the Director's decision is that the alleged violator must pay an administrative penalty, the notice of decision shall state that the recipient has ten (10) days in which to pay the penalty. Any administrative penalty assessed and received in an action brought under this Article shall be paid to the Treasurer of the City. The alleged violator against whom an administrative penalty is imposed also shall be liable for the costs and attorney's fees incurred by the City in bringing any civil action to enforce the provisions of this Section, including obtaining a court order requiring payment of the administrative penalty.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3317. APPEALS TO BOARD OF APPEALS.

(a) Right of Appeal. The final decision of the Director to grant, deny, suspend, or revoke a permit, or to impose administrative sanctions, as provided in this Article, may be appealed to the Board of Appeals in the manner prescribed in Article 1 of the San Francisco Business and Tax Relations Code. An appeal shall stay the action of the Director.
(b) Hearing. The procedure and requirements governing an appeal to the Board of Appeals shall be as specified in Article 1 of the San Francisco Business and Tax Regulations Code.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3318. BUSINESS LICENSE AND BUSINESS REGISTRATION CERTIFICATE.

(a) Every medical cannabis dispensary shall be required to obtain a business license from the City in compliance with Article 2 of the Business and Tax Regulations Code.
(b) Every medical cannabis dispensary shall be required to obtain a business registration certificate from the City in compliance with Article 12 of the Business and Tax Regulations Code.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3319. DISCLAIMERS AND LIABILITY.

By regulating medical cannabis dispensaries, the City and County of San Francisco is assuming an undertaking only to promote the general welfare. It is not assuming, nor is it imposing on its officers and employees, an obligation for breach of which it is liable in money damages to any person who claims that such breach proximately caused injury. To the fullest extent permitted by law, the City shall assume no liability whatsoever, and expressly does not waive sovereign immunity, with respect to the permitting and licensing provisions of this Article, or for the activities of any medical cannabis dispensary. To the fullest extent permitted by law, any actions taken by a public officer or employee under the provisions of this Article shall not become a personal liability of any public officer or employee of the City. This Article (the "Medical Cannabis Act") does not authorize the violation of state or federal law.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3320. SEVERABILITY.

If any provision of this Article or the application of any such provision to any person or circumstance, shall be held invalid, the remainder of this Article, to the extent it can be given effect, or the application of those provisions to persons or circumstances other than those to which it is held invalid, shall not be affected thereby, and to this end the provisions of this Article are severable.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

SEC. 3321. ANNUAL REPORT BY DIRECTOR.

(a) Once a year, commencing in January 2007, the Director shall make a report to the Board of Supervisors that:
(1) sets forth the number and location of medical cannabis dispensaries currently permitted and operating in the City;
(2) sets forth an estimate of the number of medical cannabis patients currently active in the City;
(3) provides an analysis of the adequacy of the currently permitted and operating medical cannabis dispensaries in the City in meeting the medical needs of patients;
(4) provides a summary of the past year's violations of this Article and penalties assessed.
(b) Upon receipt of this Report, the Board of Supervisors shall hold a hearing to consider whether any changes to City law, including but not limited to amendments to the Health Code or Planning Code, are warranted.
(Added by Ord. 275-05, File No. 051250, App. 11/30/2005)

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 2:35 PM
To: Public Hearing
Subject: FW: San Fransisco bylaws on Edible Cannabis
Attachments: EdibleMCRegulations.pdf; ATT00001.txt

-----Original Message-----
From: Jamie Shaw s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 1:56 PM
To: Correspondence Group, City Clerk's Office
Subject: San Fransisco bylaws on Edible Cannabis

Thank you so much for allowing me to speak on Thursday night. Here are the San Fransisco bylaws around edible cannabis carried at dispensaries.

Jamie Shaw
Spokesperson - BCCCS
President - CAMCD

Medical Cannabis Dispensary (MCD) Regulations for Preparation of Edible Cannabis Products

1. No edible cannabis products **requiring** refrigeration or hot-holding shall be manufactured for sale or distribution at an MCD, due to the potential for food-borne illness. Exemptions may be granted by the San Francisco Department of Public Health on a case-by-case basis. For such exempted edible cannabis products, DPH may require a HACCP (Hazard Analysis and Critical Control Points) plan before approving the distribution of such medical cannabis products at MCDs. Such products requiring a HACCP plan may include ice cream and other dairy products.

2. Baked medicinal products (i.e. brownies, bars, cookies, cakes), tinctures and other non-refrigerated type items are acceptable for manufacture and sale at MCDs.

3. (*Items noted in this section are advisory only, as DPH does not intend to regulate edible cannabis production occurring in one's home.*) Preparation may be completed in a home-type kitchen equipped with a sink available for hand washing (this sink may be a dishwash sink), liquid soap, and paper towels. No other food preparation should take place during the production of edible cannabis products, in order to avoid cross-contamination. During preparation, children and pets should not be in the kitchen/preparation area. Clean and sanitize all utensils, equipment, and food contact surfaces before and after preparation. Equipment and food contact surfaces should be in good, cleanable condition. Ingredient storage areas should be kept clean and vermin-free.

4. All items shall be individually wrapped at the original point of preparation. Labeling must include a warning if nuts or other known allergens are used, and must include the total weight (in ounces or grams) of cannabis in the package. A warning that the item is a medication and not a food must be distinctly and clearly legible on the front of the package. The package label must have a warning clearly legible emphasizing that the product is to be kept away from children. The label must also state that the product contains medical cannabis, and must specify the date of manufacture.

5. Packaging that makes the product attractive to children or imitates candy is not allowed. Any edible cannabis product that is made to resemble a typical food product (i.e. brownie, cake) must be in a properly labeled opaque (non see-through) package before it leaves the dispensary. Deliveries must be in properly labeled opaque packages when delivered to the patient.

6. Individuals conducting the manufacturing or sale of products shall thoroughly wash their hands before commencing production and before handling the finished product. Gloves must be worn when packaging edible cannabis products.

7. In order to reduce the likelihood of foodborne disease transmission, individuals who are suffering from symptoms associated with acute gastrointestinal illness or are known to be infected with a communicable disease that is transmissible through foodstuffs are prohibited from preparing edible cannabis products until they are free of that illness or disease, or are incapable of transmitting the illness or disease through foodstuffs. Anyone who has sores or cuts on their hands must use gloves when preparing and handling edible cannabis products.

8. Edible cannabis products for sale or distribution at an MCD must have been prepared by a member of that MCD. No non-member edible cannabis products are allowed for sale or distribution at an MCD.

9. A patient/caregiver who produces edible cannabis products that are sold at **more than one** MCD in San Francisco must become a State certified food handler. If more than one person is involved in producing edible cannabis products at one home or facility, only one person needs to be certified. The valid certificate number of the member who has prepared the edible cannabis product must be on record at the MCD where the product is sold or distributed, and a copy of the certificate kept either on-site, or made available during inspections if kept off-site.

Addendum Added – May 4, 2011

In light of recent observations during routine inspections at San Francisco Medical Cannabis Dispensaries (MCDs), the Department of Public Health has established the following policies that expand and clarify existing regulations regarding edible medical cannabis products. These policies specifically seek to clarify what is meant by prohibiting packaging that is attractive to children, as required in item number five above.

- Photos or images of food are not allowed on edible medical cannabis product labels.
- If the edible medical cannabis product is identified on the label using a common food name (i.e. Brownie, Honey, Chocolate, Chocolate Chip Cookie, or Green Tea), the phrase "MEDICAL CANNABIS" must be written before the common food name. This phrase must be as easy to read as the common food name (i.e. same font size).
- Only generic food names may be used to describe the product. As an example, using "Snickerdoodle" to describe a cinnamon cookie is prohibited.

As you know, only **medical** cannabis is allowed to be distributed at MCDs in San Francisco. With this in mind, this new policy seeks to make it clear that the edible cannabis products you distribute are solely for medical cannabis patients, and the marketing of these products should **not** be a factor in the labeling of the products.

The Department of Public Health realizes that this will cause a change in the labeling for most edible cannabis products currently distributed at MCDs in San Francisco. For this reason, we are allowing a 60 day transition to the new requirements. In the meantime, currently available edible medical cannabis products may continue to be distributed with their current labels if the package includes "MEDICAL CANNABIS" before the common food name, either pre-printed, or on a sticker. In addition, all such products must also state, as is now required, the following information:

1. Manufacture date
2. The statement "Keep Out Of Reach Of Children"
3. The statement "For Medical Use Only"
4. Net weight of cannabis in package

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 1:37 PM
To: Public Hearing
Subject: FW: Edible Ban

From: Andrew Muir s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 8:41 AM
To: Correspondence Group, City Clerk's Office
Subject: Edible Ban

My name is Andrew Muir and I was speaker #10 on June 10th. I would like to comment on statements that Dr. Daly made during her presentation.

"Colorado regrets allowing edibles" - While medical marijuana has been legal in Colorado since 2000, storefront dispensaries didn't take off until 2007, when a judge lifted the limit on the number of patients marijuana caregivers could serve. There were no regulations on edibles until this year. They regretted NOT regulating the potency and packaging of edibles.

We can learn from Colorado's experience. The new rules, some of which went into effect this year, declare that 10 milligrams of THC is a serving size and require products to be easily divided into obvious servings. No more than 100 mg can be in a package. They have also set regulations for packaging in child resistant packaging. Oregon and Washington have similar regulations.

Ron Kammerzell, the senior director of enforcement at Colorado Department of Revenue, acknowledged that he didn't anticipate the issue of overconsumption of edibles when it came to recreational consumers. "The average consumer for medical marijuana is extremely knowledgeable about the effects of THC, the effects of how edible products interact with their bodies," said Kammerzell, .

Sales of infused edibles make up about 45 percent of the legal marijuana marketplace, said Dan Anglin, the chairman of the Colorado Cannabis Chamber of Commerce.

http://www.oregonlive.com/marijuana/index.ssf/2015/04/5_takeaways_from_colorados_exp.html

Dr. Daly also made note of the risk of imparied driving. Last February the National Highway Traffic Safety Administration (NHTSA) released the results of "the first large-scale [crash risk] study in the United States to include drugs other than alcohol," which it described as "the most precisely controlled study of its kind yet conducted." The researchers found that once the data were adjusted for confounding variables, cannabis consumption was not associated with an increased probability of getting into an accident. Marijuana Prohibition Is a Moral Scandal Built on a Mountain of Lies Jacob Sullum | May 18, 2015.

Dr. Daly quoted that 34 people went to hospital after April's 420 celebration/tradeshow in Vancouver. If she had taken the time to discuss these visits with the hospital, they would have told her that many were heat exhaustion of food poisoniong. This resulted from unregulated ediblese sitting unrefrigerated in the sun for up to 10 hours. All the patients were released after examination.

As with all drugs like tobacco and alcohol, there is progression of knowledge for consumption. It starts with access then experimentation leading to moderation. Fortunately, there is no lasting harm from this learning curve.

As a member of REEP, Responsible Edible and Extract Producers, I want regulation that will give access to safe and reliable eidbles so that they are not sold in the underground market.

--

Andrew Muir
s.22(1) Personal and Confidential

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 1:35 PM
To: Public Hearing
Subject: FW: marijuana edibles

-----Original Message-----
From: Stew Brinton s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 7:45 AM
To: Correspondence Group, City Clerk's Office
Subject: Re: marijuana edibles

The Council should consider the Supreme Court decision seriously. Edibles are invaluable for those of us who use THC and other parts of the cannabis plant for our mental and physical health. To deny cannabis outlets the ability to sell edibles as well as tinctures denies those in need. Smoking is not for those of us with asthma and smoking is just smoking. It is not good for the lungs.

Stewart Brinton

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 1:34 PM
To: Public Hearing
Subject: FW: Submission regarding the regulating of Cannabis dispensaries

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From: Neil Magnuson s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 2:28 AM
To: Correspondence Group, City Clerk's Office
Subject: Submission regarding the regulating of Cannabis dispensaries

My name is Neil Magnuson, I was speaker 15 on June 10th and I would like to re-iterate my concerns.

Thank you for having this discussion and for your desire to be forward thinking with respect to this issue.

This is about the disconnect between the federal policies and the realities of public attitudes and the actual facts. I believe this issue provides a great opportunity for the city of Vancouver to stand up for whats right and to further establish itself as the greenest and most progressive city in the world.
Due to my involvement on many levels with the evolution of cannabis dispensaries in Vancouver for over a decade, I can say that the dispensaries welcome reasonable regulations that would bring them out of the shadows and into the mainstream with official status. but,,,,
That being said, unreasonable and unjustified regulations that discriminate, and continue to stigmatize and cause unnecessary harm and hardship to dispensaries and their clients are not welcome and will be met with tenacious resistance.

I represent the activist community in Vancouver more so than the dispensaries and as such I can tell you that we will not accept harmful and discriminatory regulations and there are several deal breakers here that are unacceptable and unjustified. We vow that no dispensary shall be left behind.
Dispensary owners may be in an "illegal" business but they are good people who have risked a lot to provide a much needed service and are willing to stand up against a very bad law that harms people and needs to change. They have proven to be good members of their neighborhoods and are not causing harm so they should not be harmed. No one should have to go home to their family having lost their store or their job to some arbitrary and unreasonable new policy.

I would hope that after all the decades of our community being unjustly under siege, and with how far we have come and with how progressive Vancouver has been in leading the country in its policies, that the city would be helping to undo the decades of lies rather than continuing them.
Cannabis is not on par with alcohol, cigarettes OR pharmaceutical drugs, it is not even in the same realm.

It was DEA judge Francis Young, who declared that cannabis "is one of the safest therapeutically active compounds known to man".
There are more problems associated with coffee and donuts than with even the recreational use of Cannabis.

Cannabis does not harm children and certainly Cannabis dispensaries are no threat to children.

There are no problems as a result of dispensaries being close to schools, but if they are not "allowed" then the kids will know this and be even more curious, but worse than that they will wonder whats wrong or bad with Cannabis and Cannabis consumers.
Cannabinoids are in breast milk and all kids have cannabinoids in their bodies all the time, we all do because we are born with endo-cannabinoid systems built millenia ago by our ancestors for whom Cannabis was a staple food source. Cannabis is a supplement to our endo-cannabinoid system, the system that regulates and balances all of the other systems in the human body, which is why it is useful for so many conditions and diseases and why you can't die from an overdose.
Despite the most recent reefer madness campaign, Cannabis does NOT harm the developing brain, but what does harm the developing brain is alcohol, pharmaceutical drugs refined sugar and learning to disrespect governments for enforcing bad laws.

