No. T-2030-13

FEDERAL COURT

SERVICE OF A TRUE COPY
HEREOF ADMITTED

JAN 0 9 2015

WILLIAM F. PENTNEY
Solicitor for
A.G.C.

BETWEEN:

NEIL ALLARD
TANYA BEEMISH
DAVID HEBERT
SHAWN DAVEY

PLAINTIFFS

FEDERAL COURT
COUR FÉDÉRALE
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Date JAN 0 9 2015
Registrar
Greffier

AND:

HER MAJESTY THE QUEEN IN RIGHT OF CANADA

DEFENDANTS

AFFIDAVIT OF JAMIE SHAW

1. I, JAMIE SHAW, Businessperson, of #204, 1481 E 4th Ave, Vancouver, British Columbia, V5N 1J6, MAKE OATH AND SAY AS FOLLOWS, THAT:

2. I am the President and Chief Operating Officer of the Canadian Association of Medical Cannabis Dispensaries (CAMCD), and am the Communications Coordinator for the British Columbia Compassion Club Society (BCCCS), and that as such, I have personal knowledge of the matters and facts, hereinafter deposed to save and except for same, where stated to be made upon information and belief, and in such case I verily believe them to be true.

3. The history of medical cannabis dispensaries in Canada, ironically begins in California. In 1991, with the benefits of medical cannabis becoming apparent, particularly to those afflicted with HIV or Cancer, Denis Perron began operating the

first medical cannabis dispensary in San Francisco, California. US Federal policy, and raids by the Drug Enforcement Agency led to this club being closed in 1994. Over the next few years, many clubs, mostly growers' co-ops being run by the patients themselves, began opening. Every time federal law enforcement closed one, new ones would open. Now produced and marked as Exhibit "A" to this my Affidavit is a document entitled "Medical Marijuana *Social construction of a Myth Theories, Findings, Future* by Fabio Bernabei, ECAD Seminar Killarney, Ireland, May 11, 2012.

4. In 1996, California approved a voter's initiative to allow for the medical use of cannabis. Though this did not make dispensaries legal, the cities of Berkeley, Oakland, and San Francisco began regulating things like personal growing, and dispensaries, as well as fighting the US Federal government to stop the closures of dispensaries and declaring a health emergency over HIV. Now produced and marked as Exhibit "B" to this my Affidavit is a copy of the "Medical Cannabis Dispensing Collectives and Local Regulation" by Americans for Safe Access

5. While this certainly did not change the legal status of cannabis in Canada, 4 or 5 dispensaries began operating across Canada this same year. 3 of them were in BC, which was also experiencing a health crises related to HIV. The focus of these dispensaries was on providing those with medical need access to safe, affordable cannabis. In 1997, the BC Compassion Club became the first dispensary to be recognized as a legal entity, as an incorporated nonprofit society under the laws of British Columbia, even though they were engaged in providing a controlled substance without government approval although to medically approved patients only.

6. In 2001, some courts in Canada ruled that the government needed to provide a medical exemption to those medically approved patients who may benefit from medical cannabis, and it was suggested by some in response that the government look at Compassion Clubs as a possible model and as a sources of knowledge and expertise in the field of medical cannabis. The number of medical cannabis

dispensaries remained fairly constant over the next few years, with about 7 operating in 2008. In 2011, when I began working with CAMCD, there were an estimated 30 dispensaries across Canada, mainly in BC. Now produced and marked as Exhibit "C" to this my Affidavit is a copy of the Harm Reduction Journal "Regulation Compassion: an overview of Canada's federal medical cannabis policy and practice" by Phillippe Lucas.

7. Seeing the need to regulate itself, 9 of these dispensaries founded the Canadian Association of Medical Cannabis Dispensaries. This organization was created in 2010, in order to be responsive to patients, and to provide a way of ensuring certain base-line standards between dispensaries.

8. These dispensaries and others were consulted by Health Canada while they were developing the Marihuana for Medical Purposes Regulations (MMPR), but with the pronouncement of the proposed regulations, Health Canada began denying consulting with dispensaries. Over the course of 2012 and 2013, a handful of dispensaries closed trying to find a way to integrate within the new system. While Health Canada stated many times that dispensaries were not legal, it became apparent that the majority of dispensaries felt the new system would not serve their membership (mainly due to the cost, the difficulties of those with no fixed address, the lack of edibles or other forms of cannabis, and the lack of face-to-face interaction required by some patients), and simply continued operating.

9. In March 2014, when the MMPR were slated to take effect, the number of dispensaries in Canada was still estimated at around 36. Over the last year, that number has increased exponentially, and is now estimated at around 103 across Canada (with the majority of growth in BC). While Vancouver is responsible for about 50 of those, the rest of BC also has been seeing rapid growth, with many smaller communities host to 3 or 4 dispensaries each.

10. While Halifax does not currently have a dispensary, it is a city where when one is closed, shortly after, a new one opens. The last one was closed only a few months ago.

11. Toronto has maintained the same number of dispensaries (4 or 5), and while Montreal showed the biggest initial loss of dispensaries in 2014, it is now back up to 4 or 5 dispensaries as well.

12. It is important to note that many of the patients dispensaries serve may access other dispensaries, and have also maybe enrolled in each successive Health Canada program. Some also currently grow for themselves, and use dispensaries as resources to gain knowledge information, or access to strains other than ones they may be growing.

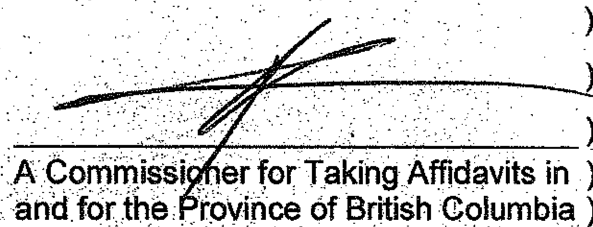
13. CAMCD is non-profit society registered in Ontario. Member dispensaries select a designate to represent them, and these designates may be elected to serve on the Board of Directors. As such, CAMCD has become a central focal point of knowledge regarding the medical cannabis dispensary industry in Canada, and is in a unique position to be aware of both the number of dispensaries in Canada and the issues they face. We also are, like dispensaries themselves, a go-to source of information for those seeking clarification on Health Canada cannabis regulations

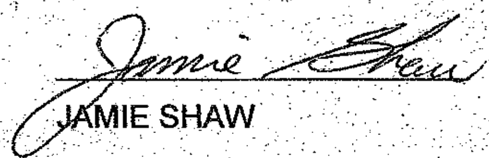
14. Now produced and marked as Exhibit "D" – "I" of this my affidavit are copies of the the following:

"D"	A list of the current Board of Directors of CAMCD
"E"	A document setting out The Mission, Vision and Objectives of CAMCD;
"F"	CAMCD Dispensary certification standards followed by Examples with respect to patient eligibility and age of patient issues
"G"	CAMCD document entitled Steps to Certification
"H"	CAMCD document entitled Certification Timeline & Cost Breakdown
"I"	A document on the Estimated number of Dispensaries in Canada.

15. I swear this affidavit as my evidence in chief for the Plaintiffs in these proceedings to inform the court with respect to the existence and regulation of Compassion Clubs and Dispensaries in Canada involved in the medical marihuana field.

SWORN BEFORE ME at the City)
of Vancouver , in the Province of)
British Columbia, this 8th day of)
January, 2015)





JAMIE SHAW

A Commissioner for Taking Affidavits in)
and for the Province of British Columbia)

MATTHEW J. JACKSON
Barrister and Solicitor
Suite 540 – 220 Cambie Street
Vancouver, British Columbia
V6B 2M9

EXHIBIT "A"

This is Exhibit "A" referred to in the Affidavit
of JAMIE SHAW sworn before me at
Vancouver, BC this 8th day of January, 2015.

A commissioner for taking affidavits
For British Columbia

Medical Marijuana

Social construction of a Myth
Theories, Findings, Future

Fabio Bernabei

ECAD Seminar
Killarney - Ireland - May 11 2012

ASSOCIAZIONE OSSERVATORIO DROGA

Medical Marijuana. Social Construction of a Myth

1. The historical beginning in USA
2. Canada Law (not Health) system
3. The biggest ever Business
4. Italy, a back door for the rest of Europe?
5. Politics, Business but not Science

The MM roots are in Hippy movement

- In **1975**, Robert Randall, who suffered from glaucoma, was arrested for cultivating marijuana and won in Court using the "medical necessity defense."
- In **1977** San Francisco Marijuana iniziative, known as Measure W. won the poll but the State law trumped it and therefore was unenforceable.
- **1980**. The Parents Movement start the War On Drugs under the Reagan Era
- Dennis Perron relaunch the MM for HIV disease in the early **1990**'s. Perron opened the first dispensatory for sick people, the "Cannabis Buyers' Club". Dispensatory became legal by "Preposition 215" in California in the **1996**.