Regulations are rules that attempt to address societal harms, in a free society, in an effort to balance human rights, they must be the least intrusive possible.
We do have things in our environment that cause real harm, Cannabis is not one of them.
So when considering regulations think about how many coffee and dough-nut stores there are?
How many tobacco vendors?
How many alcohol vendors?
How many drug stores?
Think about how close they are to each other? How close they are to schools? How visible their products and signs are?

Think about how many problems we have with the abuse of alcohol and how many children are harmed by it every year? There are no such problems or concerns with even the abuse of Cannabis (whatever that is) and we are talking here about the medical USE.

The outrageous licensing fee is not only unjustified and unnecessary, it is immoral as it will certainly be passed on to the patients.

The only problem with dispensaries being close to each other is a problem for the owners with respect to competition, no regulating of this is by the city is warranted.

Also, there is no good reason that most people who have done their time for a crime, not be able to help themselves and others by working in a dispensary.

I could say lots about the outrageous notion of banning extracts and edibles but I am confident others have and will address the wrongness of that proposal.

We should NOT be following Colorado and Washington or anyone, we should be leading the way in designing reasonable regulations.
Vancouver dispensaries have already been incorporating best practices and already have developed reasonable policies.
Dispensaries have been successfully regulating themselves for the past 18 years with guidelines written by Rielle Capler and Phillipe Lucas that, (with the possible exception of security measures, because prohibition grossly inflates the value) have proven to be all that are needed. These guidelines could be used as a

framework for more reasonable regulations.

Our community and our culture have been vilified and persecuted for the better part of the last century, reefer madness is no joke.
These proposed regulations that I have touched upon, and a few that I haven't, are not reasonable and they are scaring people, many who are already sick and suffering, people who instead deserve protection.

No significant harm is being caused by the dispensaries operating as they are, and they are providing considerable benefit.
Any action you take should be to protect patients and dispensaries from the bad law. No one needs protection from Cannabis.

It would be wrong for the city to take action that causes harm to the dispensary owners, employees and the tens of thousands of patients that rely on them.
I would hope that you will listen carefully to the science and to the concerns presented during these hearings.

I hope that you will implement regulations based in reason rather than fear and I hope that, rather than continue them, you will help put an end to the harms being caused by prohibition.

I propose that this council officially declare Vancouver to be a sanctuary for the cannabis community.

My bottom line appeal to you is to recognize that cannabis has been demonized and lied about for decades with the reality being that it is one of the safest, most benign and most beneficial natural substances in our environment and as such requires much LESS regulation than most other substances.

Thank you for your considerable effort and thoughtful consideration.

Sincerely and with gratitude,
Neil Magnuson

s.22(1) Personal and Confidential

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 8:24 AM
To: Public Hearing
Subject: FW: Brief: comment re dispensaries from someone who has been using the first one for 18 years

-----Original Message-----
From: p.oleary@telus.net s.22(1) Personal and Confidential
Sent: Thursday, June 11, 2015 7:10 PM
To: Correspondence Group, City Clerk's Office
Subject: Fwd: Brief: comment re dispensaries from someone who has been using the first one for 18 years

This is a copy of an email sent to the Mayor on April 24, to be included in the Public Hearings regarding the licensing of dispensaries in Vancouver, please.
Thank you.
Sincerely,

Kim Patrick O'Leary
s.22(1) Personal and Confidential

----- Forwarded Message -----
s.22(1) Personal and Confidential

Sent: Friday, April 24, 2015 8:25:36 PM
Subject: Brief: comment re dispensaries from someone who has been using the first one for 18 years

Dear Gregor,

Thank you for your recent statement rejecting Rona Ambrose's suggestion that all marijuana dispensaries be shut down, because children will become addicts!

This is outrageous.
Dispensaries do not serve children.
And, she does not seem to have done any research on the subject based on many of her ignorant comments about cannabis/marijuana.

I am one of the first members of the first marijuana dispensary in Canada, the BC Compassion Club Society.
I think that you will find that this Society is very different from almost all of the other dispensaries.
The BCCCS was founded in the most "legal" way possible, and they have spent a great deal of (our) money to hire lawyer John Conroy to represent them over the past 18 years.
The profits from this dispensary are used to pay the rent, hydro, staff salaries and then all the remainder of the money goes toward the Wellness Centre!
This is the only dispensary I know of that has a Wellness Centre.
Members are able to access herbalists, massage therapists, counsellors, acupuncture - at reduced cost, because some of these services are covered by the dispensary.

Quite apart from all this... marijuana works for my pain!
I went through a series of tests with my former doctor.
He was surprised with the extent of arthritis in my hips even in 1998...
He was still reluctant to prescribe cannabis/marijuana until I explained about nausea in the morning since my gall bladder was removed at age 17.
More tests were carried out, and he finally announced to me that "you are a mess inside"... he did not know why, could not suggest what to do, or who to send me to see. (My parents poisoned me.) And, he finally realized why I was using cannabis/marijuana and not arthritis medication. Because arthritis medication causes a lot of internal problems and pain for me.
So, he finally gave me a prescription for cannabis.

I have been a member of the BCCCS since almost the very beginning.
There is no other dispensary like this that I know of.

I have read through all of the regulations proposed for dispensaries by the City of Vancouver.
I read law for 12 years.
I think a few of the regulations need to be amended, based on discussions with everyone involved, including the dispensaries.
Especially the fee, for a place such as the BCCCS - which is NOT in business for profit, but to help people with their suffering and pain.
I do not know about other dispensaries, but the BCCCS tests all the products before selling.
The issue of cannabis infused food or tincture is important. If I am unable to smoke for any reason, I need to eat it, or use a tincture.
I have never been sick from ingesting any cannabis food or tincture. I certainly can't say the same about eating out in restaurants in Vancouver

Also, shutting down these dispensaries will simply force everything underground again!
This is not good!
This is how children become involved when it is an illegal black market product.
And, the problem with buying cannabis on the street is that it may be laced with other dangerous chemicals.
NO ONE has EVER died from cannabis use. So, please everyone stop all the hysterical arguments about it's dangers.
There are very few dangers. Which is why people use it. Grandmothers even!
I am 60 years old, and I have read a great deal of material on the subject.
I read the LeDain Commission Report in it's entirety when published, but had to read the report in the library so that I would not end up on an RCMP list of people who had borrowed the item.
It was brilliant, and if it's proposals had been implemented we would have been having an "adult" and reasonable discussion about the subject of cannabis 30 years ago!
And we would not be in this situation now.

Sincerely,

Kim Patrick O'Leary

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Thursday, June 11, 2015 5:59 PM
To: Public Hearing
Subject: FW: our assistance

From: Green Penguin s.22(1) Personal and Confidential
Sent: Thursday, June 11, 2015 5:52 PM
To: Correspondence Group, City Clerk's Office
Subject: our assistance

Dear Mayor & Council,

Hello. I was speaker #5 and Andrew was speaker #10.

We would like to offer our full assistance in helping with:
providing product information
suggestions for the regulation of edibles & extracts
Anything else you may require in your en devour

We commend the council for their continued efforts and work on this very important matter.

--
Cheers,
Brina & Andrew
(Edible Producers)
Green Penguin Delights Inc.
s.22(1) Personal and Confidential

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 3:42 PM
To: Public Hearing
Subject: FW: Requested Submission From Hilary Black
Attachments: Submission to Vancouver City Council and Mayor June12.pdf

From: hilary black s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 3:03 PM
To: Correspondence Group, City Clerk's Office
Subject: Requested Submission From Hilary Black

Dear Mayor and Council,

As requested I have prepared the responses to your questions following my presentation. I wanted to ensure this material was before you today in case you end the hearings and deliberate tomorrow. With more time, I would have prepared a more thorough report for you.

I will send an additional email with the reports to Health Canada and the Senate report you requested.

Thank you for taking the time to consider my thoughts on this important and complex issue.

I am at your service.

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

Submission of Hilary Black to the City of Vancouver on the Proposed Regulation of Retail Dealers – Medical Marijuana-Related Uses

Introduction

Pursuant to my presentation to the mayor and council on June 10th, I have prepared the following information to answer the questions you tasked me with.

For those counsellors not in attendance on June 10th , highlights of my background include:

- Founder of the first medical cannabis dispensary in Canada, the BC Compassion Club Society and Wellness Center, in 1997.
- Recipient of the Diamond Jubilee Medal recognizing a significant contribution to Canada for medical cannabis related work.
- Currently the Director of Community and Patient services for Bedrocan Canada, one of the federally license producers of medical cannabis.
- Advisor to the Canadian Medical Cannabis Industry Association
- Advisor to the Canadian Association of Medical Cannabis Dispensaries
- Advisor to the BC Compassion Club Society

I understand this document needs to be submitted to the city before the close of the public hearings, in fact if you are to have time to look at it, I am told it needs to submitted by 3 pm June 12th. Given the short timeline, this will not be as thorough of a report as I would like to prepare for you, instead a summary of my suggested solutions. If the council and mayor choose to send the regulations back to city for further revisions I am at your service and would be happy to provide further information.

The council and mayor requested input on four issues:

1. Solutions to address coastal health authorities concerns regarding edible cannabis products.

2. A list of the long-standing dispensaries who contribute to their community and should not be forced to move.

3. Suggestions for altering the fee structure to account for *true* non-profits Societies and to mandate giving back to the patients and community.

4. How the proposed regulations need to be amended to better address the needs of critically and chronically ill patients.

To address these four issues I submit 8 recommendations for your consideration.

Submission of Hilary Black to the City of Vancouver on the Proposed Regulation of Retail Dealers – Medical Marijuana-Related Uses

Recommendations

Recommendation #1 – Edible cannabis products should be regulated in a responsible manner, not banned, consistent with the recent Supreme Court ruling.

(Recommended Regulations 3. Operational Regulations, Table 1)

The coastal health authority is concerned about edible cannabis products being attractive to children and posing a danger to youth. As the council has already repeatedly heard in the hearing, the proposal to only allow infused oil is not adequate account for patients diverse medical needs. The Supreme Court unanimously voted that all medical cannabis products, including edibles, are constitutionally equivalent and they therefore legalized possession of edibles for medicinal use. I encourage Vancouver to consider regulations that follow the spirit of the Supreme Court Ruling.

The following are suggestions to address the concerns of the Coastal Health Authority.

Packaging

- Opaque or solid packaging materials are used so the product is not visible
- Childproof pouches used as shopping bags to place edible products in before the patient leave the dispensary.
- Example: (http://www.marijuanapackaging.com/dispensary-supply/child-resistant-astm-bags.html)
- Child resistant lids for products administered in bottles or jars.

Labelling

- Plain and "boring" print only
- No bright colours used
- Clear warning labels
    - NOT FOR CHILDREN This product contains cannabis and has intoxicating and potentially psychoactive effects. Keep out of the reach of children. Do not operate heavy machinery or drive when using this medical product. Do not mix with alcohol as this will intensify the effects. For personal and medical use only.
- Safe dosing instructions
    - DOSE LOW AND GO SLOW. Ingesting cannabis affects your body very differently than inhaling. Always start with a small dose until you know your body's tolerance level. Time of onset can be up to 2 hours. The length of effect can be up to 8 hours or more. Check the strength of each new batch of products before consuming a regular portion. If you are new to consuming edible cannabis

products talk to your medical cannabis dispensary for education on how to safely self-titrate.

- Ingredients List
- Nutrition Facts
- Allergy warning
- Potency Testing
  - Total milligrams and total % of THC and CBD / serving -- *please note this will take some time to implement as certified labs are currently not authorized to test products from dispensaries.*
- Food Safe Production Requirements

Recommendation #2 – Include an exemption process to allow the council to "grandfather in" longstanding dispensaries who contribute to their communities.

(Recommended Regulations 4. Implementation Process a) Existing Marijuana-Related Uses)

The following dispensaries should not have to move from their current location. They have been serving their communities for many years, contribute resources back into their respective communities and are supported by many other patient service organizations in Vancouver. A forced move would likely cause the organizations to shut down causing immeasurable hardship for thousands of patients and interruption of important healthcare services.

- BC Compassion Club Society, founded in 1997. Located at 2995 Commercial Drive.
- Green Cross Society, founded in 2005. Located at 2145 Kingsway and 4296 Main St
- Vancouver Dispensary, founded in 2008, Located at 880 East Hastings and 1182 Thurlow St

Recommendation # 3 – Create a new category of licensing fees for non-profits who are contributing resources back into their communities.

(recommended regulations 1.c.c.)

True non-profit dispensaries should be able to apply for an exemption to the $30,000 licensing fee and be **required to provide evidence of significant community contributions.** There are few organizations who would deserve such an exemption, therefor not significantly affecting the city's proposed budget for implementing these regulations.

There is a distinction to be made between the non-profit societies distributing cannabis; some are actual membership-based non-profits with a full voting membership who

maintains care and control over direction of the society, while others are not. Victoria city council has recently made this distinction.
https://victoria.civicweb.net/Documents/DocumentList.aspx?ID=82575'

Registered non-profits are required to submit yearly financial statements and are financially transparent and accountable.

Recommendation #4 – All dispensaries should be required to have natural healthcare professionals on staff.

Subsidizing complimentary healthcare services is a direct and effective way of contributing to the health of the patients supporting the cannabis dispensaries. Making additional healthcare services available supports the healthy and responsible use of medical cannabis. For example, if a patients' intake dramatically increases, one might discover they recently had a death in the family and are using cannabis to manage their depression, what would serve their health in a more responsible manner would be speak with a counsellor.

Similar to the strategy of the safe injection site, offering subsidized healthcare services at medical cannabis dispensaries creates an access point for these services to marginalized and impoverished citizens of Vancouver, who would otherwise never be able to access complimentary healthcare.