USA:

NORML Cannabis Laws of America

WA
OR
CA
NV 2ng
ID
MT
WY
UT 48hrs
AZ 24hrs
CO
NM
ND
SD Under 21yo
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MI
IN
OH 2ng
KY
TN
MS
AL
GA 24hrs
FL
SC
NC
VA
WV
PA 5ng
NY
AK
HI
FED
ME
VT
NH
MA
RI
CT
NJ
DE
MD
DC

State Marijuana Laws

13 Decriminalization States
16 Medical Marijuana States
6 Medical and Decrim States

State Driving Under the Influence of Drugs (DUID) Laws

Demonstrated Impairment
Failure to pass field sobriety tests, drug impairment shown by DRE or tests

Detected THC in Blood
x ng/ml THC in Blood = Per Se Impairment

Any THC in Blood
Any THC in Blood = x hrs Mandatory Jail Time

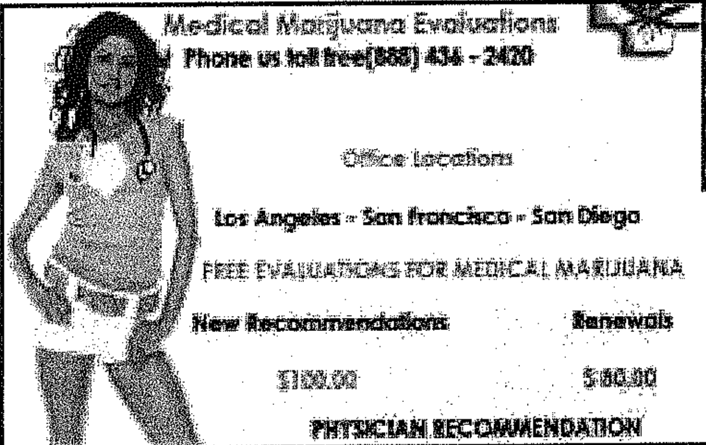
Detected Metabolites
Any metabolites in urine = x hrs Mandatory Jail Time

DUID laws make exception for Patients

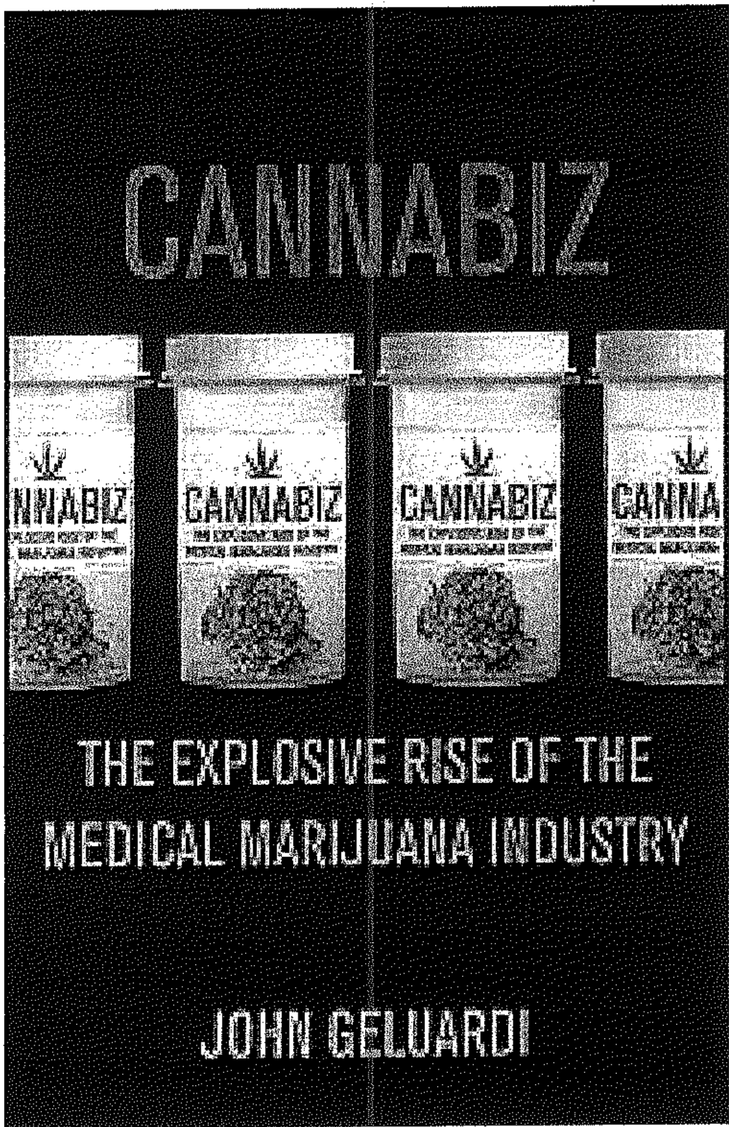
USA: 17 States, 17 laws

1. Alaska	1998	Ballot Measure 8 (58%)	$25/$20	1 oz usable; 6 plants (3 mature, 3 immature)	unknown[1]
2. Arizona	2010	Proposition 203 (50.13%)	$150/$75	2.5 oz usable; 0-12 plants[2]	Yes[3]
3. California	1996	Proposition 215 (56%)	$66/$33	8 oz usable; 6 mature or 12 immature plants[4]	No
4. Colorado	2000	Ballot Amendment 20 (54%)	$35	2 oz usable; 6 plants (3 mature, 3 immature)	No
5. DC	2010	Amendment Act B18-622 (13-0 vote)	*	2 oz dried; limits on other forms to be determined	unknown
6. Delaware	2011	Senate Bill 17 (27-14 House, 17-4 Senate)	**	6 oz usable	Yes[5]
7. Hawaii	2000	Senate Bill 862 (32-18 House; 13-12 Senate)	$25	3 oz usable; 7 plants (3 mature, 4 immature)	No
8. Maine	1999	Ballot Question 2 (61%)	$100/$75	2.5 oz usable; 6 plants	Yes[6]
9. Michigan	2008	Proposal 1 (63%)	$100/$25	2.5 oz usable; 12 plants	Yes
10. Montana	2004	Initiative 148 (62%)	$25/$10	1 oz usable; 4 plants (mature); 12 seedlings	No
11. Nevada	2000	Ballot Question 9 (65%)	$150+	1 oz usable; 7 plants (3 mature, 4 immature)	No
12. New Jersey	2010	Senate Bill 119 (48-14 House; 25-13 Senate)	$200/$20	2 oz usable	unknown
13. New Mexico	2007	Senate Bill 523 (36-31 House; 32-3 Senate)	$0	6 oz usable; 16 plants (4 mature, 12 immature)	No
14. Oregon	1998	Ballot Measure 67 (55%)	$200/$100[7]	24 oz usable; 24 plants (6 mature, 18 immature)	No
15. Rhode Island	2006	Senate Bill 0710 (52-10 House; 33-1 Senate)	$75/$10	2.5 oz usable; 12 plants	Yes
16. Vermont	2004	Senate Bill 76 (22-7) HB 645 (82-59)	$50	2 oz usable; 9 plants (2 mature, 7 immature)	No
17. Washington	1998	Initiative 692 (59%)	***	24 oz usable; 15 plants	No

How Medical Marijuana System works in USA



MM: "The" business



- **2000**: "Oaksterdam University" trains students in MM Industry: cultivation, dispensary operation, cannabis law, history and science, cannabis business and economics and political activism.
- In California there are more MM dispensaries than Starbucks and the average profit of a single dispensary is about $ 20.000 each day !
- Sales of MM: 1 billion and 700 millions of dollars a year vs. 1 billion and 900 millions of dollar of the Pfizer medicine, Viagra.
- The experts: the MM sales to double in 5 years

Canada: the Supreme Court not the Science!

The Supreme Court declared, on July 2000. the legalization of medical marijuana.

For the court the defendant was forced to choose between his health and the prison and this violated his rights.

The same court ordered the Canadian government to change the law on drugs, otherwise could be declared as unconstitutional.

In April 2001, Canada government obeys the imposition of the Suprem Court and the cannabis is distributed through the National Health System.

That regulation and related restrictions on supply were found unconstitutional by the Federal Court of Canada in January, 2008.

The court found that these regulations did not allow a sufficient supply of medical cannabis, and thus forced many patients to purchase their "medicine" from black market sources.

Canada
MM Access Regulations

Health Canada / Santé Canada

Form A

Application for Authorization to Possess Marihuana for Medical Purposes

A4 Proposed Source of Marihuana

You are required to indicate your proposed source of marihuana by choosing one of the following:

☐ I plan to produce my own marihuana.

You must apply to get licence to grow your own plants and you must fill out ***Form C: Application for Licence to Produce Marihuana by Applicant.***

To purchase seeds from Health Canada so you can grow your own plants, you must fill out ***Form E2: Application to Obtain Marihuana Seeds.***

OR

☐ I plan to have a designated person grow the marihuana for me.
My designated person will be:______________________________

You must apply to get a licence for someone to grow plants for you and you must fill out ***Form D: Application for Licence to Produce Marihuana by a Designated Person.***

To purchase seeds from Health Canada so someone can grow plants for you, you must fill out ***Form E2: Application to Obtain Marihuana Seeds.***

OR

☐ I plan to purchase dried marihuana from Health Canada.