This model:

- ensures a higher level or responsibility and professionalism when managing with issues such as mental health concerns.
- supports harm reduction services to those in need
- reduces financial impact on public health services

1-1000 active clients	1 full time practitioner is required
1000-2000 active clients	2 full time practitioners are required
2000-3000 active clients	3 full time practitioners are required
3000-4000 active clients	4 full time practitioners are required
4000 + active clients	5 full time practitioners are required

Submission of Hilary Black to the City of Vancouver on the Proposed Regulation of Retail Dealers – Medical Marijuana-Related Uses

Recommended healthcare practitioners appropriate to compliment cannabis therapies:

- Clinical Herbalist
- Certified Counsellor
- Certified Nutritionist
- Dr. of Traditional Chinese Medicine
- Massage Therapist
- Cranio-Sacral Therapist
- Other body workers
- Naturopathic Dr
- Nurse Practitioner

Note: At the BC Compassion Club Society there is currently a 1.5 year wait list for clinical herbalists and counsellors.

Recommendation # 5 – Allow minors to enter dispensaries if supervised by a parent or guardian or if authorized by a healthcare professional to use cannabis therapies.

(Recommended Regulations 3. Operational Regulations Table 1)

Unaccompanied minors without medical authorization to use cannabis as a medicine should not be allowed in medical cannabis dispensaries. Minors with parental or guardian supervision and those minors with an authorization to use medical cannabis in conjunction with parental permission should be allowed on the premises.

Recommendation # 6 – All dispensaries should be required to be members of the Canadian Association of Medical Cannabis Dispensaries (CAMCD) or, alternatively, should be given a demerit point if they are not.

CAMCD has developed extensive and thorough standard operating procedures to ensure high quality patient care in every aspect of operating a real medical cannabis dispensary. The certification process is rigorous ensures the safety, transparency, accountability and professionalism of the services offered.

The city's proposed regulations do not speak to intake and eligibility; in order to ensure these dispensaries are indeed for medical purposes, requiring CAMCD certification ensures appropriate intake requirements are in place.

Membership and certification in this organization should be mandatory. Alternatively, demerit points should be granted for dispensaries who are not members of CAMCD.

Recommendation #7 – The Vancouver City Council should lobby the Federal Government to include medical cannabis dispensaries in the federal regulations, the Marijuana for Medical Purposes Regulations (MMPR).

Long standing dispensaries have spent years lobbying the federal government to bring us in out of cold and allow us to operate in a legal framework. This may be helpful position to take when taking heat from the federal government for these regulations.

Recommendation # 8 - The council should limit the number of dispensary licenses to 20.

I believe 90 medical cannabis dispensaries in Vancouver is too many. The needs of patients could be more than adequately be met by 20 high quality responsible organizations spread across the city. I suggest starting with a smaller program that is more manageable and easier to regulate.

Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 3:41 PM
To: Public Hearing
Subject: FW: Regulation of Retail Dealers – Medical Marijuana-Related Uses
Attachments: Senate Report Summary.pdf; Cannabis as a stigmatized medicine.pdf; Health Effects of Using Cannabis for Therapeutic Purposes- A Gender Analysis of Users' Perspectives.pdf

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From: Rielle Capler s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 2:46 PM
To: Correspondence Group, City Clerk's Office
Subject: Regulation of Retail Dealers – Medical Marijuana-Related Uses

Hello Mayor and Council,

Some additional documents.

CAMCD certification standards: http://cannarx.ca/wp-content/uploads/2013/06/CAMCD-Certification-Standards.pdf

Hitzig v. Canada - one of the many cases to find the federal MMAR unconstitutional, note this par. referring to dispensaries : [174] - Fourth, 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. http://www.canlii.org/en/on/onca/doc/2003/2003canlii30796/2003canlii30796.html

attached:

1) Senate report summary (you may want to look specifically at chapter 9 and 13 which can be found http://www.parl.gc.ca/Content/SEN/Committee/371/ille/rep/repfinalvol2-e.htm
2) Cannabis as a Stigmatized Medicine (dispensary-based research)
3) Health Effects of using Cannabis for Therapeutic Purposes (Dispensary-based research)

Sénat Senate

CANADA

CANNABIS:

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

SUMMARY REPORT

CHAIR

PIERRE CLAUDE NOLIN

DEPUTY CHAIR

COLIN KENNY

SEPTEMBER 2002

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Senator Sharon CARSTAIRS, P.C. (ex officio)
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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 2 million 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.

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ORIGINAL ARTICLE

Health Effects of Using Cannabis for Therapeutic Purposes: A Gender Analysis of Users' Perspectives

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The purpose of this qualitative study was to describe how individuals who self-report therapeutic use of cannabis perceive its health effects. Data from 23 individual interviews were transcribed and analyzed. Understandings of gendered roles and identities were used to explore the data and interpret differences in perceptions. Descriptions of the health benefits of cannabis for therapeutic purposes included cannabis as life preserving, a disease therapy, a medicine for the mind, a means for self-management, and a way to manage addiction. Self-management of risks focused on the potential effects of excessive use, smoking-related risks, and purchasing precautions. Although the reports of women and men were similar in many respects, there were important differences in patterns and practices of use that reflected gender influences. Insights from the study provide direction for developing gender-specific information to support decision making and usage for therapeutic users.

Keywords cannabis, medical marijuana, gender influences, health benefits, perceived risks

INTRODUCTION

Information regarding the possible physical and psychological risks associated with high levels of recreational cannabis use continues to emerge. Simultaneously, a growing number of studies reporting the medical benefits of cannabis for people living with a diverse range of illnesses are evident in the literature (Amar, 2006). While cannabis remains an illegal substance in Canada, the Canadian government has created a regulatory framework for therapeutic use to provide a mechanism for legal access to cannabis for individuals with diagnosed medical conditions and debilitating symptoms. To date, there has been a remarkable lack of research into how individuals make sense of diverse and seemingly conflicting messages describing the health benefits and risks of using cannabis for therapeutic purposes (CTP). The goal of this article is to describe users' perceptions of the health effects of CTP and use a gender lens to explore similarities and differences among men and women and to provide direction for developing tailored information to support decision making regarding therapeutic use of cannabis.

BACKGROUND LITERATURE

Therapeutic Cannabis Use in Canada

Studies of the prevalence of cannabis use suggest that over 44% of Canadians have tried cannabis at least once in their lifetime and approximately 14% report use in the past year (Patton & Adlaf, 2005; Stockwell, Sturge, Jones, Fischer, & Carter, 2004). Furthermore, a 2004 national survey indicated that one third of current cannabis users in British Columbia and 28% of users in the rest of Canada reported using cannabis for medical reasons (Tjepkema, 2004). High-prevalence rates (14%–61%) of cannabis use have also been found in specific disease populations, including HIV/AIDS (Belle-Isle & Hathaway, 2007), multiple sclerosis (MS; Clark, Ware, Yazer, Murray, & Lynch 2003), and cancer (Tramer et al., 2001). There are also gender differences. Canadian men are more likely than women (50% vs. 39%) to have used cannabis recreationally at least once in their lifetime and to have used it more frequently (Patton & Adlaf, 2005). Similarly, therapeutic cannabis use in Canada is also more significantly associated with men (Ogborne & Smart, 2000; Ogborne,

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Smart, & Adlaf, 2000; Stockwell et al., 2004). These gender differences, however, are poorly understood.

Evidence Regarding the Health Benefits and Risks of Cannabis Use

CTP has been studied in a limited but growing number of clinical trials and its efficacy in symptom management in individuals with HIV/AIDS (Beal et al., 1995), MS (Zajicek et al., 2003), cancer (Tramer et al., 2001), and hepatitis C (HCV; Fischer et al., 2006) has been observed. As the visibility of cannabis in health care increases, the number of conditions for which cannabis has shown promising therapeutic effects has grown to include Alzheimer's disease (Eubanks et al., 2006), Parkinson's disease (Croxford, 2003), rheumatoid arthritis (Blake, Robson, Ho, Jubb, & McCabe, 2006), mood disorders (Ashton, Moore, Gallagher, & Young, 2005), and several others.

Researchers have examined the adverse health effects of cannabis use, particularly the risks associated with smoking cannabis that is by far the most common mode of administration among CTP users. Early research showed that heavy smoking of cannabis, independent from tobacco smoking, is associated with chronic inflammation of the respiratory tract (Taylor, Poulton, Moffitt, Ramankutty, & Sears, 2000), impaired lung function (Tetrault et al., 2007), and other respiratory complications (Sherrill, 1991). Although some studies suggest cannabis use increases an individual's risk of experiencing a cardiovascular event (Aryana & Williams, 2007) and can precipitate the development of psychotic disorders (Hall, Degenhardt, & Teesson, 2004), conflicting results have also been reported (Degenhardt, Hall, & Lynskey, 2003; Rodondi, Pletcher, Liu, Hulley, & Sidney, 2006). Empirical evidence has also emerged that suggests chronic cannabis users exhibit dependence behaviors and mild withdrawal symptoms when attempting to cease cannabis use (Budney, Hughes, Moore, & Vandrey, 2004). Nonetheless, the validity of this evidence has also been criticized for its lack of controlled studies and the absence of operational definitions of withdrawal symptoms and severity (Smith, 2002; Soellner, 2005).

Perceived Health Benefits and Risks of CTP

Individuals' perceptions of the health benefits and risks of using CTP have also been examined. Among current users, CTP is perceived as superior to conventional medications in the treatment of various illnesses (Coomber, Oliver, & Morris, 2003; Ware, Adams, & Guy, 2005). Persons with MS report CTP to be helpful in relieving both specific symptoms (e.g., reduction in pain, tremors, numbness, falling/balance problems) and general symptoms (e.g., relaxation of whole body, stress relief; Clark, Ware, Yazer, Murraym, & Lynch, 2004; Page & Verhoef, 2006; Page, Verhoef, Stebbins, Metz, & Levy, 2003). While those with HIV/AIDS report that the benefits of CTP use include decreased anxiety/depression, pain, nausea and vomiting, and increased appetite (Braitstein et al., 2001; Prentiss, Power, Balmas, Tzuang, & Israelski, 2004), as well as improved adherence to antiretroviral therapy (de Jong, Prentiss, McFarland, Machekano, & Israelski, 2005). Perceptions of negative health effects by CTP users include impaired cognition and balance, fatigue and/or insomnia, dry mouth/throat, mood changes, anxiety and paranoia, and the feeling of being high (Harris et al., 2000; Howard, Kofi, Holdcroft, Korn, & Davies, 2005; Page & Verhoef, 2006; Swift, Gates, & Dillon, 2005; Ware, Rueda, Singer, & Kilby, 2003). However, these were perceived to be rare and manageable. CTP users also perceive cannabis as a useful complementary therapy to existing medications because it produces fewer adverse effects and enables them to reduce or discontinue conventional medications (Reiman, 2009; Swift et al., 2005; Ware et al., 2005). The use of CTP has also been linked to relieving side effects of conventional medications and reinstating patients' "control" across their illness trajectories (Coomber et al., 2003).

Therapeutic Cannabis and Gender

Researchers have begun to explore how gender influences CTP use. Gender refers to socially prescribed and experienced roles, attitudes, and behaviors that influence gender identity and health practices (Bird & Rieker, 1999). Gendered dimensions of "femaleness" and "maleness" are increasingly recognized as important health determinants and an essential aspect of health research (Johnson, Greaves, & Repta, 2009). In the case of CTP use, there is some evidence that more men report CTP use than women (Page et al., 2003; Ware et al., 2003), and in a study of HIV/AIDS patients, women were found to be more likely to use cannabis for strictly therapeutic purposes, whereas men used it both therapeutically and recreationally (Furler, Einarson, Millson, Walmsley, & Bendayan, 2004). Swift and colleagues (2005) observed that among CTP users, men were typically long-term users (more than 1 year) who used CTP several times a day, while women reported more inconsistent and short-term use. However, when asked to compare the effects of CTP with other medications, few gender differences emerged aside from slightly more men reporting reduced use of conventional medications and higher satisfaction with CTP compared with conventional medications. As the role of CTP expands in the management of chronic illnesses, particularly among those diseases with higher reported incidence in women than men (e.g., MS, chronic pain, fibromyalgia, and arthritis), further investigation of gendered experiences is necessary.

In light of the existing policy context and evidence surrounding CTP use, the specific research questions guiding this study were as follows: (1) How do individuals who self-report using CTP perceive the potential health effects of cannabis use? (2) What role does gender play in the perception of the potential health effects of CTP use? (3) How do messages and regulations related to CTP influence men's and women's perceptions and decision making regarding CTP?

METHODS

A qualitative descriptive design informed by the tenets of naturalistic inquiry (Lincoln & Guba, 1985) and

gender-based methodology (Women's Health Bureau, 2003). The assumptions underlying the later approach were (1) social constructions of gender shape individual experience, (2) gendered experiences are informed by one's position in society, and (3) there is a prevailing gender order in which dominant forms of masculinity subordinate women (and some men) and create unequal access to social power and resources.

Study Setting

This study was conducted in south-western British Columbia, Canada. The use of CTP in Canada is directly influenced by laws surrounding cannabis production, distribution, and use. Individuals seeking to legally use CTP must apply to Health Canada's Medical Marihuana Access Division (MMAD) and have a diagnosis within one of two categories: (1) receiving compassionate end-of-life care or suffering from specific serious medical conditions (i.e., MS, spinal cord injury/disease, cancer, HIV/AIDS, arthritis, or epilepsy) or (2) have a serious medical condition (other than those in Category 1) where conventional treatments have failed or are inappropriate (Health Canada, 2005). Health Canada maintains that "marihuana is not an approved therapeutic product and the provision of this information should not be interpreted as an endorsement of the use of this product, or marihuana generally," (Health Canada, 2003). Those authorized to possess cannabis under the Marihuana Medical Access Regulations (MMAR) can obtain a legal supply of dried cannabis in three ways: (1) access Health Canada's cannabis supply, (2) obtain a license from Health Canada to produce for themselves, and (3) to obtain a license from Health Canada to designate someone to produce on their behalf. However, CTP has also been available in Canada to individuals with medical documentation of a chronic or debilitating illness through community-based medical cannabis dispensaries. These dispensaries, often referred to as compassion clubs, provide illegal, high-quality cannabis to their members with medical documentation of an illness along with education regarding safe and effective use of cannabis (Capler & Lucas, 2006). Although operating outside of Canadian laws, these organizations have attracted over 11,000 members nationwide (Lucas, 2008). Since completing data collection for this research, a police "crackdown" on compassion centres in Quebec has resulted in several arrests and the closure of five dispensaries (Health Canada, 2010; "Quebec compassion club," 2010). Other compassion centres in Canada continue to operate in other jurisdictions. Mixed messages reflected in regulations, policy statements and police actions, as well as public health strategies directed toward reducing cannabis use, create a complex context for women and men making informed decisions about CTP use.