To purchase a supply of dried marihuana from Health Canada, you must fill out ***Form E1: Application to Obtain Dried Marihuana.***

Canada 2
MM Access Regulations

Form D

Application for Licence to Produce Marihuana by a Designated Person

D4 Production Site

Please choose one of the following three options:

- ☐ As the designated person, I plan to produce marihuana at my <u>ordinary place of residence</u> (the address that was provided on Page 1 of this form).

OR

- ☐ As the designated person, I plan to produce marihuana at the <u>applicant's ordinary place of residence</u> (the address that was provided by the applicant on Page 1 of Form D).

  If you make either of these two selections, please proceed directly to D5.
  If not, please check the box on page 3 and provide the requested information.

OR

☐ As the designated person, I plan to produce marihuana somewhere other than either at my ordinary place of residence or at the ordinary residence of the applicant.
If you make this selection, please complete the rest of this page.

Proposed production site:

Address: .... Apartment Number: ....

City: .... Province: .... Postal Code: ....

If no street address is available, please provide lot and concession number:

Lot Number: ....

Concession Number: ....

This site is owned by either the applicant or the designated person: ☐ Yes ☐ No

IMPORTANT: If the marihuana is to be produced at a site that is not the ordinary residence of and not owned by the applicant or the designated person, the owner(s) of the production site must complete Form F: *Consent of Property Owner.*

D5 Mode of Production

The marihuana will be produced (please choose only one):

☐ entirely indoors;

OR

☐ entirely outdoors;

OR

☐ indoors in the winter and outdoors in the summer.

IMPORTANT:

1. **The Regulations allow you to grow marihuana indoors in the winter and outdoors in the summer. You cannot grow marihuana indoors and outdoors at the same time.**
2. **Please be sure to read the declaration on D8 Part B with respect to growing marihuana near locations frequented by minors if you plan to grow marihuana outdoors.**

Canada 4
MM Access Regulations. What about Hypocrisy ?!

Form D

Application for Licence to Produce Marihuana by a Designated Person

D8 Part B – Designated Person's Declaration and Signature

I, the designated person, declare that:

i. Within the ten (10) year period preceding the date of this application, I have not been convicted as an adult of a designated drug offence committed in Canada and that I have attached a document from a Canadian police force in support of this declaration. (**Note: Please consult the Applicant Guide for explanation of "designated drug offence."**)

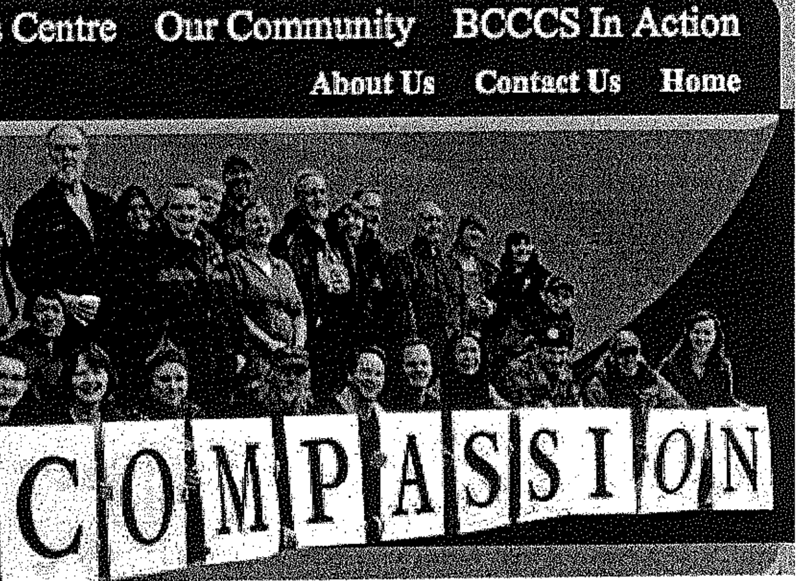
ii. I declare that, within ten (10) years preceding the date of this application, I have not been convicted, as an adult, of an offence committed outside of Canada that, if committed in Canada, would have constituted a designated drug offence.

iii. If I've indicated on this application that I plan to produce marihuana outdoors, I declare and confirm that the production site does not share a border or common point of contact with a school, public playground, day-care facility or other public place frequented mainly by persons under 18 years of age.

Cannabis Dispensary Wellness Centre Our Community BCCCS In Action
About Us Contact Us Home

The British Columbia
COMPASSION CLUB
Providing medical cannabis and natural therapies to those in need

COMPASSION



BCCCS Daily Menu for June 21st, 2006

photo: Jon Kamen

Medical Marijuana: Social construction of a myth

Towards a full Drugs Legalization: the Medical strategy

The Transnational Radical Party wrote an important manual in the 1995: I radicali e le Droghe. *Basta con il proibizionismo.*

In that essay worldwide esperts explain the three main strategies to get the drugs legalization.

First is the "Modello Medico", a sort of medicalization of illicit drugs

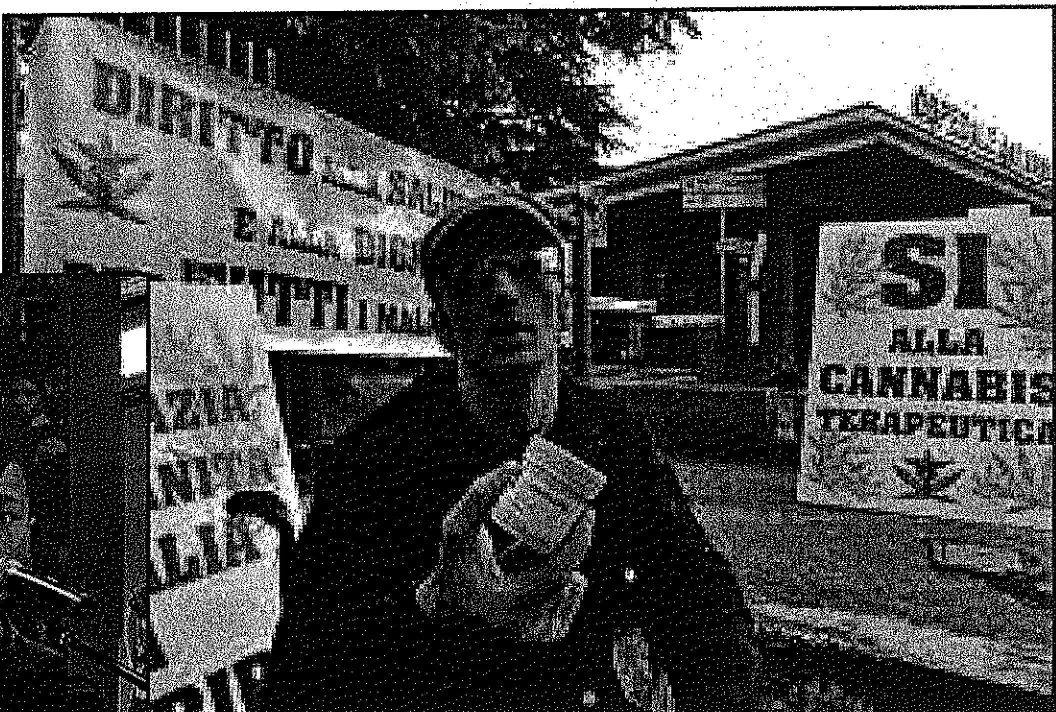
It's seems to be the less revolutionary strategy, they say, BUT is comfortable, reassuring the public opinion

Eurispes poll show the 69,5 of italians is against legalization of marijuana BUT the same research shows the 84,7 is open to Medical Marijuana

The two strategies to legalize MM also in Italy

Regional Laws

members of Tuscany Regional Council presented a bill to legalize MM for chronic and severe pain



Legal actions

the first medical marijuana doses in Italy in October 2011 due to a judge sentence

Actions to Stop the Legalization of MM

Consigli Regionali vogliono legalizzare la **Marijuana**

COMPASSIONE o IDEOLOGIA ?

...regionali stanno preparando il voto ...ge per la vendita di «farmaci e ...iche» «a base di cannabinoidi» ...peutiche» che prevedono la ...foglie di marijuana in farmacia, anche a minori, a carico del Sistema Sanitario Nazionale.

VISTO CHE

- L'Ente per il riconoscimento dei farmaci USA, la Food and Drugs Administration (FDA) ricorda che «nessun studio scientifico serio» supporta l'uso medico della Marijuana/Cannabis, e che «fumare marijuana non produce alcun beneficio medico accertato o provato», che fumarla «e' dannoso alla salute» e che «non è ammessa come trattamento medico»;

- Il verdetto della FDA è condiviso dalla European Medicines Agency (EMA) per la valutazione scientifica dei farmaci europeo. Anche l'Agenzia Italiana del Farmaco (AIFA) non ha mai autorizzato la produzione o l'immissione in commercio della cannabis/marijuana;

- Nessun medicinale può essere immesso in commercio sul territorio nazionale senza aver ottenuto una autorizzazione AIFA o una autorizzazione comunitaria a norma del regolamento (CE) n. 726/2004;

- La vendita di marijuana/cannabis e' una aperta violazione delle Convenzioni ONU contro le sostanze stupefacenti e psicotrope di cui l'Italia e' cofirmataria;

- La Carta dei Diritti dell'Infanzia, all'art. 33, riconosce al giovane il «diritto di essere protetto dalle droghe illegali», non a trovarle gratis in farmacia promosse a farmaci benefici da partiti politici e movimenti ideologici.