Recruitment and Sampling

Following ethics approval by a university review board, purposive sampling was employed to recruit men and women who were CTP users. Specifically, our decision to recruit a sample for heterogeneity was guided by our desire to understand how CTP use is perceived by diverse subgroups of men and women (i.e., different health conditions and social contexts). Participants were recruited through an online forum and through four British Columbia community-based compassion centers. Individuals were eligible if they (1) self-reported CTP use in the last 30 days and for over 6 months, (2) were at least 19 years of age, and (3) were English speaking. Following procedures outlined by the ethics review board, participants were given a consent form to review and then gave their consent verbally on tape. All participating individuals received a C$25 honorarium for their time. Thirteen women (including two participants who self-identified as transgendered) and 10 men participated in the study. To recognize the authenticity of their identities and transformations (Lombardi, 2001), the interviews of the transgendered (male to female) participants were included in the women's data. The average age of participants was 45 ($\bar{x} = 46$ years for women and 43 years for men). Three women and two men were married or in a common-law relationship; the remaining were single, divorced, or separated. The majority of the sample was White/Caucasian; other groups represented included Aboriginal (5), South Asian (2), and Japanese (1). Although all participants completed high school and a majority had postsecondary education, reported annual income was low by Canadian standards ($\bar{x} = \$13{,}250$ for women and $29,300 for men). The participants were long-term ($\bar{x} = 8.3$ years, range = 2–16 years) and current CTP users, with formal diagnoses that met either Health Canada or compassion society eligibility requirements. Health conditions included HIV/AIDS (3 women, 3 men), fibromyalgia (3 women, 2 men), arthritis (2 women, 2 men), mood/anxiety disorders (3 women), cancer (1 woman, 1 man), neurological disorders (1 woman, 1 man), gender dysphoria (2 women), and HCV, epilepsy, MS, and chronic pain (each reported by 1 man). Many of the participants reported more than one health problem. All participants reported smoking CTP, although other common methods of use included eating cannabis and using a vaporizer. A few reported using tinctures, sprays, or poultices to administer the drug. Estimating the amount of cannabis used each month was difficult for some participants, because the money they had to purchase the drug varied from month to month. Furthermore, it was often difficult to keep track of the amount they used (in grams) when it came from various sources (i.e., their own plants, provided by friends, and purchases). While some accessed CTP through compassion clubs (12 women, 8 men), others were licensed growers (6 women, 4 men), nonlicensed growers (5 women, 5 men), or purchased cannabis through the Health Canada program (5 women).

Data Collection

Data collection involved semistructured, individual face-to-face or telephone interviews conducted by a trained male research assistant or the female project manager. With a few exceptions, participants were interviewed by

a research staff member of the same gender. Participants were asked about their attitudes toward and experiences of CTP use including their perceptions of the health effects of CTP. Interviews were conducted in a location convenient to the participant and lasted 1–3 hours. A short survey was used to collect demographic data, history of cannabis use, and information about the health issues influencing CTP use.

Data Analysis

Employing an inductive thematic approach to data analysis (Lincoln & Guba, 1985), interview transcripts were read and reread by the authors and passages that reflected emergent ideas, themes, and examples were highlighted. In investigative team meetings, independent reviews of the data were summated and shared to reach consensus about categories for coding the data. The qualitative data management software program, NVivo, was used to organize the data for retrieval and in-depth analysis. Comparative strategies were used to explore participants' perceptions of CTP across and within genders. To extend interpretation of the data from the perspective of gender, we focused on the influence of gender roles as well as gender identities, drawing on understandings of hegemonic masculine and feminine ideals that shape individual identities and practices (Howson, 2006; Schippers, 2007). We used these concepts of gender to explore the data (e.g., by raising questions about whether patterns in the data might reflect gendered roles or gendered identities) and offer explanations of differences reflected in women and men's practices with respect to CTP.

RESULTS

Participants were eager to share their perceptions about the health benefits of CTP. For many, this eagerness may have been reinforced by experiences of sustained respite, often for the first time, in a long trajectory of efforts to address health problems. It was also clear they believed that this medicine, which they found so valuable in a culture that did not consistently support its use, needed to be more available to people who needed it. The health effects of CTP use emerged from personal experiences of accessing and trying cannabis to treat health problems and finding a therapeutic regime that best met their individual needs. Themes related to perceived health benefits included cannabis as life preserving, an adjuvant disease therapy, a medicine for the mind, a means toward self-management, and a way of managing addiction. The health risks of using CTP were largely discounted, and participants presented themselves as responsible consumers who were able to manage potential risks in relation to purchasing the drug, excessive use, and smoking. The influence of gender and contextual factors are highlighted, when these were evident in themes related to both perceived health benefits and risks.

Health Benefits of CTP

Constructions of Cannabis as Life Preserving

Participant narratives often began with detailed accounts about complex health problems and a long history of efforts to find effective medical treatments. Underlying many participant stories was increasing despair and desperation, as medical treatments failed to live up to expectations and/or were accompanied by intolerable side effects. In these situations, often without any other options, the participants tried CTP. The therapeutic effects of cannabis were reported to be immediate in many instances, and for the first time in many years, participants could manage life again. In these narratives, cannabis was constructed as life preserving.

While the circumstances leading individuals toward CTP were similar among men and women, gender differences emerged in how cannabis was constructed as life preserving. For women, cannabis was a "holistic" therapeutic tool, enabling them to keep on living despite their diagnoses. Women were strongly committed to using CTP, in part, because they attributed their survival to their use of the drug. When asked to complete the sentence, "To me, cannabis is . . .," three women responded by stating it was their "lifesaver." Other descriptions included CTP as a "life force" and a "lifelong partner." A woman in her 30s who had used CTP daily for over 15 years suggested that she had no choice in using cannabis because it enabled her to function each day. When asked what she would do if her access to CTP was lost, she replied, "I would die, there's no doubt in my mind that I would die of my disease."

In contrast, men were less likely to explicitly frame CTP as life preserving. However, those who did held pragmatic views of the benefits of CTP reflected in their focus on the functional benefits of cannabis. For example, several described it as a medicine that "works quite well when you need it." One man matter-of-factly stated that it was a "necessary product," while another positioned cannabis as life preserving because it reinstated his control and the conduit through which he was able to "present [himself] to the world":

> I know for a fact what it's [CTP] done because at one stage of my life I wasn't able to eat and I was less than a hundred and forty pounds, I was almost dead so to me it's already proven itself. I hopefully will keep myself together in this process but it's done its job and I'm happy with it.

Constructions of Cannabis as an Adjuvant Disease Therapy

Constructions of CTP as an adjuvant disease therapy prevailed across participants and reflected their desire to assemble the most effective treatment regime possible for the chronic diseases they were experiencing. In this context, CTP was used strategically by both men and women as a supplemental aid to ensure their adherence to prescribed drug regimens needed to manage their chronic illness. One participant, a 39-year-old woman with HIV/AIDS, maintained, "I need [CTP] to take my medication, that's the biggest thing, if I don't have my

appetite, I don't take my medication and then there's problems." Similarly, a man diagnosed with AIDS and HCV explained:

> Well, it's a great supplementary treatment when you're dealing with AIDS or hepatitis [HCV], it reduces pain, it calms you down, it gets rid of nausea, it gives you an appetite. So as far as I'm concerned it's quite beneficial... [and] with hepatitis and the AIDS drugs, sometimes you have a heck of a problem taking the pills [because] they just come back up... so once in a while I'll just take some marijuana.

Despite using both CTP and prescription medications, efforts were often made to avoid using them simultaneously to maximize the individual effects of these substances and/or to offset any negative interactions. One man with attention-deficit hyperactivity disorder (ADHD) and a CTP user for over 25 years stated, "If I use [prescription methylphenidate and cannabis together], it messes the marijuana, it messes up the whole process, it makes me tired, it doesn't work right, it has to be an hour ahead." Additionally, he would alternate his CTP use with methylphenidate daily to increase its effectiveness, to achieve a "balance" in their desired effects, and to avoid developing a tolerance for both drugs.

Constructions of Cannabis as Medicine for the Mind

CTP was also linked to significant improvements in mental health. The benefits were most often verbalized by women and were among the most significant benefits they attributed to cannabis. For example, a 51-year-old woman with bipolar disorder stated that her improved mood has been "the most important effect" of CTP. Another woman stated that CTP helped her deal with depression related to her terminal prognosis and reduced her anxiety and stress. CTP enabled her to gain a logical perspective of her prognosis and achieve a sense of detachment and clarity toward an otherwise highly stressful situation:

> I would be terribly depressed without it [CTP]... I don't find that I'm going through the same up and down that I would go through with dealing with my death. I mean, it's hard. It's difficult to deal with this.

Most men, on the other hand, focused on CTP's physical health benefits. However, some reported mental health benefits. Typically, their use was most often related to quelling anger and controlling rage both of which are common masculine characteristics of men's depression (Branney & White, 2008). A 36-year-old man described how CTP had improved his affect: "I also use it now for keeping my anger in control when I rage... I guess the marijuana calms me down, I've been using it to calm me down way before I figured out that I had ADHD." Likewise, a 38-year-old man diagnosed with HCV initially began using CTP to control his temper related to an underlying depression:

> I was so depressed it was ridiculous and honestly I started smoking probably more for the depression .... So I'm smoking a joint every 40 minutes because to me that's what it takes to maintain a glow and keep my life moving along in a fashion that I can deal with it and I don't have obstacles that are too challenging and I don't lose my temper with people.

Thus, there were important differences in the way women and men framed their use of CTP for mental health. Women's narratives invoked feminine ideals (e.g., related to recognizing and managing emotions) and the legitimacy of treating women's mental illness (which more commonly afflicts women). Men's narratives, on the other hand, focused on using CTP to dull or blunt experiences and expressions of depression, which might also be interpreted as naturally occurring and culturally tolerated masculine ideals.

Constructions of Cannabis as a Means to Self-management

CTP was conceived by many participants as being beneficial to their health because it enabled them to take control over their health by choosing a drug that they perceived to be a safer and more effective alternative to prescription medications. For both men and women, these perceptions were based on the limited success or relief they received from conventional medications. In this context, conventional drugs were classified as "toxic" and likely to cause more harm than good and potentially hasten one's death. Fears of being "overtoxified" were substantiated by unwanted side effects experienced while taking prescribed medications. Frustrated with therapies affording limited success or relief, replacing prescribed medications with CTP provided a way for participants to take control over managing their health conditions because it placed them in charge of prescribing their own medication. The illegal status of cannabis and health care providers' lack of knowledge to direct its use provided additional impetus for self-management when it came to using CTP.

There were, however, important gender differences with regard to using CTP for self-management. Men's approach to CTP reflected masculine preferences for self-monitoring, self-reliance in illness management, and, at times, avoidance of professional health services (Oliffe & Phillips, 2008). Accordingly, men were more likely to draw on their previous successful experiences with CTP in positioning it as their "first line of defence." As one man explained, "I've used cannabis all of my life and I just decided to stick with using cannabis." Women, on the other hand, were more likely to engage with health providers, progressing toward illness self-management while continuing to use but hoping to wean themselves off prescribed medications. As one woman with Crohn's disease described the uptake of CTP was thoughtfully considered and incrementally integrated as a possible substitute for conventional medicine:

> I [was] on a variety of different prescription drugs through the years. I was dying. My system was collapsing, I could feel my intestinal tract rotting and I found I was very nauseated with [mesalamine], the prednisone made me feel bloated, uncomfortable, slightly depressed... a dear friend of mine from childhood suggested to me why don't you start smoking pot and I tried it. I found immediately the cannabis was like a baby blanket and I started to

wean myself off of the pharmaceuticals and I stopped asking for prescriptions from my general practitioner.

Constructions of Cannabis as a Way to Manage Addiction

Since the risk of addiction with long-term cannabis use has not been clearly established, it was perhaps not surprising that participants did not focus per se on any real or imagined potential for addiction to cannabis itself. Instead, using CTP was viewed as a valuable aid in managing other addictions because of its perceived benefits as a substitute for addictive substances and a treatment for withdrawal symptoms. Positioning CTP as the "lesser of two evils," CTP use was particularly important in reducing the uptake of alcohol, tobacco, and street drugs. For one man (CTP user for over 10 years, HCV), cannabis was integral in reducing his excessive use of alcohol and tobacco—his self-described "temptations." Through his personal experiences and observations of others, he supported using cannabis as a "substitute" for addictive substances and espoused its benefits in keeping others away from illicit drugs and alcohol. In a similar vein, one woman (aged 39, HIV/AIDS) had previously been a "practicing alcoholic," but since beginning to use CTP, her use of alcohol and other illicit drugs had drastically reduced. She conceptualized her use of CTP as an effective means of harm reduction, stating, "It keeps me from doing all kinds of other nasty stuffs like all the street drugs, [including] cocaine, speed." Another woman (aged 63, fibromyalgia) indicated that she was first introduced to the therapeutic benefits of CTP when she began to wean herself off of her addiction to heroin and cocaine. As her use of CTP progressed, she began to experience additional therapeutic benefits (e.g., pain relief) and believed it was the "gateway" out of addiction. Interestingly, some women's conceptions of using CTP in the management of addiction were in reference to avoiding addiction to prescribed medications for the treatment of their illnesses (e.g., pain killers). For one woman who suffered from extreme pain and fibromyalgia (aged 59), conventional medication meant "struggling not to be addicted" to drugs such as acetaminophen, codeine, and lorazepam. CTP offered her another option and enabled her to discontinue using these drugs because it provided a "very calming place for [her] and for [her] pain."