CHIEDIAMO

- che ogni Proposta di Legge sulla legalizzazione della Marijuana, a qualunque titolo, venga ritirata;

- che si permetta agli Enti competenti una serena ricerca scientifica per farmaci sicuri ed efficaci;

- che le risorse previste per la cannabis "medica" vengano impiegate nella Prevenzione delle droghe.

Nome ____________________

Cognome ____________________

Via ____________________

CAP ______ Citta' ____________________ Pr. ____

Email ____________________

Informativa sulla Privacy. Il conferimento dei dati personali e' facoltativo e i dati saranno trattati nel rispetto del "Codice in materia di protezione dei dati personali" (D. Lgs. n. 196/2003), per svolgere le normali attività dell'associazione e ciò attendendo tutti i principi ... la raccolta di fondi. In ogni momento potrà esercitare i suoi diritti e richiedere di consultare, integrare, modificare, opporsi al trattamento dei dati (art. 7 del D.lgs. 196/2003) scrivendo al Centro Culturale Lepanto – C.P. 6080 – 00195 – Roma, oppure con una email a lepanto@lepanto.org

Invii il tagliando con la sua adesione a:
CENTRO CULTURALE LEPANTO
C.P. 6080 - 00195 - ROMA
fax 06.60513116 *email:* lepanto@lepanto.org
Contribuisca alla campagna con una donazione
sul C/C Postale n. 47952007 o sul C/C Bancario
IBAN: IT86 C031 2703 2010 0000 0001 641

LA Petizione del CEN... CULTURALE LEPANTO le chiedo di aderire, ... fermare le Proposte ... Regionali per ven... farmacia con una s... ricetta medica, e senz... la Marijuana anche ai m...

Politici locali pretendon... a salutare medicina, ... decidere per quali pat... prescritta !!

Con la SUA FIRMA pos... pericoloso per i malati e...

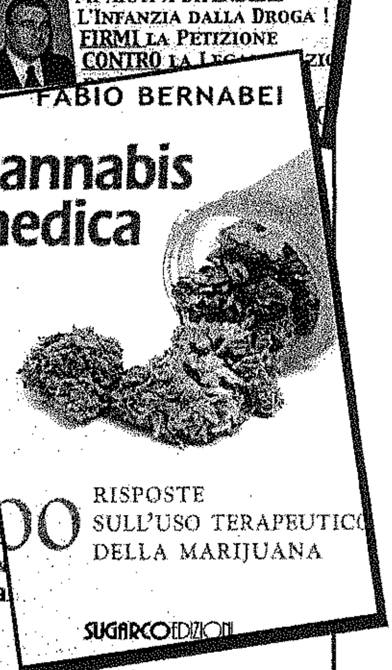
Analoghe iniziative in a... conseguenze gravi, speci... della confusione che si cre... questa pericolosa sostanza...

I figli sono il nostro futuro.

Aiutiamo il futuro dei nostri figli !

Mi mandi la SUA ADESIONE oggi stesso!

Fabio Bernabei
Presidente Centro Culturale Lepanto



SI ALLA VITA
NO ALLA DROGA

Il THC, principio psicoattivo della cannabis, è una molecola lipofila e per questo può facilmente attraversare la barriera placentare.

Il fumo di cannabis, quando fumato da donne in gravidanza, può danneggiare il cervello del feti ancora in fase di crescita.

L'esposizione prenatale alla cannabis è stata associata ad un minor peso e ridotta circonferenza cranica del bambino alla nascita.

Studi hanno osservato come l'esposizione intrauterina alla cannabis provochi seri problemi nello sviluppo neurologico e comportamentale del feto con effetti che includono forti tremori, ritardi mentali e problemi intellettivi.

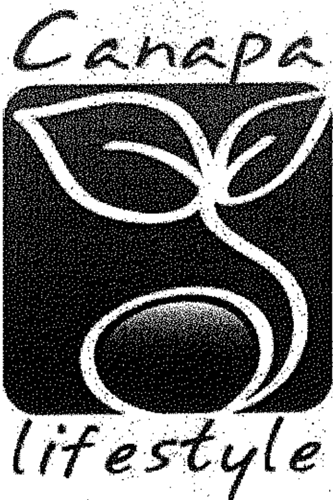
Importanti studi documentano il comportamento impulsivo, deficit sociali, danni cognitivi, consumo di droghe e disordini psichiatrici quali la schizofrenia, la depressione e l'ansia, in adulti che erano stati esposti alla cannabis durante la vita intrauterina e all'inizio dell'adolescenza.

MI AIUTI A DIFENDERE L'INFANZIA DALLA DROGA !
FIRMI LA PETIZIONE CONTRO LA LEG...

FABIO BERNABEI
Cannabis medica
...00 RISPOSTE SULL'USO TERAPEUTICO DELLA MARIJUANA
SUGARCO EDIZIONI

Pro Marijuana Lobby got some political support

Political parties and members of parliament glorify the marijuana



DROGHE
CAMBIAMO
UNA LEGGE
PER CAMBIARCI
LA VITA

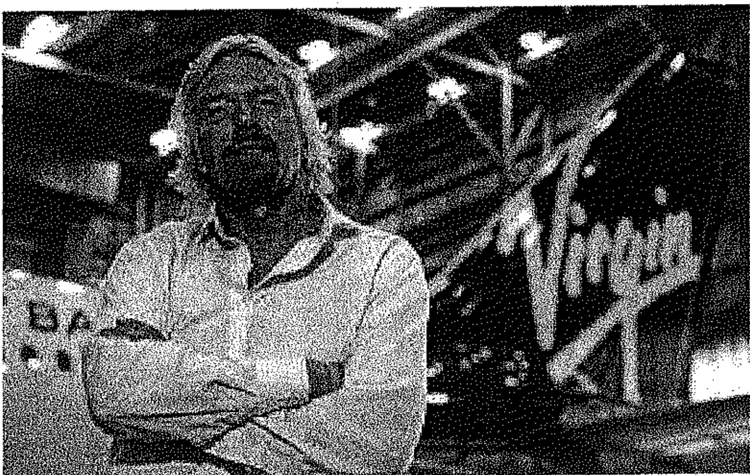
GLI ANTIPROIBIZIONISTI CON
DANIELE FARINA
CAMERA DEI DEPUTATI
CIRCOSCRIZIONE LOMBARDIA 1

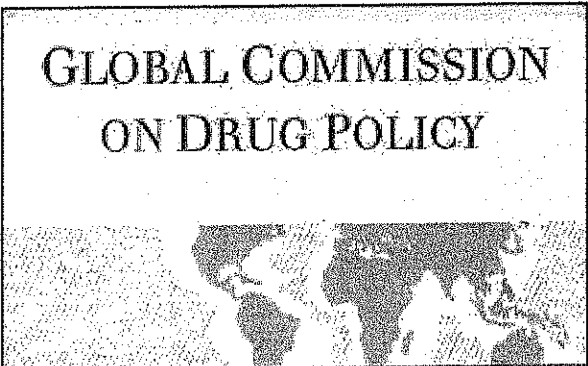
LEGALIZZARE
E TASSARE
per battere le mafie
e uscire dalla crisi

MARIJUANA ®
QUELLA CHE NN SI PUò PROIBIRE

VUOI VEDERE CHE L'ITALIA CAMBIA DAVVERO.

Pro Marijuana Lobby got financial support





Richard Branson, with his *Global Commission on Drug Policy*, and George Soros with his *Open Society*, are two of the well known supporters of the pro marijuana lobby.

Marijuana don't get any support from Science

Food and Drugs Administration - FDA Statement (April 2006)

Marijuana is listed in schedule I of the Controlled Substances Act (CSA), the most restrictive schedule. Marijuana has a high potential for abuse, ***has no currently accepted medical use*** *in treatment in the United States, and* ***has a lack of accepted safety*** *for use under medical supervision Furthermore, there is currently sound evidence that* ***smoked marijuana is harmful.***

A past evaluation by several Department of Health and Human Services (HHS) agencies, including the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute for Drug Abuse (NIDA), ***concluded that no sound scientific studies supported medical use of marijuana for treatment*** *in the United States, and* ***no animal or human data supported the safety or efficacy of marijuana for general medical use.***

Marijuana is a dangerous and illicit DRUG NOT a Medicine

La MARIJUANA
e' una DROGA
NON una Medicina!

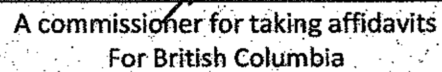
Thank you for your attention !

For more info:

bernabei@osservatoriodroga.it

EXHIBIT "B"

This is Exhibit "B" referred to in the Affidavit
of JAMIE SHAW sworn before me at
Vancouver, BC this 8th day of January, 2015.



A commissioner for taking affidavits
For British Columbia

Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS, AND PATIENTS HELPING PATIENTS

MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

Advancing Legal Medical Marijuana Therapeutics and Research

MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

February 2011

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Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS AND PATIENTS HELPING PATIENTS

EXECUTIVE SUMMARY

California's original medical cannabis law, the Compassionate Use Act of 1996 (Prop. 215), encouraged state and federal governments to develop programs for safe and affordable distribution of medical cannabis (marijuana). Although self-regulated medical cannabis dispensing collectives (dispensaries) have existed for more than 14 years in California, the passage of state legislation (SB 420) in 2003, court rulings in *People v. Urziceanu* (2005) and *County of Butte v. Superior Court* (2009), and guidelines from the state Attorney General, all recognized and affirmed their status as legal entities under state law. With most of the 300,000 cannabis patients in California relying on dispensaries for their medicine, local officials across the state are developing regulatory ordinances that address business licensing, zoning, and other safety and operational requirements that meet the needs of patients and the community.

Americans for Safe Access, the leading national organization representing the interests of medical cannabis patients and their doctors, has undertaken a study of the experience of those communities that have dispensary ordinances to act as a guide to policy makers tackling dispensary regulations in their communities. The report that follows details those experiences, as related by local officials; it also covers some of the political background and current legal status of dispensaries, outlines important issues to consider in drafting dispensary regulations, and summarizes a recent study by a University of California, Berkeley researcher on the community benefits of dispensaries. In short, this report describes:

Benefits of regulated dispensaries to communities include:

- providing access for the most seriously ill and injured,
- offering a safer environment for patients than having to buy on the illicit market,
- improving the health of patients through social support,
- helping patients with other social services, such as food and housing,
- having a greater than average customer satisfaction rating for health care.

Creating dispensary regulations combats crime because:

- dispensary security reduces crime in the vicinity,
- street sales tend to decrease,
- patients and operators are vigilant; any criminal activity is reported to police.

Regulated dispensaries are:

- legal under California state law,
- helping revitalize neighborhoods,
- bringing new customers to neighboring businesses,
- not a source of community complaints.

This report concludes with a section outlining the important elements for local officials to consider as they move forward with regulations for dispensaries. ASA has worked successfully with officials across the state to craft ordinances that meet the state's legal requirements, as well as the needs of patients and the larger community.

Please contact us if you have questions: 888-929-4367.

OVERVIEW OF MEDICAL CANNABIS DISPENSARIES

"As the number of patients in the state of California who rely upon medical cannabis for their treatment continues to grow, it is increasingly imperative that cities and counties address the issue of dispensaries in our respective communities. In the city of Oakland we recognized this need and adopted an ordinance which balances patients' need for safe access to treatment while reassuring the community that these dispensaries are run right. A tangential benefit of the dispensaries has been that they have helped to stimulate economic development in the areas where they are located."

—Desley Brooks, Oakland City Councilmember

ABOUT THIS REPORT

Land-use decisions are now part of the implementation of California's medical marijuana, or cannabis, laws. As a result, medical cannabis dispensing collectives (dispensaries) are the subject of considerable debate by planning and other local officials. Dispensaries have been operating openly in many communities since the passage of Proposition 215 in 1996. As a compassionate, community-based response to the problems patients face in trying to access cannabis, dispensaries are currently used by more than half of all patients in the state and are essential to those most seriously ill or injured. Since 2003, when the legislature further implemented state law by expressly addressing the issue of patient collectives and compensation for cannabis, more dispensaries have opened and more communities have been faced with questions about business permits and land use options.

In an attempt to clarify the issues involved, Americans for Safe Access has conducted a survey of local officials in addition to continuously tracking regulatory activity throughout the state (see AmericansForSafeAccess.org/regulations). The report that follows outlines some of the underlying questions and provides an overview of the experiences of cities and counties around the state. In many parts of California, dispensaries have operated responsibly and provided essential services to the most needy without local intervention, but city and county officials are also considering how to arrive at the most effective regulations for their community, ones that respect the rights of patients for safe and legal access within the context of the larger community.

ABOUT AMERICANS FOR SAFE ACCESS

Americans for Safe Access (ASA) is the largest national member-based organization of patients, medical professionals, scientists, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. ASA works in partnership with state, local and national legislators to overcome barriers and create policies that improve access to cannabis for patients and researchers. We have more than 50,000 active members with chapters and affiliates in all 50 states.

THE NATIONAL POLITICAL LANDSCAPE

A substantial majority of Americans support safe and legal access to medical cannabis. Public opinion polls in every part of the country show majority support cutting across political and demographic lines. Among them, a Time/CNN poll in 2002 showed 80% national support; a survey of AARP members in 2004 showed 72% of older Americans support legal access, with those in the western states polling 82% in favor. The two largest physician-based professional organizations in the U.S., the American Medical Association and the

American College of Physicians, have urged the federal government to reconsider its regulatory classification of cannabis.

For decades, the federal government has maintained the position that cannabis has no medical value, despite the overwhelming evidence of marijuana's medical efficacy and the broad public support for its use. Not to be deterred, Americans have turned to state-based solutions. The laws passed by voters and legislators are intended to mitigate the effects of the federal government's prohibition on medical cannabis by allowing qualified patients to use it without state or local interference.

Fifteen states have adopted medical marijuana laws in the U.S. Beginning with California in 1996, voters passed initiatives in nine states plus the District of Columbia—Alaska, Arizona, Colorado, Maine, Michigan, Montana, Nevada, Oregon, and Washington. State legislatures followed suit, with elected officials in Hawaii, Maryland, New Jersey, New Mexico, Rhode Island, and Vermont taking action to protect patients from criminal penalty. Understanding the need to address safe and affordable access to medical cannabis, Arizona, California, Colorado, Maine, New Jersey, New Mexico, and Rhode Island all adopted local or state laws that regulate its production and distribution.

Despite *Gonzales v. Raich*, a U.S. Supreme Court ruling in 2005 that gave government the discretion to enforce federal cannabis laws even in medical cannabis states, more states continue to adopt laws each year.

With the election of President Barack Obama, a new approach to medical cannabis is taking shape. In October 2009, the Justice Department issued guidelines discouraging U.S. Attorneys from investigating and prosecuting medical cannabis cases. While this new policy specifically addresses enforcement, ASA continues to work with Congress and the President to push for expanded research and protection for all medical cannabis in the U.S. The public advocacy of well-known cannabis patients such as the Emmy-winning talk show host Montel Williams and music artist Melissa Etheridge has also increased public awareness and helped to create political pressure for changes in state and federal policies.

HISTORY OF MEDICAL CANNABIS IN CALIFORNIA

Since 1996, when 56% of California voters approved the Compassionate Use Act (CUA), public support for safe and legal access to medical cannabis has steadily increased. A statewide Field poll in 2004 found that "three in four voters (74%) favors implementation of the law." In 2003, the state legislature recognized that the Compassionate Use Act (CUA) gave little direction to local officials, which greatly impeded the safe and legal access to medical cannabis envisioned by voters.

Legislators passed Senate Bill 420, the Medical Marijuana Program (MMP) Act, which provided a greater blueprint for the implementation of California's medical cannabis law. Since the passage of the MMP, ASA has been responsible for multiple landmark court cases, including *City of Garden Grove v. Superior Court*, *County of San Diego v. San Diego NORML*, and *County of Butte v. Superior Court*. Such cases affirm and expand the rights granted by the CUA and MMP, and at the same time help local officials better implement state law.

In August 2008, California's Attorney General issued a directive to law enforcement on state medical marijuana law. In addition to reviewing the rights and responsibilities of patients and their caregivers, the guidelines affirmed the legality of storefront dispensaries and outlined a set of requirements for state law compliance. The attorney general guidelines also represent a roadmap by which local officials can develop regulatory ordinances for dispensaries.

WHAT IS A MEDICAL CANNABIS DISPENSING COLLECTIVE?

The majority of medical marijuana (cannabis) patients cannot cultivate their medicine for

themselves and cannot find a caregiver to grow it for them. Most of California's estimated 300,000 patients obtain their medicine from a Medical Cannabis Dispensing Collective (MCDC), often referred to as a "dispensary." Dispensaries are typically storefront facilities that provide medical cannabis and other services to patients in need. As of early 2011, ASA estimates there are approximately 2,000 medical cannabis dispensaries in California.

Dispensaries operate with a closed membership that allows only qualified patients and primary caregivers to obtain cannabis, and only after membership is approved (upon verification of patient documentation). Many dispensaries offer on-site consumption, providing a safe and comfortable place where patients can medicate. An increasing number of dispensaries offer additional services for their patient membership, including such services as: massage, acupuncture, legal trainings, free meals, or counseling. Research on the social benefits for patients is discussed in the last section of this report.