Management of CTP Health Risks

In general, participants were not overtly concerned with the health risks of using CTP. When potential risks were discussed, participants often considered these to be overstated by experts. Participants argued that there were risks associated with prescribed medications and that in this respect CTP was no different. They were willing to live with any risks posed by CTP in order to receive the benefits they valued so highly. Having made the decision to use CTP, participants focused on how to manage potential CTP health risks. As a 27-year-old man with cancer explained, "I'm trying to do it [CTP] as healthy as possible... but I am aware of the negative effects and that's part of any drug, and it definitely the benefits outweigh the negativity." Self-management of risks focused on the potential effects of excessive use, smoking-related risks, and safe access.

Avoiding Effects of Excessive Use

The potential for addiction associated with the use of CTP was discussed by some participants. Men were more likely than women to discount the potential for addiction, suggesting that physical addiction to cannabis was unlikely, while conceding that therapeutic users might develop a psychological or behavioral attachment to the drug. To test his dependence, one man would periodically quit using CTP for a few days to "reset [his] clock," a practice that resulted in vivid dreams, nausea, and a shorter attention span. However, these symptoms were not debilitating for him, and when he compared these withdrawal symptoms with other medications and substances, he considered them "very small."

The potential for health risks associated with the excessive use of CTP was linked to the circumstances surrounding its use and an individual's characteristics, rather than the cannabis itself. Several participants suggested that these risks only became an issue when CTP use expanded beyond what they considered to be therapeutic levels. Women suggested that smoking CTP was likely to be problematic when the person was a "chronic user" consuming "exaggerated amounts" over a period of several years. The men generally took a more pragmatic view of this, believing that there was no prescribed or absolute dose where CTP became problematic. Rather, consumption levels needed to be considered in light of an individual's tolerance and the impact it had on his or her life.

Participants frequently provided detailed explanations of their efforts to use only the amounts of CTP needed to address their health concerns. The right amount of CTP to use was often determined (particularly by unlicensed CTP users) through trial and error because specific dosages were not recommended by doctors, and the amount used often needed to be retitrated in response to changes in symptoms and disease progression. And while they sometimes used more than they thought they needed, only one participant (aged 55, woman, daily consumer) believed that she had experienced serious side effects from using too much CTP in an attempt to reduce her need for chemotherapy. However, despite the side effects experienced, she did not consider stopping her use of CTP and simply reduced her intake.

Smoking Cannabis

Although many participants expressed smoking-related concerns (including coughing, lung/breathing difficulties, and fear of lung cancer), most participants primarily smoked CTP. For some, these risks were not perceived as serious and were manageable. Several men and women believed that smoking-related health issues emerged when the amount consumed was very high and the product was of low quality. Because of their access to high-quality cannabis, they believed that the amount needed to manage

their symptoms was minimized. While participants knew of other methods for administering CTP, they continued to smoke because it was convenient and affordable and enabled them to more effectively regulate their dosing. As one woman stated:

> Smoking is the [poorest] option but reliability and consistency and amount of dosing eating-wise is equally unpredictable and difficult, and to almost double the amount you're consuming orally to what you're smoking. . .. it becomes ridiculously overpriced.

Some participants believed that smoking CTP posed no added risk to their health. Several indicated that they had "perfect" lungs despite their use and believed that they were "a lot more safe" smoking cannabis than anything else. One man questioned the impact of his smoking CTP since he had previously smoked tobacco and questioned, "What's a couple of joints going to do anyway?" He additionally suggested that while tobacco cigarettes offered "absolutely no benefit," at least CTP had "some benefits." Although practices related to smoking tobacco are gendered (World Health Organisation, 2007), in the context of smoking CTP parallel to gender influences appeared to be muted because across women and men in this study the impact of the drug was foregrounded.

Safe Access

The complex and often gray legal climate regarding the use of and access to CTP in Canada created particular challenges for the study participants. They were aware of the possible health risks posed by accessing CTP from "street" and other unregulated sources. Characterizing this activity as "hit and miss," several participants suggested that purchasing from these sources was accompanied by two major hazards. First, the risk of using cannabis of unknown strain and quality was considered to result in inadequate relief. Not knowing the specific strains they purchased was a concern for the participants because they might not experience the desired effects. A woman with rheumatoid arthritis suggested that some strains were too strong for her and could worsen her symptoms. Consequently, not knowing the strain she used was potentially hazardous to her health. Participants also expressed concern over not knowing the particular growing conditions of cannabis because this had a direct effect on the quality. Purchasing cannabis that was potentially moldy or grown improperly, a common characteristic of street-level cannabis according to participants, was considered a high-risk activity and needed to be avoided.

Second, accessing unregulated cannabis was associated with the potential for purchasing cannabis "laced" with dangerous drugs or chemicals, including cocaine, crystal methamphetamine, heroin, ecstasy, and others. Participants listed addiction and death as the primary consequences of using laced cannabis. One woman described her firsthand experience:

> Oh my God, you can get anything mixed in with it. My boyfriend who died of cancer smoked some with me one night that he'd gotten off the street and he [had] a heart attack, he [had] a stroke. . . and I knew it was laced with something, methamphetamine or something. . . you just don't know what you're getting and it's very dangerous.

To minimize these risks, participants chose to only access "safe" cannabis primarily through trusted and established channels, such as well-known friends and acquaintances, their local compassion centers, or they grew it themselves. Among the participants only five (all women) accessed cannabis directly through the Health Canada program, perhaps reflecting women's law-abiding and risk-aversive tendencies compared with men. Several participants praised the support they received through their compassion center (and often advised others to use them) because they could choose their preferred strain and were guaranteed premium quality cannabis products. One 63-year-old woman who used CTP on a daily basis explained:

> The [centre I purchase from] is fantastic. You're assured of the quality. You're assured of what kind of dope you want to smoke. It's great. It's like, you know, being able to go to the supermarket and just buy it and know you're not being hassled or going up some strange person's apartment to buy what you're not sure of.

Also, the use of trusted sources (e.g., compassion centers) to access cannabis represented important efforts to minimize their involvement in (or the perception of engaging in) overt criminal activity and protect their personal safety, despite the illegal status of cannabis accessed through these means. In the case of participants authorized to possess cannabis under Health Canada's MMAR, the approval was perceived to validate their medical need for the drug and provide legal protection in addition to a safe supply. Participants believed that the potential health risks of using CTP were related to cannabis prohibition, not the cannabis itself, and that supply through a controlled and regulated market would minimize these risks.

DISCUSSION

The experiences related to using CTP described herein provide important empirical evidence to supplement and extend the growing body of knowledge addressing cannabis use for medical conditions. In contrast to the framing of cannabis as an unproven medicine, participants perceived significant benefits from CTP and positioned themselves as responsible and knowledgeable CTP users. Constructions of the benefits of CTP use as life preserving, an adjunct disease therapy, medication for the mind, a means to self-management, and a way to manage addictions suggest a range of perceived benefits that extend beyond those reported elsewhere. Similar to Reiman's study (2009), participants' perceptions of the use of cannabis as a harm reduction tool to manage addictions associated with other types of substance use stood in direct contrast to traditional views of cannabis as a gateway drug. Furthermore, participants did not consider that cannabis might be a replacement addiction because few believed they experienced any symptoms associated with cannabis dependence. Instead, views of cannabis were shaped by perceptions of its benefits and the lack of serious side

effects in using cannabis in comparison with other addictive substances and prescription drugs. In summary, discourses that question the therapeutic benefit of cannabis were largely ignored by participants.

In relation to the health risks of using cannabis, participants in this study positioned themselves as aware of potential risks and constructed them as relatively minor in comparison with the benefits they received. Mental health risks reported in the literature (Moore et al., 2007) were not supported by the participants in our study. Their views are supported by a recent review of cohort studies suggesting serious psychotic disorders may not be directly related to cannabis use (McLaren, Silins, Hutchinson, Mattick, & Hall, 2010).

While difference tends to be the feedstock of gender analyses, important similarities were observed among women and men participating in this study. For example, the desire to self-manage their illness and treatment, along with many of the practices used in relation to purchase/production (access), dosage (titration), and route of administration (smoking), revealed thoughtful engagement in using CTP on the part of both men and women. This level of interest in self-care may be a reflection of the context in which participants were using cannabis where many were living with poorly managed chronic illnesses via conventional therapies, CTP use was not fully supported by physicians and family members, and in many cases, participants were engaged in illegal activity to use this medication. A high level of independence and persistence was needed to use cannabis as a medication. In addition, it is noteworthy that self-care is affirmed as a feminine ideal but marks a departure from the health practices typically expected of men (Galdas, Cheater, & Marshall, 2005). Men's tendency for frequent and long-term use of cannabis (including recreational cannabis) and willingness to participate in illegal activity has the potential to afford them more access to cannabis than women, which in effect may have leveraged and legitimated men's knowledge and expertise around CTP.

There was also evidence of gender differences in constructions of the health effects associated with using CTP. The women in our study consistently detailed their CTP experiences at the nexus of self and professional management (i.e., by physicians and other health care providers), and their patterns of CTP usage suggest a collaborative enterprise by many participants amid emancipatory endeavors to be self-sufficient through CTP. Feminine ideals position women as connected emotionally and somatically with their bodies, yet conciliatory with medical management (Lyons, 2009). Men, on the other hand, tended to treat symptoms as needed, reflecting tendencies to be more amenable to self-management than seeking or receiving professional help (Courtenay, 2000; Lee & Owens, 2002). These common men's health practices serve to reinstate the physical and emotional control that is central to idealized masculine identities, characteristics that are so often threatened and eroded by illness and disease (Charmaz, 1995). Varying alignments to masculine and feminine ideals in health practices and evidence that gender may play a role in CTP use and decision making indicate the potential usefulness of further research to explore the need for gender-sensitive decision support for individuals contemplating and using CTP.

With the privileging of the health benefits of cannabis over the potential health risks reported by participants in this study, information resources that adopt a pejorative approach to cannabis (e.g., abstinence, addiction) are unlikely to be effective in translating knowledge or to have significant uptake within populations using CTP. Instead, a therapeutic-centered approach that acknowledges the social, gendered, and health reality of individuals who use CTP is needed, while transmitting key harm reduction messages aimed at ameliorating the potential risks associated with cannabis in the context of therapeutic use. Within the drug education literature, other researchers have similarly acknowledged the importance of a harm reduction message, particularly for individuals already using cannabis (Butters, 2004; Coggans, Dalgarno, Johnson, & Shewan, 2004). Given that many CTP users were using cannabis along with their prescribed medications for their chronic conditions, facilitating conversations between CTP users and health care professionals is crucial. The lack of guidance from physicians may be related to a reluctance to discuss CTP because they feel illinformed, unsupported by licensing bodies, and concerned about the potential risks of cannabis use (Canadian Medical Protective Association, 2001; College of Physicians and Surgeons of British Columbia, 2009). Furthermore, when patients are seeing positive effects of CTP, physicians' adherence to messages that cannabis is not therapeutic undermines helpful patient–provider communication. Ready access to reliable information about CTP, therefore, could facilitate these discussions.

One way to increase receptivity of health messages related to using CTP is to draw on the experiences of compassion centers in addressing the information needs of CTP users (Capler & Lucas, 2006), the "personal cannabis rules" originally described by Coggans and colleagues (2004), and the information provided by the participants in this study. On the basis of this, particularly relevant information for CTP users includes (1) how to safely titrate dosage, (2) how to manage potential health risks, (3) how to assess for dependency, and (4) the importance of communicating to one's primary care provider changes in conventional treatment protocols as a result of cannabis use. As evidence related to the health effects of cannabis in the treatment and management of select illnesses emerges, harm reduction messages will need to be balanced with information regarding the potential health benefits of cannabis to support informed decision making. Additionally, many CTP users are likely to be frail and/or disabled when they make the decision to use CTP. Tailoring these resources to address the influence of health problems in addition to gender differences on patterns of CTP use is also likely to be important.

The findings of this study need to be considered in light of several limitations. While every attempt was made to include a variety of CTP experiences, the results may not

represent the full range of possible experiences among CTP users. Furthermore, this study was conducted in a region well known for its illicit production of the cannabis and greater acceptance of cannabis use and support for its decriminalization than the rest of Canada (Stockwell et al., 2004). Nevertheless, the results include important insights regarding perceptions of the health effects of cannabis use among CTP users.

CONCLUSION

This study adds to an emergent body of research by giving voice to women's and men's experiences of using CTP. Such insights are essential to understanding why CTP is utilized, what benefits and risks are perceived to be associated with CTP, and how public health messages need to be framed to best meet the needs and contextual realities of potential and current users. Further research is needed, however, to determine how assessments of the health effects of CTP use may change over time and in different and shifting social and legal environments. Additionally, the influence of gender in patterns of the use of CTP warrants further study and suggests new directions for developing information resources and providing decision support.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

RÉSUMÉ

Cette étude qualitative a pour but de comprendre de quelle façon les individus disant faire usage de cannabis à des fins thérapeutiques perçoivent les effets de celle-ci sur leur santé. Les données provenant de 23 entretiens individuels ont été retranscrites et analysées. Une approche orientée selon l'identité et les genres a été utilisée dans l'exploration de données et lors de l'interprétation des différences perceptuelles. Les effets bénéfiques perçus sur la santé recensés comprennent l'usage comme moyen de préservation du bien-être, comme traitement médical, comme médicament pour l'esprit, comme outil d'autogestion et enfin, comme moyen de gérer sa dépendance. Par ailleurs, l'autogestion des risques semble se concentrer principalement sur les effets néfastes possibles dus à un usage excessif, à l'inhalation de fumée ou encore aux risques liés à l'achat de cannabis. Bien que les données des sujets masculins et féminins soient similaires à plusieurs égards, il semble qu'il y ait une différence significative quant aux modes et aux pratiques d'usage selon le sexe du sujet. Cette étude permet de nous donner un aperçu quant aux nouvelles façons de développer des supports informatifs plus sensibles au genre, ceci afin de mieux orienter les prises de décisions et l'usage de cannabis à des fins thérapeutiques auprès des usagers.