RATIONALE FOR MEDICAL CANNABIS DISPENSING COLLECTIVES

While the Compassionate Use Act does not explicitly discuss medical cannabis dispensaries, it calls for the federal and state governments to "implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana" (Health & Safety Code § 11362.5). This portion of the law has been the basis for the development of compassionate, community-based systems of access for patients in various parts of California. In some cases, that has meant the creation of patient-run growing collectives that allow those with cultivation expertise to help other patients obtain medicine. In most cases, particularly in urban settings, that has meant the establishment of medical cannabis dispensing collectives, or dispensaries. These dispensaries are typically organized and run by groups of patients and their caregivers in a collective model of patient-directed health care that is becoming a prototype for the delivery of other health services.

MEDICAL CANNABIS DISPENSARIES ARE LEGAL UNDER STATE LAW

In an effort to clarify the voter initiative of 1996 and aid in its implementation across the state, the California legislature passed the Medical Marijuana Program Act (MMP), or Senate Bill 420, in 2003, establishing that qualified patients and primary caregivers may collectively or cooperatively cultivate and distribute cannabis for medical purposes (Cal. Health & Safety Code section 11362.775). The Act also exempts collectives and cooperatives from criminal sanctions associated with "sales" and maintaining a place where sales occur.

In 2005, California's Third District Court of Appeal affirmed the legality of collectives and cooperatives in the landmark case of *People v. Urziceanu*, which held that the MMP provides collectives and cooperatives a defense to marijuana distribution charges. Another landmark decision from the Third District Court of Appeal in the case of *County of Butte v. Superior Court* (2009) not only affirmed the legality of collectives but also found that collective members could contribute financially without having to directly participate in the cultivation.

In August 2008, the State Attorney General issued guidelines declaring that "a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law." The Attorney General provided law enforcement with a list of operational practices for collectives to help ensure compliance with state law. By adhering to a set of rules—including not-for-profit operation, the collection of sales tax, and the verification of patient status for collective members—dispensaries can operate lawfully and maintain legitimacy. In addition, local officials can use the Attorney General guidelines to help them adopt local regulatory ordinances.

In September 2010, the California Legislature

enacted Assembly Bill 2650, which states that medical marijuana dispensaries must be located further than 600-ft from a school. By recognizing "a medical marijuana cooperative, collective, dispensary, operator, establishment, or provider that is authorized by law to possess, cultivate, or distribute medical marijuana and that has a storefront or mobile retail outlet which ordinarily requires a local business license," the Legislature has expressed its intent that storefront dispensaries and delivery services are legal under California law.

WHY PATIENTS NEED CONVENIENT DISPENSARIES

While some patients with long-term illnesses or injuries have the time, space, and skill to cultivate their own cannabis, the majority of patients, particularly those in urban settings, do not have the ability to produce it themselves. For those patients, dispensaries are the only option for safe and legal access. This is all the more true for those individuals who are suffering from a sudden, acute injury or illness.

Many of the most serious and debilitating injuries and illnesses require immediate relief. A cancer patient, for instance, who has just begun chemotherapy will typically need immediate access for help with nausea, which is why a Harvard study found that 45% of oncologists were already recommending cannabis to their patients, even before it was legal in any state. It is unreasonable to exclude those patients most in need simply because they are incapable of gardening or cannot wait months for relief.

WHAT COMMUNITIES ARE DOING TO HELP PATIENTS

Many communities in California have recognized the essential service that dispensaries provide and have either tacitly allowed their operation or adopted ordinances regulating them. Dispensary regulation is one way in which the cities can exert local control and ensure that the needs of patients and the community at large are being met. As of January 2011, 42 cities and nine counties have enacted regulations, and many more are considering doing so soon.

Officials recognize their duty to implement state laws, even in instances where they may not have previously supported medical cannabis legislation. Duke Martin, former mayor pro tem of Ridgecrest said during a city council hearing on a local dispensary ordinance, "it's something that's the law, and I will uphold the law."

This understanding of civic obligation was echoed at the Ridgecrest hearing by then-Councilmember Ron Carter, now mayor pro tem, who said, "I want to make sure everything is legitimate and above board. It's legal. It's not something we can stop, but we can have an ordinance of regulations."

Similarly, Whittier Planning Commissioner R.D. McDonnell spoke publicly of the benefits of dispensary regulations at a city government hearing. "It provides us with reasonable protections," he said. "But at the same time provides the opportunity for the legitimate operations."

Whittier officials discussed the possibility of an outright ban on dispensary operations, but Councilmember Greg Nordback said, "It was the opinion of our city attorney that you can't ban them; it's against the law. You have to come up with an area they can be in." Whittier passed its dispensary ordinance in December 2005.

Placerville Police Chief George Nielson commented that, "The issue of medical marijuana continues to be somewhat controversial in our community, as I suspect and hear it remains in other California communities. The issue of 'safe access' is important to some and not to others. There was some objection to the dispensary ordinance, but I would say it was a vocal minority on the issue."

IMPACT OF DISPENSARIES AND REGULATORY ORDINANCES ON COMMUNITIES IN CALIFORNIA

DISPENSARIES REDUCE CRIME AND IMPROVE PUBLIC SAFETY

Some reports have suggested that dispensaries are magnets for criminal activity and other undesirable behavior, which poses a problem for the community. But the experience of those cities with dispensary regulations says otherwise. Crime statistics and the accounts of local officials surveyed by ASA indicate that crime is actually reduced by the presence of a dispensary. And complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of local regulations.

This trend has led multiple cities and counties to consider regulation as a solution. Kern County, which passed a dispensary ordinance in July 2006, is a case in point. The sheriff there noted in his staff report that "regulatory oversight at the local levels helps prevent crime directly and indirectly related to illegal operations occurring under the pretense and protection of state laws authorizing Medical Marijuana Dispensaries." Although dispensary-related crime has not been a problem for the county, the regulations will help law enforcement determine the legitimacy of dispensaries and their patients.

The sheriff specifically pointed out that, "existing dispensaries have not caused noticeable law enforcement problems or secondary effects for at least one year. As a result, the focus of the proposed Ordinance is narrowed to insure Dispensary compliance with the law" (Kern County Staff Report, Proposed Ordinance Regulating Medical Cannabis Dispensaries, July 11, 2006).

The presence of a dispensary in the neighborhood can actually improve public safety and reduce crime. Most dispensaries take security for their members and staff more seriously than many businesses. Security cameras are often used both inside and outside the premises, and security guards are often employed to ensure safety. Both cameras and security guards serve as a general deterrent to criminal activity and other problems on the street. Those likely to engage in such activities tend to move to a less-monitored area, thereby ensuring a safe environment not only for dispensary members and staff, but also for neighbors and businesses in the surrounding area.

Residents in areas surrounding dispensaries have reported improvements to the neighborhood. Kirk C., a long time San Francisco resident, commented at a city hearing, "I have lived in the same apartment along the Divisadero corridor in San Francisco for the past five years. Each store that has opened in my neighborhood has been nicer, with many new restaurants quickly becoming some of the city's hottest spots. My neighborhood's crime and vandalism seems to be going down year after year. It strikes me that the dispensaries have been a vital part of the improvement that is going on in my neighborhood."

Oakland city administrator Barbara Killey, who was responsible for the ordinance regulating dispensaries, noted that "The areas around the dispensaries may be some of the safest areas of Oakland now because of the level of security, surveillance, etc...since the ordinance passed."

Likewise, former Santa Rosa Mayor Jane Bender noted that since her city passed its ordinance, there appears to be "a decrease in criminal activity. There certainly has been a decrease in complaints. The city attorney says there have been no complaints either from citizens or from neighboring businesses."

Neighboring Sebastopol has had a similar experience. Despite public opposition to medical cannabis dispensaries, Sebastopol Police Chief Jeffrey Weaver admitted that for more than two years, "We've had no increased crime associated [with Sebastopol's medical cannabis dispensary], no fights, no loitering, no increase in graffiti, no increase in littering, zip."

"The parade of horrors that everyone predicted has not materialized. The sky has not fallen. To the contrary...California jurisdictions have shown that having medical cannabis in place does not impact...public safety." —San Francisco Supervisor David Campos

Those dispensaries that go through the permitting process or otherwise comply with local ordinances tend, by their very nature, to be those most interested in meeting community standards and being good neighbors. Many local officials surveyed by ASA said dispensaries operating in their communities have presented no problems, or what problems there may have been significantly diminished once an ordinance or other regulation was instituted.

Several officials said that regulatory ordinances had significantly improved relations with other businesses and the community at large. An Oakland city council staff member noted that prior to adopting a local ordinance, the city had received reports of break-ins. However, the council staff member said that with the adoption of Oakland's dispensary ordinance, "That kind of activity has stopped. That danger has been eliminated." Assistant City Administrator Arturo Sanchez, a nuisance enforcement officer, affirmed that since 2004 he has "never received a nuisance complaint concerning lawfully established medical marijuana dispensaries in Oakland...[or] had to initiate an enforcement action."