RESUMEN

Efectos sobre la salud por el uso de mariguana con fines terapéuticos: Un análisis de género de las perspectivas de los consumidores

El propósito de este estudio cualitativo es el de describir como los individuos quienes dicen usar mariguana con fines terapéuticos perciben los efectos sobre la salud que esto trae. Los datos de 23 entrevistas individuales fueron transcritos y analizados. La comprensión de los roles de género e identidad fueron usados para explorar los datos e interpretar las diferencias en percepción. Las descripciones de los beneficios de usar la mariguana con fines terapéuticos incluyen al cannabis como un preservador de vida, una terapia para enfermedades, una medicina de la mente, un medio de autocontrol y una manera de manejar la adicción. El automanejo de los riesgos fue centrado en los efectos potenciales del uso excesivo, riesgos relacionados con fumar y precauciones de compra. Aunque los reportes de hombres y mujeres fueron similares en varios respectos, hubo importantes diferencias en los patrones y prácticas de uso que reflejaron influencias de género. Estadísticas del estudio proveen dirección para el desarrollo de información específica en cuanto a género para apoyar la toma de decisiones y uso de quienes consumen mariguana con fines terapéuticos.

L'usage du cannabis à des fins thérapeutiques et ses impacts sur la santé: une perception différenciée selon le sexe de l'usager

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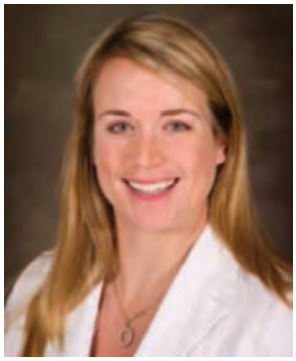

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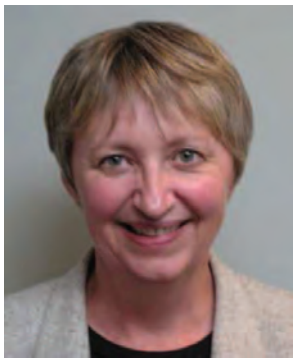

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GLOSSARY

Cannabis for therapeutic purposes (CTP): Also known as "medical marijuana," where a licensed physician has determined that an individual's health would be improved by the use of cannabis in the treatment of HIV/AIDS, cancer, anorexia, chronic pain, neurological disorders, or any other illnesses for which cannabis is probable to provide relief.

Compassion center: Also known as a "compassion club," a nonprofit, community-based cannabis dispensary that sells cannabis and cannabis-based products as therapeutic aids to members in defiance of antidrug laws.

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Perceptions of cannabis as a stigmatized medicine: a qualitative descriptive study

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Perceptions of cannabis as a stigmatized medicine: a qualitative descriptive study

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Abstract

Background

Despite its increasing prevalence and acceptance among the general public, cannabis use continues to be viewed as an aberrant activity in many contexts. However, little is known about how stigma associated with cannabis use affects individuals who use cannabis for therapeutic purposes (CTP) and what strategies these individuals employ to manage associated stigma. The aim of this Canadian study was to describe users' perceptions of and responses to the stigma attached to using CTP.

Methods

Twenty-three individuals who were using CTP for a range of health problems took part in semi-structured interviews. Transcribed data were analyzed using an inductive approach and comparative strategies to explore participants' perceptions of CTP and identify themes.

Results

Participant experiences of stigma were related to negative views of cannabis as a recreational drug, the current criminal sanctions associated with cannabis use, and using cannabis in the context of stigmatizing vulnerability (related to existing illness and disability). Strategies for managing the resulting stigma of using CTP included: keeping CTP 'undercover'; educating those who did not approve of or understand CTP use; and using cannabis responsibly.

Conclusions

Understanding how individuals perceive and respond to stigma can inform the development of strategies aimed at reducing stigma associated with the use of CTP and thereby address barriers faced by those using this medicine.

Keywords

Cannabis, Medical marijuana, Stigma, Cannabis, Legal consequences, Social consequences

Concurrent with its increasing use as an illegal recreational drug, a growing number of studies have highlighted the medical benefits of cannabis for diverse health conditions [1,2]. In 2001, the Canadian government officially created a medical cannabis programme to authorize the possession, production and distribution of cannabis for therapeutic purposes (CTP) for individuals meeting specific criteria. Nevertheless, researchers report that cannabis use continues to be viewed as aberrant and CTP users experience stigma related to their use of cannabis [3]. The goal of this study was to describe users' perceptions of and responses to the stigma they experience related to CTP in order to provide a foundation for developing strategies for reducing the stigma and supporting CTP users in their use of this medicine.

Background

Notwithstanding its current illegal status in Canada, cannabis has become the most widely used illicit drug and its use is on the rise among most population groups [4]. In British Columbia, Canada, the setting of the current research, over 50% of the population 15 years and older have consumed cannabis at least once in their lives [5]. As a result, consuming cannabis has transitioned from a once underground activity to one more openly accepted by many. Public opinion continues to shift towards the elimination or reduction of criminal penalties for cannabis-related activities. However, those who continue to believe these activities should be penalized are increasingly more likely to hold favourable attitudes toward cannabis when it is used for strictly therapeutic benefits [6,7]. Despite these changes in public attitudes towards cannabis, users continue to experience a certain level of stigma and risk in their use of CTP, particularly from authorities such as employers, landlords, and law enforcement [3,8]. Specific civic norms and etiquette are often employed by users in public spaces to avoid drawing attention to their cannabis use. Even with the establishment of Health Canada's Canada Medical Marihuana Access Regulations (MMAR) in 2001 stigma against CTP users remains an issue [9]. Little is known about how the stigmatization of cannabis use influences therapeutic users' patterns of use and their personal lives, and in-depth explorations of the strategies they employ to manage these experiences are limited.

Stigma, Health and CTP

Goffman's (1963) ground breaking work on stigma underpins our understanding of health-related stigma [10]. In this work, he defines stigma as: "*The phenomenon whereby an individual with an attribute wich is deeply discredited by his/her society is rejected as a result of the attribute"* (p.21) and argues that stigma is an interactional process that "spoils identity." As such, people who are perceived by others to deviate physically and behaviourally from social norms and values are subject to disapproval, and marginalization, and often experience discrimination and loss of status. These social interactions can result in enacted stigma (i.e., external stigma) when others' judgements about difference are translated into rejection, distancing and other discriminatory practices; as well as perceived stigma (i.e., internal stigma) wherein individuals' assumptions or fears of discrimination lead to self-perceptions of shame and guilt, and protective action such as self-imposed isolation.

Efforts to use and refine the concept of stigma for public health have been prompted by observations of the profound negative health effects of the social disqualification of individuals and groups who are identified with particular diseases or disorders [11,12]. For example, disease-related stigma in the context of mental health problems highlight the significant deleterious effect of stigma on health and well-being when individuals avoid health care or seeking other forms of support because of feelings of shame or embarrassment.

As chronically ill individuals and illicit drug users, CTP users are at a high risk of experiencing multiple sources of stigma from various fronts [13]. A diagnosis of chronic illness that is either visible (e.g., multiple sclerosis, and epilepsy) or relatively invisible (e.g., HIV/AIDS, fibromyalgia, and mental illness) often results in stigma and social isolation [14-17]. Although substance use is associated with varying degrees of stigma, illicit drug users are among the most stigmatized groups [18,19]. Beyond the stigma of being labelled a drug user, the additional stigma of being formally charged as a criminal can also have lasting negative effects. Social disqualifications targeting other features of a person's identity (e.g.,

poverty, gender, sexual orientation) can compound these experiences of stigma [20,21]. An understanding of the experiences of stigma among CTP users is, therefore, important and relevant to the health services provided to these individuals.

Social and Legal Consequences of Using CTP

While studies that investigate the experiences and concerns of recreational cannabis users are common, CTP remains poorly understood. A Canadian study of current HIV/AIDS CTP users reported many CTP users were met with "laughter, scepticism, or with negative reactions" (p. 41) from non-users for their CTP use [22]. They felt stigmatized for their choice of therapy both by their "healthy" peers and the medical system in general. Becoming licensed users through the MMAD Health Canada program helped alleviate some of the related stress and perceived stigma of CTP use and empowered them to improve their overall health. Other authors have reported that social and legal concerns motivated some individuals to conceal their CTP use and avoid disclosure beyond immediate family members [23]. When CTP users met with disapproval from family members, they reported it was often based on concern over the legal implications of CTP use and the potential of negative health effects and addiction.

The negative social implications of using CTP have also been observed elsewhere. A California-based study of pregnant women suffering from Hyperemesis Gravidarum (a highly debilitating pre-partum illness characterized by severe nausea, vomiting, malnutrition and weight loss) found that for participants, cannabis was their best option when traditional treatments were ineffective and, at times, traumatic [24]. Being pregnant and using cannabis, however, put participants at high risk for stigmatization. They were often belittled and declared deviant by their peers and the medical community for their decision to use CTP. Additionally, while these women were open and successful in using cannabis to treat extreme symptoms, they continued to experience strong feelings of anxiety, guilt and fear over CTP use. As Canadian CTP regulations are now over a decade old, it is timely that research be conducted examining the social context of CTP use and the influence of stigma on CTP users' lives. The specific research questions guiding this study were: 1) What are CTP users' experiences of stigma? and 2) What strategies do CTP users employ to negotiate their experiences of stigma? By understanding how individuals perceive the potential social implications of CTP use, new approaches can be developed to reduce the stigma associated with CTP and support individuals using CTP cope with stigma.

Methods

This research employed a qualitative descriptive design [25] and drew on the tenets of naturalistic inquiry [26] – a method recognised as particularly useful when investigating vulnerable persons with health disparities [27]. Using qualitative methods, inductive analysis and purposive sampling, we developed an in-depth account of the experiences of CTP users.

Study Setting

This study was conducted in Canada, where the use of CTP is directly shaped by the federal laws governing what is considered to be a controlled substance. Cannabis production, distribution and possession remain illegal in Canada, with the exception of Health Canada's licensing program for therapeutic users, the Medical Marihuana Access Program (MMAP). Since the MMAP's formation in 2001, those persons wishing to legally possess and obtain CTP must apply for a license directly to Health Canada, which acts as the governing body that oversees the implementation of the Medical Marihuana Access Regulations (MMAR). Paradoxically, Health Canada continues to state that "marihuana [sic] is not an approved therapeutic product" [28]. Ostensibly mixed messages, such as this policy statement, along with public health strategies directed towards reducing cannabis use (e.g., the National Anti-drug Strategy), has complicated the context within which individuals use CTP. Although the establishment of the MMAP has been seen as a step forward by some groups [29-31], others have expressed reservations about the program [9,32,33] pointing to access issues, the complexity of the application forms and the length of time required to process applications [9]. Apprehension about the quality, potency, and lack of quality control and strain selection of MMAD-supplied cannabis also continues to be a source of controversy for many CTP users [9]. Concerns about access have resulted in a recent court decision in Canada that has found the MMAR to be "constitutionally invalid and of no force and effect" [34], forcing Health Canada to engage in a community consultation process to discuss potential changes to the regulations and programme.

The need for safe and informed access to cannabis has been central to the development of community-based dispensaries (i.e., compassion clubs) in Canada. The dispensaries provide illegal, high quality cannabis to their members (who must have medical documentation of an approved medical condition) as well as information regarding CTP to assist with making decisions about cannabis use. The dispensaries reduce the risk of legal repercussions associated with accessing illegal cannabis by providing a safe environment for members to purchase CTP and by acting as members' social and legal advocates [35]. Although access to CTP through dispensaries is a form of civil disobedience, many law enforcement officers and courts recognize identification cards from these dispensaries as adequate proof of legitimate CTP use, giving discharges to verified members and to dispensary operators who manage their clubs in a transparent and responsible manner [35].

Recruitment and Sampling

Following university ethical approval, purposive sampling was used to recruit current CTP users through four British Columbia community-based cannabis dispensaries as well as through a Canadian online forum of CTP users in 2007–2008. Eligibility criteria required participants to: a) report using CTP in the last 30 days and for over 6 consecutive months, b) be at least 19 years of age, and c) speak English. In accordance with ethical requirements and to protect individual identities, all participants reviewed the consent form and were asked to give their consent verbally on tape at the start of the interview. No record of participants' names or identifying characteristics was kept and all participants received a C$25 honorarium for their time.

The sample comprised 23 participants (13 women, 10 men). Two transgendered (male to female) participants were included in the women's subgroup. Participants ranged in age from 25 to 66 years (mean = 45 years) and had an average annual income of $21,000, slightly below Canada's 2008 low income cut-off for individuals living in a large urban area ([36], p.25). Approximately 78% were either single or divorced/separated and over two thirds had completed at least some university or college. Most participants were engaged in paid work (52%) or caring for a family member (39%). HIV/AIDS was the most commonly reported disorder for which CTP was used (6 participants), followed by fibromyalgia (n = 5), arthritis (n = 4), mood/anxiety disorders (n = 3), cancer (n = 2), neurological disorders (n = 2), gender dysphoria (n = 2) and other disorders (n = 4). Some individuals were living with multiple diagnoses. Participants described their CTP use as long-term (mean = 8.3 years, range = 2 to 16 years). All participants smoked CTP; 15 indicated they also ingested it and nine used a vaporizer. Other methods used by participants included tinctures (n = 5), sprays (n = 2), cannabis mixed with tobacco (n = 1) and use of a poultice (cannabis mixed with alcohol and applied topically) (n = 1). When asked about their purchase locations, only five of the eleven participants that currently held a Health Canada license indicated they purchased their cannabis from Health Canada and most (n = 20) purchased it from a community-based dispensary. Participants also indicated they accessed CTP directly through licensed growers (n = 10) and non-licensed growers (n = 10).

Data Collection

Data were collected using semi-structured, individual face-to-face or telephone interviews. Participants were invited to discuss their beliefs about and experiences of using CTP and their experiences of stigma. At a time and location convenient to the participant, interviews were conducted by trained research assistants and lasted approximately 1–3 hours. A short questionnaire was administered to gather demographic data, history of cannabis use, and information about health issues influencing use of CTP.

Data Analysis

Using an inductive thematic approach to data analysis, interview transcripts were read and re-read by the authors and sections of the data that reflected emergent ideas and themes were highlighted. In investigative team meetings, independent reviews of the data were summated and shared to reach consensus about categories for coding the data. The qualitative data management software program, NVivo^{TM}, was used to organize the data for retrieval and in-depth analysis. Comparative strategies were used to explore participants' perceptions of CTP.

Results

Participants' narratives included a predominant discourse of stigma associated with CTP use. Experiences of stigma arose in interactions with family members and close friends, as well as from others in society. The multiple dimensions of stigma associated with using CTP use identified in the data afforded a view of participants' experiences whereby most contributed to more than one dimension. In order to achieve the benefits of cannabis use, participants had to negotiate social censorship, disapproval, threats, and isolation. Ways participants coped with and minimized their experiences of stigma associated with CTP use are also described.

Dimensions of stigma associated with CTP

Three dimensions of stigma were identified that related to negative views of cannabis as a recreational drug, illegal activity surrounding cannabis use, and layered vulnerabilities related to poverty and particular illnesses and disabilities. Each dimension is described in the following sections.

Medicine in a joint

Unlike other medications the participants used, CTP was more difficult to conceal particularly when consumed through smoking. The distinctive and often times strong smell, appearance, and behaviours associated with smoking a joint invoke negative images for some, such as the "pothead," and have been reinforced by the media and public opinion. We use the word "joint" deliberately to highlight the stigma participants' experienced. Dominant views of cannabis, as a recreational drug used for pleasure, to just "get high" and to escape the realities of life were perceived to make it difficult for the medicinal value of cannabis to be recognized and defended in an objective way. As a consequence, participants reported being labelled as "potheads" by their families, healthcare providers and society at large. Some were falsely accused of using CTP not for medicinal purposes but "just to have some fun" (woman, aged 45, digestive disorder). These labels positioned CTP users as irresponsible, non-contributing, and on the margins of society, unbecoming attributions participants refuted. One man (aged 45, fibromyalgia) resented "being perceived as something less than acceptable" and felt that he was unfairly judged by others specifically because of his use of CTP:

> Nobody turns around and says you're a junkie if you have terminal cancer and are on heroin. But it doesn't matter why you're on marijuana, [if] you're on marijuana, "You're a pothead and get the hell away from me."

In this example, the man reveals a comparison point whereby harder drugs such as heroin can be packaged as therapeutic and legitimate in the context of buffering the symptoms that accompany advanced disease when there is little hope of survival. Yet, cannabis is not understood as affording the same relief – rather, its use brings into question both the legitimacy of the illness and the role of smoked cannabis as a medicine. Constructions of cannabis as an addictive substance were also perceived to contribute to condemnations of its use as a medicinal drug of choice, and thereby stigmatized users. Users of CTP reported being labelled "drug addicts" and that others, including physicians, continually reminded users that cannabis was a "bad medicine" that could lead to addiction. Even when participants were prescribed other potentially addictive medications (e.g., oxycotin, sleeping pills), it was their use of cannabis that was scrutinized and criticized. Healthcare providers went as far as to offer participants counselling to "get help" with their assumed marijuana addiction.

External stigma was also reflected in the lack of trust expressed by family members as well as health professionals as a result of participants' use of CTP. Participants reported not being believed by others when they described the medical benefits they experienced from cannabis and their requests for cannabis led to a questioning of the severity of their reported symptoms. Participants recounted that others thought they were "making things up," "faking things" or "manipulating symptoms" to get safe access to cannabis. There was an underlying sense that participants were viewed as being unreliable, dangerous, unsavoury, and "abusing

the system" when in fact, they believed they were attempting to resolve the health problems they experienced in a responsible way.

Perceptions that cannabis use "changed" people and interfered with their ability to think clearly and act responsibly also contributed to the stigmatization that CTP users experienced. Participants reported to be reluctant to tell their employers or coworkers of their CTP use, fearing that they would lose their professional status, and they and their work performance would be negatively judged.

In summary, there was consensus that the stigma associated with cannabis use negatively impacted participants' social, professional and family ties as well as their relationships with healthcare providers. These reactions forced participants to self-regulate and withdraw from some of their social networks and resulted in social isolation, estrangement from family and friends, and for some, relocation to another city. The reactions also acted as a barrier to receiving the health care many participants needed.

Medicine on the wrong side of the law

Cannabis as a stigmatized medicine was also confounded with the fact that it is an illegal substance. Users of CTP, therefore, explained they were faced with not only being labelled as "potheads" but also criminals. They reported being viewed with suspicion and marginalized for their illegal activities associated with using CTP. One woman (aged 45, digestive disorder) indicated that she was initially hesitant to begin using CTP because of the stigma associated with cannabis as an illegal substance:

> When I first came to the compassion club it was an emotional thing for me, I cried when l left. I was like, "Oh my God, this is where my life has thrown me? I've lost my career. I'm in the ditch vomiting. Now this is what I have come to". I was like, "it's illegal! It's illegal!" I want to be an upstanding citizen; I don't want to be a criminal. But then, as I was realizing a little clearer what was really going on, I realized it was the biggest gift and my complete ally and then my whole concept just shifted.

Having a federal license or community-based dispensary membership card provided recognition of their need for medical cannabis and thus distinguished users of CTP from illegal recreational users. However, for some holding a license or membership card did not negate the stigma they experienced as CTP users because they felt "branded" as being involved in an apparently illegal activity, and described additional scrutiny and differential treatment that negatively impacted their lives. For example, a 55-year-old woman thought her fears would be relieved upon receiving her license from Health Canada, but instead felt much regret over the process and believed she was in a worse situation:

> I thought I'd feel different but I don't… I don't feel as safe now because I've identified myself as a pot smoker where before I was anonymous and I think I was in a better position… If I had to do it over again I wouldn't even tell my doctor, it wasn't worth it.

Similarly, a 27-year-old man with cancer believed that since receiving his Health Canada licence, he was "discriminated upon constantly" by police who would often detain him until they verified the legitimacy of his license:

> It's all fun and games the first 10 times you do it but after, you know, you get pretty annoyed. I mean if I just had to flip them a card and walk away then that would be a little different but they've got to run your name. They've never heard of the program, they want to have it explained to them or if they have heard [of the MMAD], you know, I've literally had cops make me wait while they bring a couple of other cops over to look at the licence.

The inclination that those producing their own CTP might be dealers was also a site for stigma. Despite being "legal," those that cultivated their own cannabis with licences were often harassed by local police, landlords and subsidised housing investigators. Several had been subjected to what they believed were unwarranted raids on their property and would often lose their cannabis plants in the process either due to confiscation by the police or by their own hand to conceal their gardens. One 36-year-old woman living with AIDS was repeatedly harassed by the police who were supposed to be checking the security of her residence. They wanted to see her garden and questioned the validity of her federal licence. Legal producers also had difficulty finding and keeping their housing due to landlords' concerns about the legitimacy and impact on other tenants of their cultivation of cannabis. One participant, a man living with AIDS in a subsidised housing residence, complained that he was constantly investigated by the housing officials. He often dismantled his garden to avoid confrontation and to keep his lease despite the loss of his home-grown medicine.

Because of the current criminal sanctions associated with cannabis, participants believed their CTP use also raised suspicions and judgements about their ability to parent. Several participants feared losing custody of, or access to, their children as a result of being caught with CTP. One user of CTP (aged 34, AIDS) resented this, stating people "shouldn't have to fear [their] kid being taken away because of [their] choice in medicine." Being a parent, therefore, led participants to take steps to conceal their use of CTP.

Using cannabis in the context of layered vulnerabilities

For many participants, the stigmatization they experienced in using cannabis was entangled with other stigmatized vulnerabilities, such as living with a marginalized disorder (e.g., HIV/AIDS, fibromyalgia, mental illness, history of drug addiction), transitioning gender identity, being homosexual, or living in poverty. A 34-year-old man who held a federal licence, talked about the multiple stigmas he lived with which made his cannabis use less acceptable than that of others who did not have AIDS or a history of drug addiction:

> It doesn't matter how many federal licences [I have]… I've got the stigma of AIDS, I've got the stigma of an ex-junkie, okay, so I've got a lot of dirt in my closet that can be thrown up, right. But if one of [my brother's] friends who don't have this dirt, if one of those friends suddenly started smoking cannabis and he got a federal licence like me, I think it would be a little more accepted.

In this example, the man's history of addiction prevails and the remnants of his past drug use (i.e., HIV/AIDS) locate CTP as little more than a new addiction. These vulnerabilities created challenges in accessing CTP. Requests for CTP were often questioned or not taken seriously on the basis of already suspect diagnosis and practices, and frequently resulted in long delays in accessing CTP. Other individuals who had struggled for years to get diagnosed or be referred to specialists had difficulty generating enough energy to lobby or negotiate access to CTP when healthcare providers had already labelled them "problem" patients or held judgemental attitudes about their illnesses.

Coping with Stigma Associated with CTP Use

Choosing to continue their use of CTP because of the significant benefits experienced in relation to managing their health problems, participants engaged in a variety of coping strategies to respond to the stigma associated with CTP use. Strategies identified in this data were: keeping use of CTP undercover, convincing others of the benefits of CTP, being responsible in their use of CTP and actively defending their right to choose their own medication.

Covert use: keeping CTP use undercover

Some participants believed that with the overwhelming condemnation attributed to cannabis and the current criminal sanctions associated with cannabis in Canada, there was little they could do except be covert in their CTP use. As such, they guarded and hid their use of cannabis from others. When one 55-year-old woman was asked if she had any advice for other CTP users, she stated: "Keep your mouth shut, grow it, use it, don't tell anybody, don't even tell your family, don't tell your friends, keep it to yourself and save your own life." Individuals went to great length to cover up their CTP use, including lighting incense to mask the smell, smoking away from their home, changing their clothes after smoking cannabis, and being vigilant about who was around when they smoked.

By using CTP covertly, participants also protected themselves through self-imposed social isolation. Some isolated themselves in order to avoid criticism and feeling "guilty" about their use. Others smoked in private to avoid children seeing them smoke cannabis. One woman who isolated herself from her family explained:

> I have a very difficult time convincing my family why I have to use it and it's just got to the point where I don't even bother talking to my family because of the fact that they just keep dissing me because I use it.... They're old school, a drug's a drug, that's their mentality.

Expert use: convincing others of the benefits of CTP use

Several participants believed that the harsh judgemental attitudes they had experienced were the result of "misinformation" from the media and a general lack of knowledge of CTP. As such, several participants believed that the only way to address this was to educate and discuss the therapeutic properties of cannabis "to open other people's eyes." One man (aged 42, daily user, AIDS) argued that if the perception of cannabis was to change to being a therapeutic agent rather than a recreational drug, much would be improved:

> It's that stigma attached to pot, that lovely word pot has such a bad condemnation to it. Meanwhile people can pop sleeping pills left, right and center and nobody thinks anything of it. So it's a perception. When we can change that perception of what this is and what the approach is [cannabis as therapy], the battle is half won. [It would help for] people to talk about the issue, get proper information out there, and if you can stack the seats with informed people and reach out to a community where you need to reach out to, then you can start the process.

The work of informing friends and family was often a long (but important) process of education on the part of participants. A 36-year-old woman's experience with her mother typified this experience:

> She [participant's mother] goes, "I think you have a problem, I think you have an addiction." Now I looked at her and said "I'm not taking really any pain killers at all, okay, nothing, I've taken myself off prednisone, taken myself off the [mesalamine], not taking [acetaminophen/codeine], and you're telling me, Mother, I'm possibly addicted to cannabis?" We had a slight fight about it [*laughing*] and then, of course, she changed her mind because I had to educate her, as well as many others, and now she doesn't like to admit to that little story because now she is a full on cannabis granny, raging granny. I mean she is so supportive. Now she looks at me and she is very, very proud. She doesn't feel I have an addiction problem in any way.

Responsible use: doing everything "right"

In an effort to reinforce the differences between recreational and therapeutic uses of cannabis, some participants cast aspersions on recreational users while exulting themselves as being a responsible user and "clean on other fronts" (aged 43, daily user, Fibromyalgia). For example, when asked how her therapeutic use compared to recreational users, one woman (aged 36, licensed user, HIV-AIDS) asserted, "They act stupid some of them…because they flaunt it, they'll smoke it anywhere." In contrast and as a "responsible" CTP user, she took precautions and always smoked with discretion: "I don't flaunt it, like sit there with my arm out the window." She identified recreational users as "pimps, pushers and, people in the criminal world" and stated they were "different" from her. A 36-year-old man (daily user, chronic back pain) believed therapeutic use was fundamentally different because "recreational people are the people who use it and giggle and laugh and joke around and then that's it." Participants perceived their use of CTP as "necessary" while recreational use was often strictly "social" in nature. A third participant (aged 36, daily user, HIV/AIDS) who indicated she never used cannabis recreationally stated: "I think the recreational is more for relaxation not for pain, what it's supposed to be for, it's more for them to party with. For us, it's more of a life thing." As a result of the necessity of their use of CTP, participants were very particular in how they procured their cannabis, how much they used, and when so as not to be confused with recreational drug addicts.

Leading by example was what one participant (aged 42, daily user, HIV/AIDS) believed he could do to change society's perceptions of him and his CTP use. And while he was fully aware that he would not be able to change opinions overnight, he remained hopeful and believed that once others saw him as a responsible user, their attitudes towards him and CTP would start to change:

> I can only do what I can do for myself and present myself and approach my life in the way that shows that I am not a drug addict. I am not a detriment to society. I'm actually trying to be a part of society but I am kind of running into a lot of roadblocks. I know how the world works. It happens slowly, very slowly and usually it's one or two or three people who start and take it somewhere and then other people build on it. That's all you can do.

Participants also attempted to control the stigma surrounding their use of CTP by being open and honest about their use. Applying for a federally-issued licence for CTP use and production, and notifying law enforcement of their CTP production were ways some participants attempted to manage their image as a responsible cannabis user.

Activist use: CTP as a human rights issue

Notwithstanding the stigma experienced for using an illegal substance therapeutically, participants continued to staunchly defend their right to choose their own medication. And despite "swimming [in a] pool with sharks" and illegally accessing CTP, many participants were committed to using CTP and helping others gain access regardless of the potential risks, including arrest and/or imprisonment. Several participants became activists in their own right and argued that neither the government nor the medical community had the right to deny them access to their "medication", or to persecute them for using it. Doing what he felt was "logically and ethically correct in [his] heart", one 34-year-old man living with AIDS dared the government to take away his CTP:

> Screw them, I'm a free man, you know? Furthermore, I'm [now] like a 60 or 70 year old man. I'm living out my final years. Do you really think I'm going to listen to some federal regulation for Christ's sake? I mean this is insane.