The absence of any connection between dispensaries and increased local crime can be seen in data from Los Angeles and San Diego. During the two-year period from 2008 to 2010 in which Los Angeles saw the proliferation of more than 500 dispensaries, the overall crime rate in the city dropped considerably. A study commissioned by Los Angeles Police Chief Charlie Beck, comparing the number of crimes in 2009 at the city's banks and medical marijuana dispensaries, found that 71 robberies had occurred at the more than 350 banks in the city, compared to 47 robberies at the more than 500 medical marijuana facilities. Chief Beck observed that, "banks are more likely to get robbed than medical marijuana dispensaries," and that the claim that dispensaries attract crime "doesn't really bear out." In San Diego, where some officials have made similar allegations about increased crime associated with dispensaries, an examination of city police reports by a local paper, the San Diego CityBeat, found that as of late 2009 the number of crimes in areas with dispensaries was frequently lower than it was before the dispensary opened or, at worst, stayed the same.

WHY DIVERSION OF MEDICAL CANNABIS IS TYPICALLY NOT A PROBLEM

One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. But the experience of those cities that have instituted ordinances is that such problems, which are rare in the first place, quickly disappear. In addition to being monitored by law enforcement, dispensaries universally have strict rules about how members are to behave in and around the facility. Many have "good neighbor" trainings for their members that emphasize sensitivity to the concerns of neighbors, and all dispensaries absolutely prohibit the resale of cannabis. Anyone violating that prohibition is typically banned from any further contact with the dispensary.

As Oakland's city administrator for the regulatory ordinance explains, "dispensaries themselves have been very good at self policing

against resale because they understand they can lose their permit if their patients resell."

In the event of an illegal resale, local law enforcement has at its disposal all of the many legal penalties provided by the state. This all adds up to a safer street environment with fewer drug-related problems than before dispensary operations were permitted in the area. The experience of the City of Oakland is a good example of this phenomenon. The city's legislative analyst, Lupe Schoenberger, stated that, "...[P]eople feel safer when they're walking down the street. The level of marijuana street sales has significantly reduced."

"The areas around the dispensaries may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc. since the ordinance passed."
—Barbara Killey, Oakland

Dispensaries operating with the permission of the city are also more likely to appropriately utilize law enforcement resources themselves, reporting any crimes directly to the appropriate agencies. And dispensary operators and their patient members tend to be more safety conscious than the general public, resulting in greater vigilance and better preemptive measures. The reduction of crime in areas around dispensaries has been reported anecdotally by law enforcement in several communities.

DISPENSARIES CAN BE GOOD NEIGHBORS

Medical cannabis dispensing collectives are typically positive additions to the neighborhoods in which they locate, bringing additional customers to neighboring businesses and reducing crime in the immediate area.

Like any new business that serves a different customer base than the existing businesses in the area, dispensaries increase the revenue of other businesses in the surrounding area simply because new people are coming to access services, increasing foot traffic past other establishments. In many communities, the opening of a dispensary has helped revitalize an area. While patients tend to opt for dispensaries that are close and convenient, particularly since travel can be difficult, many patients will travel to dispensary locations in parts of town they would not otherwise visit. Even if patients are not immediately utilizing the services or purchasing the goods offered by neighboring businesses, they are more likely to eventually patronize those businesses because of convenience.

ASA's survey of officials whose cities have passed dispensary regulations found that the vast majority of businesses either adjoining or near dispensaries had reported no problems associated with a dispensary opening after the implementation of regulations.

Kriss Worthington, longtime councilmember in Berkeley, said in support of a dispensary there, "They have been a responsible neighbor and vital organization to our diverse community. Since their opening, they have done an outstanding job keeping the building clean, neat, organized and safe. In fact, we have had no calls from neighbors complaining about them, which is a sign of respect from the community. In Berkeley, even average restaurants and stores have complaints from neighbors."

Mike Rotkin, councilmember and former mayor of the City of Santa Cruz, said about the dispensary that opened there last year, "The immediately neighboring businesses have been uniformly supportive or neutral. There have been no complaints either about establishing it or running it."

And Dave Turner, mayor of Fort Bragg, noted that before the passage of regulations there were "plenty of complaints from both neighboring businesses and concerned citizens," but since then, it is no longer a problem. Public officials understand that, when it comes to dispensaries, they must balance both the humanitarian needs of patients and the

concerns of the public, especially those of neighboring residents and business owners.

Oakland City Councilmember Nancy J. Nadel wrote in an open letter to her fellow colleagues across the state, "Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses, law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parities in advance of adopting an ordinance while keeping the patients' needs foremost, problems that may seem inevitable never arise."

Mike Rotkin of Santa Cruz stated that since the city enacted an ordinance for dispensaries, "Things have calmed down. The police are happy with the ordinance, and that has made things a lot easier. I think the fact that we took the time to give people who wrote us respectful and detailed explanations of what we were doing and why made a real difference."

BENEFITS OF DISPENSARIES TO THE PATIENT COMMUNITY

DISPENSARIES PROVIDE MANY BENEFITS TO THE SICK AND SUFFERING

Safe and legal access to cannabis is the reason dispensaries have been created by patients and caregivers around the state. For many people, dispensaries remove significant barriers to obtaining cannabis. Patients in urban areas with no space to cultivate cannabis, those without the requisite gardening skills to grow their own, and, most critically, those who face the sudden onset of a serious illness or who have suffered a catastrophic illness—all tend to rely on dispensaries as a compassionate, community-based solution as a preferable alternative to potentially dangerous illicit market transactions.

Many elected officials in California recognize the importance of dispensaries to their constituents. As Nathan Miley, former Oakland city councilmember and now Alameda County supervisor said in a letter to his colleagues, "When designing regulations, it is crucial to remember that at its core this is a healthcare issue, requiring the involvement and leadership of local departments of public health. A pro-active healthcare-based approach can effectively address problems before they arise, and communities can design methods for safe, legal access to medical marijuana while keeping the patients' needs foremost."

West Hollywood Mayor John Duran agreed, noting that with the high number of HIV-positive residents in the area, "Some of them require medical marijuana to offset the medications they take for HIV."

Jane Bender, former mayor of Santa Rosa, says, "There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine."

And Mike Rotkin of Santa Cruz said that this is also an important matter for his city's citizens: "The council considers it a high priority and has taken considerable heat to speak out and act on the issue."

It was a similar decision of social conscience

that lead to Placerville's city council putting a regulatory ordinance in place. Former Councilmember Marian Washburn told her colleagues that "as you get older, you know people with diseases who suffer terribly, so that is probably what I get down to after considering all the other components."

> "There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine." —Jane Bender, Santa Rosa

While dispensaries provide a unique way for patients to obtain the cannabis their doctors have recommended, they typically offer far more that is of benefit to the health and welfare of those suffering from both chronic and acute medical problems.

Dispensaries are often called "clubs" in part because many of them offer far more than a clinical setting for obtaining cannabis. Recognizing the isolation that many seriously ill and injured people experience, many dispensary operators choose to offer a wider array of social services, including everything from a place to congregate and socialize to help with finding housing and offering meals. The social support patients receive in these settings has far-reaching benefits that also influences the development of other patient-based care models.

RESEARCH SUPPORTS THE DISPENSARY MODEL

A 2006 study by Amanda Reiman, Ph.D. of the School of Social Welfare at the University of California, Berkeley examined the experience of 130 patients spread among seven different dispensaries in the San Francisco Bay Area. Dr. Reiman's study cataloged the patients' demographic information, health status, consumer satisfaction, and use of services, while also considering the dispensaries' environment, staff, and services offered. The study found that "medical cannabis patients have created a system of dispensing medical cannabis that also includes services such as counseling, entertainment and support groups, all important components of coping with chronic illness." She also found that levels of satisfaction with the care received at dispensaries ranked significantly higher than those reported for health care nationally.

Patients who use the dispensaries studied uniformly reported being well satisfied with the services they received, giving an 80% satisfaction rating. The most important factors for patients in choosing a medical cannabis dispensary were: feeling comfortable and secure, familiarity with the dispensary, and having a rapport with the staff. In their comments, patients tended to note the helpfulness and kindness of staff and the support found in the presence of other patients.

MANY DISPENSARIES PROVIDE KEY HEALTH AND SOCIAL SERVICES

Dispensaries offer many cannabis-related services that patients cannot otherwise obtain. Among them is an array of cannabis varieties, some of which are more useful for certain afflictions than others, and staff awareness of what types of cannabis other patients report to be helpful. In other words, one variety of cannabis may be effective for pain control while another may be better for combating nausea. Dispensaries allow for the pooling of information about these differences and the opportunity to access the type of cannabis likely to be most beneficial.

Cannabis-related services include making cannabis available in other forms for patients who cannot or do not want to smoke it. While most patients prefer to have the ability to modulate the dosing that smoking easily allows, for others, the effects of extracts or edible cannabis products are preferable. Dispensaries typically offer a wide array of edible products for those purposes. Many dispensaries also offer classes on how to grow your own

cannabis, classes on legal matters, trainings for health-care advocacy, and other seminars.