Similarly, other participants believed it was the duty and "moral ethical obligation" of Health Canada to explore the therapeutic uses of cannabis and to "open up access in order to maximize the benefits of medical cannabis in society as a whole". Some were hopeful that through their activism, the laws surrounding CTP would eventually change and they would be able to use their medication freely and openly without fear of prosecution (woman aged 36, daily user, AIDS):

> I will get the message across, because I know it's coming. Yeah, freedom is a right. I hope this all goes through finally [and] that we shouldn't have to go to jail for what we believe in, for helping sick people. I don't believe it's a crime and I believe it's a waste of taxpayer's money, and the government

should stay out of it. This should be a medical, a medical thing and that's it.

Discussion

Stigmatization as a form of social control which functions to discourage and penalize deviant behaviour, characteristics or identities was reflected in the findings. The findings suggest there are complex and overlapping factors that produce both the stigmatization experienced by CTP users that related to the ambiguous status of cannabis, lack of acknowledge about medical cannabis, and stigma associated with particular health disorders. While public acceptance of cannabis continues to grow, it appears that CTP users remain highly vulnerable to stigma at both interpersonal and institutional levels. Participant experiences of stigma related to CTP use stemmed from external sources, including their friends, family, healthcare providers, and law enforcement, and from their own internalized guilt and discomfort related to using a medication that is also often used recreationally and illegally. In addition, victim blaming discourse was evident, whereby the illness for which CTP was used attracted harsh judgements about the person's previous health practices (e.g., HIV/AIDS in homosexual and IV drug users, smokers who get cancer) and the validity of their treatment requests. Suspicion about previous risky behaviours was prompted by CTP use and interpreted as emerging from irresponsible acts and disregard for self-health. In addition, illnesses for which others adjust or adequately cope with using conventional medical treatments, rendered suspect the use of CTP as a legitimate course of treatment.

Stigmatization related to cannabis as a substance and its illegal status are clearly intertwined. Historically, cannabis was made illegal not because of problems associated with its use, but rather, as a result of propaganda that encouraged the public to view cannabis as risky and untoward in order to reify its criminal classification [37]. Engaging in illegal activities, more generally, is stigmatized in society. Criminalizing activities render them deviant, and it is generally assumed within society that there is a good reason for this status. Even though deviance and criminality were not central to the majority of participants' self concepts, "disidentifiers" [10] were commonly used to distance themselves from these labels. For these individuals who were already living with a chronic, often life-limiting illness and on the margins of society, this additional form of stigmatization increased the physical and emotional distress they experienced.

Even more problematic from a human rights perspective is the potential for discrimination in the healthcare system, where individuals fail to receive appropriate assessment and treatment for a health condition because of being labeled as drug dependent or a pothead. In this context, patient-provider consultations become focused on extraneous issues, such as addiction and one's moral fiber, rather than the larger concerns of symptom management and the underlying pathology of illness. Amid this preoccupation resides an uneasiness and lingering doubt that CTP use is contrived and manipulative, whereby cannabis is masking, and in many cases adding to, the individual's and societal problems. This discourse threatens the trust essential for a caring patient-provider relationship and may disrupt future care-seeking behaviour by patients as well as the delivery of efficacious treatments by healthcare providers. Physicians, in particular, have the obligation and duty to provide safe, competent, and ethical care to all individuals in accordance with current and accepted standards of practice [38]. Although CTP remains in the hinterland of accepted standards of practice within North America, the growing body of evidence supporting its use as a medical treatment and its availability through an established federal health program is forcing the

hand of physicians and other healthcare providers to consider the potential value of cannabis as a therapeutic agent. To not do so could be potentially viewed as a breach in care and a discriminatory action.

The Supreme Court of Canada recognized that it is constitutionally problematic to put people in a position to have to choose between their liberty and their health, and this led to the establishment of the federal medical cannabis programme [39,40]. And while there continue to be advancements in the rights of CTP users at the judicial level, they are often on a case by case basis, and incidents of discrimination continue to be documented and arrests are common [41,42]. All participants in this study were either MMAD licence holders or medical cannabis dispensary members, meaning that their use of CTP was legitimate (i.e., it was for a documented medical condition). However, only those with MMAD licences who procured CTP from Canada's contracted producer were using CTP legally. For some, choosing the legal government route was a way to quell their internal concerns about acting lawfully. However, it was apparent from our interviews that this did not necessarily relieve external stigma. Outing themselves as CTP users made them feel more vulnerable, and some actually found themselves facing more external stigma than if they had been hiding their use. It appears that due to the overarching illegal status of cannabis outside of the narrow exception for therapeutic use, the legal route does not necessarily alleviate stigma for CTP users.

Although the use of CTP appeared to be a marker of individual expression or identity, not unlike some recreational users experiencing stigma, fear of shame and loss of status necessitated efforts to manage stigma. Management of personal information and others' knowledge of CTP use appear to be of critical importance to CTP users, with many choosing between hiding their use from others in order to pass as normal to avoid sanctions (i.e., *social avoidance)* or being open about it (*selective or indiscriminate disclosure*) in an attempt to inform others about CTP and assist with redefining users as "normal" law-abiding citizens [43]. These reactions are common in the stigma literature and both serve as an attempt to protect oneself from further stigma [44,45]. Study participants' efforts to be responsible and discrete in their CTP use to avoid drawing attention (particularly from law enforcement) are similar to those observed among both therapeutic and recreational cannabis users [3,23,46]. The fact that some participants chose to be open about their CTP use may reflect established coping strategies developed in response to long-standing stigmatizing illnesses.

While many study participants took it upon themselves to educate others about the value of cannabis as a medicine, it is unrealistic that the work of stigma reduction rest solely on individuals compromised by health problems. Instead, formal education programs and policy reform is required that targets healthcare providers, law enforcement personnel, government authorities, as well as members of general society. Interventions that address the history of cannabis criminalization, as well as the legitimacy of CTP use and the options for legal CTP use, would go a long way to ensuring CTP users experience the full spirit of their constitutional right to health without fearing legal repercussions or experiencing the stigma of being associated with an illegal activity. Such programs could be modelled after other successful stigma reduction interventions that have been developed for other marginalized groups, including HIV/AIDS and mental illness [47-49].

Several limitations to this research are recognized. Participants were from British Columbia, a Canadian province known for its illegal cannabis production and tolerance of recreational use. The contradictions experienced by the CTP users in this study cannot be understood apart from the social and structural conditions that influenced how users viewed themselves and how they are viewed by others. Experiences of and reactions to using CTP may have differed if participants had been recruited from more conservative regions. As most of the participants indicated they were long-term users and had made the decision to use CTP several years before, their experiences of stigma may not be the same as those who have just begun to use CTP. Furthermore, the participants were self-selected (i.e., they were willing to speak openly about CTP). As a result, it could be that those who had experienced more negative stigma while using CTP, those who no longer used CTP for fear of its social and legal ramifications or who did not want to be a magnet for their friends' or families' discontent were thus likely underrepresented in this study. Further research is required to examine how experiences of stigma evolve over the course of CTP treatment and among different populations in different legal/social climates.

Conclusion

Experiences of stigma among those with illness and the role stigma plays in seeking treatment are not new in the literature. However, in this literature it is not necessarily the treatment that is stigmatized, but the illness for which the treatment is used. CTP stands as one of the few treatments where users are directly stigmatized for their use of it regardless of their particular illness. The findings of this study shed light on how individuals using CTP experience stigma, and the effect on their physical and emotional wellbeing as well as the impact on healthcare interactions. The stigmatization of CTP users is related to the ambiguous status of cannabis (an illegal substance and a legal therapeutic agent at the same time), and to the lack of acknowledge about medical cannabis among the public, physicians, and law enforcement personnel. The findings reinforce the urgent need for finding better solutions and strategies to reduce stigmatization associated with use of CTP.

Competing interests

There are no competing interests to report.

Authors' contributions

JLB and LGB were the principal study investigators, contributed to the conceptualization, design, conduct and analyses of the study, interpretation, and writing of this manuscript. LJLB, JLO, NRC, JB contributed to the conceptualization, design, analysis and interpretation of the data, and writing of the manuscript. All authors read and approved the final manuscript.

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Isfeld, Lori

From: Correspondence Group, City Clerk's Office
Sent: Friday, June 12, 2015 3:56 PM
To: Public Hearing
Subject: FW: BC Pain Society Submission Vancouver City Hall June 12, 2015.docx
Attachments: BC Pain Society Submission Vancouver City Hall June 12, 2015.docx; ATT00001.txt

-----Original Message-----
From: Chuck s.22(1) Personal and Confidential
Sent: Friday, June 12, 2015 3:51 PM
To: Correspondence Group, City Clerk's Office
Subject: BC Pain Society Submission Vancouver City Hall June 12, 2015.docx

City council,
Please see the attached document for your consideration for my marijuana dispensary.

BC Pain Society
BCPS

s.22(1) Personal and Confidential

June 12, 2015 By E-mail

City of Vancouver
453 West 12th Ave
Vancouver, BC
V5Y 1V4

Attn: City of Vancouver Mayor and Council Members

Dear Mayor and Council Members

Re: Proposed Bylaw Amendments Regarding Medical Marijuana

My name is Chuck Varabioff and I am the owner of the BC Pain Society dispensary with its head office and retail dispensary located at 2908 Commercial Drive. We have operated at this location since 2013.

The BC Pain Society is one of the leading medical marijuana dispensaries in the City of Vancouver. We were the first dispensary in Canada to provide vending machines for our members. We currently operate two outlets in Vancouver, together with two additional outlets in Victoria, BC and Deroche, BC, respectfully. We have attracted a strong following in the community because of our excellent reputation for customer service, high standards and low prices for patients in need of medical marijuana. We have been featured in many media sources across Canada because of our safe and secure dispensing methods, including recently on CBC's Fifth Estate in an broadcast by journalist Mark Kelly entitled "Medical Marijuana: Pot Fiction". This program was originally aired in January 2015 and is available for viewing on CBC's website (www.cbc.television.ca)

We have some of the lowest prices in North America for medical marijuana because we offer true compassionate pricing. We have approximately 8,500 registered members from all ages (19 to 90 years) and from all walks of life, doctors, lawyers, construction workers, city workers, housewives etc.

We have adopted our own standards to conduct safe and secure operations. Each member has been provided with a BC Pain Society ID card that must be produced for inspection before being permitted to enter the retail area of our dispensary. We use the same ID scanning software as the bars and casinos use and have been complimented by the VPD on the level of sophistication of our cameras and security systems developed for our operations. We also have roll down, lockable shutters on all doors and windows for extra security.

We are open from 10 am to 7 pm daily for our member's convenience, 365 days a year and employ ten full-time staff at our head office. Our staff are all very knowledgeable and are trained to check ID and membership cards. All of our staff receive medical and extended health benefits and pay taxes. We have three or more staff working at all times.

All of our medical marijuana suppliers are licensed by Health Canada. We do not purchase any product from the black market. We don't sell candies or anything that is appealing to children. Our product is packaged in food grade double tamper proof, heat sealed bags. We label ALL bags and carry FULL INSURANCE for our dispensary underwritten by Lloyds of London.

We have found that the use of vending machines in our operations has several advantages. It provides a much safer and secure method for purchasing medications after membership has been verified. Our products are in heat sealed bags and hence odors are drastically reduced and the marijuana is not potentially being handled by other sick patients before purchase. Since our dispensary is quite busy, it also decreases the waiting times and it frees up counter staff to answer questions and help other members. Many members do not wish to speak to anybody or may have disabilities which affect their speech, so the machines provide them with a convenient way to make a purchase and be on their way as quickly as possible.

The machines also reduce employee theft and cuts down on the possibility of being robbed as everything is locked inside the machines. It also reduces the amount of cash handled by our employees and thus makes it safer for them and our members too.

We are very active in the community. In November 2014, we organized and promoted a very successful music festival at the Croatian Cultural Centre on Commercial Drive known as CannaFest 2014. It featured some very famous Canadian rock bands such as Helix, The Headpins and Prism and helped raise awareness for medical cannabis. Although this year's festival will be held outside the Lower Mainland, we are planning to return to the City of Vancouver next spring with CannaFest 2016. A portion of the proceeds from ticket sales from this event will be donated to the Canadian Cancer Society.

In December 2014 we organized our first annual warm clothing drive with our staff and members and distributed these items to homeless individuals on the Downtown Eastside. During the month of July 2015 we will be donating one percent (1%) of our vending machine revenues to the Vancouver Food Bank.

We are generally in favour of the licensing regulations proposed by City Staff and commend the Council for their bold moves in this regard. Although the $30,000 annual licensing fee is a large amount, we don't believe it is excessive and we are happy to pay it if it leads to a safer working environment for our staff and our members and it maintains a level playing field for all dispensaries.

We provide an ATM on our premises for the convenience of our members. We don't believe it would negatively impact our members if we had to remove it but would prefer it remain.

We are very much in favour of free competition because we believe it results in lower prices and more choices for our members and therefore we do not support the 300 metre separation between dispensaries. Our primary location is located in the same block of Commercial Drive as the BC Compassion Club Society. We believe we can co-exist with the BC Compassion Club Society because we both serve very different types of clientele (i.e., wellness centre model vs reasonable access to medicine for low income patients). There is a school 1.5 blocks away, but it is a PRIVATE SCHOOL and not part of the Vancouver School District. We have never had an issue with this School or any concerns reported to us. We have excellent relationships with the other businesses in our neighbourhood and would be pleased to enter into a Good Neighbour Agreement.

We would encourage the Council to proceed with caution before making a distinction between societies, compassion clubs or incorporated businesses or from adopting a two-stage licensing fee structure or fee exemptions, except in the most extraneous of circumstances. Our concern is that although on the surface an organization may appear to be not-for-profit, upon a closer inspection it may be revealed that its directors, consultants and/or employees are receiving inflated salaries, benefits, fees, bonuses or expenses to soak up potential earnings.

Respectfully submitted,

Chuck Varabioff
President, BC Pain Society