Beyond providing safe and legal access to cannabis, the dispensaries studied also offer important social services to patients, including counseling, help with housing and meals, hospice and other care referrals. Among the broader services the study found in dispensaries are support groups, including groups for women, veterans, and men; creativity and art groups, including groups for writers, quilters, crochet, and crafts; and entertainment options, including bingo, open mic nights, poetry readings, internet access, libraries, and puzzles. Clothing drives and neighborhood parties are among the activities that patients can also participate in through their dispensary.

Examples of health services offered at dispensaries across California:

- Naturopathic medicine
- Reiki
- Ayurvedic medicine
- Chinese medicine
- Chiropractic medicine
- Acupuncture
- Massage
- Craniosacral Therapy
- Rolfing Therapy
- Group & Individual Yoga Instruction
- Hypnotherapy
- Homeopathy
- Western Herbalists
- Individual Counseling
- Integrative Health Counseling
- Nutrition & Diet Counseling
- Limited Physical Therapy
- Medication Interaction Counseling
- Condition-based Support Groups

Social services such as counseling and support groups were reported to be the most commonly and regularly used, with two-thirds of patients reporting that they use social services at dispensaries one to two times per week. Additionally, life services such as free food and housing help were used at least once or twice a week by 22% of those surveyed.

"Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parties in advance of adopting an ordinance, while keeping the patients' needs foremost, problems that may seem inevitable never arise."

—Nancy Nadel, Oakland

Dispensaries offer chronically ill patients even more than safe and legal access to cannabis and an array of social services. The study found that dispensaries also provided other social benefits for the chronically ill, an important part of the bigger picture:

> Beyond the support that medical cannabis patients receive from services is the support received from fellow patients, some of whom are experiencing the same or similar physical/psychological symptoms... It is possible that the mental health benefits derived from the social support of fellow patients is an important part of the healing process, separate from the medicinal value of the cannabis itself.

Several researchers and physicians who have studied the issue of the patient experience with dispensaries have concluded that there are other important positive effects stemming from a dispensary model that includes a component of social support groups.

Dr. Reiman notes that, "support groups may have the ability to address issues besides the illness itself that might contribute to long-term physical and emotional health outcomes,

such as the prevalence of depression among the chronically ill."

For those who suffer the most serious illnesses, such as HIV/AIDS and terminal cancer, groups of people with similar conditions can also help fellow patients through the grieving process. Many patients who have lost or are losing friends and partners to terminal illness report finding solace with other patients who are also grieving or facing end-of-life decisions. A medical study published in 1998 concluded that the patient-to-patient contact associated with the social club model was the best therapeutic setting for ill people.

Cannabis dispensaries have been operating successfully in California for more than 14

CONCLUSION

After more than 14 years of existence, dispensaries are proving to be an asset to the communities they serve, as well as the larger community in which they operate. This is especially the case when public officials choose to implement local ordinances that recognize the lawful operation of dispensaries. Since the Medical Marijuana Program Act was enacted by the California legislature in 2004, more than 50 localities have adopted ordinances regulating dispensaries.

By surveying local officials and monitoring regulatory activity throughout the State of California, ASA has shown that once working regulatory ordinances are in place, dispensaries are typically viewed favorably by public officials, neighbors, businesses, and the community at large, and that regulatory ordinances can and do improve an area, both socially and economically.

Dispensaries—now expressly legal under California state law—are helping revitalize neighborhoods by reducing crime and bringing new customers to surrounding businesses. They improve public safety by increasing the security presence in neighborhoods, reducing illicit market marijuana sales, and ensuring that any criminal activity gets reported to the appropriate law enforcement authorities.

More importantly, dispensaries benefit the community by providing safe access for those who have the greatest difficulty getting the medicine their doctors recommend: the most seriously ill and injured. Many dispensaries also offer essential services to patients, such as help with food and housing.

Medical and public health studies have also shown that the social-club model of most dispensaries is of significant benefit to the overall health of patients. The result is that medical cannabis patients rate their satisfaction with dispensaries as far greater than the customer satisfaction ratings given to health care agencies in general.

Public officials across the state, in both urban and rural communities, have been outspoken in praise of the dispensary regulatory schemes they enacted and the benefits to the patients and others living in their communities.

As a compassionate, community-based response to the medical needs of more than 300,000 sick and suffering Californians, dispensaries, and the regulations under which they operate, are working.

years with very few problems. And, although the legislature and courts have acted to make dispensaries legal under state law, the question of how to implement appropriate zoning laws and business licensing is still coming before local officials all across the state. What follows are recommendations on matters to consider, based on adopted code as well as ASA's extensive experience working with community leaders and elected officials.

COMMUNITY OVERSIGHT

In order to appropriately resolve conflict in the community and establish a process by which complaints and concerns can be reviewed, it can often be helpful to create a community oversight committee. Such committees, if fair and balanced, can provide a means for the voices of all affected parties to be heard, and to quickly resolve problems.

The Ukiah City Council created such a task force in 2005; what follows is how they defined the group:

> The Ukiah Medical Marijuana Review and Oversight Commission shall consist of seven members nominated and appointed pursuant to this section. The Mayor shall nominate three members to the commission, and the City Council shall appoint, by motion, four other members to the commission...
>
> Of the three members nominated by the Mayor, the Mayor shall nominate one member to represent the interests of City neighborhood associations or groups, one member to represent the interests of medical marijuana patients, and one member to represent the interests of the law enforcement community.
>
> Of the four members of the commission appointed by the City Council, two members shall represent the interests of City neighborhood associations or groups, one member shall represent the interests of the medical marijuana community, and one member shall represent the interests of the public health community.

ADMINISTRATION OF DISPENSARY REGULATIONS ARE BEST HANDLED BY HEALTH OR PLANNING DEPARTMENTS, NOT LAW ENFORCEMENT AGENCIES

Reason: To ensure that qualified patients, caregivers, and dispensaries are protected, general regulatory oversight duties—including permitting, record maintenance, and related protocols—should be the responsibility of the local department of public health (DPH) or planning department. Given the statutory mission and responsibilities of DPH, it is the natural choice and best-suited agency to address the regulation of medical cannabis dispensing collectives. Law enforcement agencies are ill-suited for handling such matters, having little or no expertise in health and medical affairs.

Examples of responsible agencies and officials:

- Angels Camp—City Administrator
- Citrus Heights—City Manager
- Cotati—City Manager
- Dunsmuir—Planning Commission
- Eureka–Dept of Community Development
- Laguna Woods—City Manager
- Long Beach—Financial Management
- Los Angeles—Building and Safety
- Malibu—City Manager
- Napa—City Council
- Palm Springs—City Manager

- Plymouth—City Administrator
- Sebastopol—Planning Department
- San Francisco—Dept. of Public Health
- San Mateo—License Committee
- Santa Barbara—Community Development
- Selma—City Manager
- Stockton—City Manager
- Visalia—City Planner

ARBITRARY CAPS ON THE NUMBER OF DISPENSARIES CAN BE COUNTER-PRODUCTIVE

Reason: Policymakers do not need to set arbitrary limitations on the number of dispensing collectives allowed to operate because, as with other services, competitive market forces and consumer choice will be decisive. Dispensaries that provide quality care and patient services to their memberships will flourish, while those that do not will fail.

Capping the number of dispensaries limits consumer choice, which can result in both decreased quality of care and less affordable medicine. Limiting the number of dispensing collectives allowed to operate may also force patients with limited mobility to travel farther for access than they would otherwise need to.

Artificially limiting the supply for patients can result in an inability to meet demand, which in turn may lead to unintended and undesirable effects such as lines outside of dispensaries, increased prices, and lower quality medicine, in addition to increased illicit-market activity.

Examples of cities and counties without numerical caps on dispensaries:

- Dunsmuir
- Fort Bragg
- Laguna Woods
- Long Beach
- Placerville
- Redding
- Ripon
- San Mateo
- Santa Barbara
- Selma
- Tulare
- Calaveras County
- Kern County
- City and County of San Francisco
- San Mateo County
- Sonoma County

RESTRICTIONS ON WHERE DISPENSARIES CAN LOCATE ARE OFTEN UNNECESSARY AND CAN CREATE BARRIERS TO ACCESS

Reason: As described in this report, regulated dispensaries do not generally increase crime or bring other harm to their neighborhoods, regardless of where they are located. And since travel is difficult for many patients, cities and counties should take care to avoid unnecessary restrictions on where dispensaries can locate. Patients benefit from dispensaries being convenient and accessible, especially if the patients are disabled or have conditions that limit their mobility.

It is unnecessary and burdensome for patients and providers to restrict dispensaries to industrial corners, far away from public transit and other services. Depending on a city's population density, it can also be extremely detrimental to set excessive proximity restrictions (to residences, schools or other facilities) that can make it impossible for dispensaries to locate anywhere within the city limits, thereby establishing a de facto ban on dispensing. It is important to balance patient needs with neighborhood concerns in this process.

PATIENTS BENEFIT FROM ON-SITE CONSUMPTION AND PROPER VENTILATION SYSTEMS

Reason: Dispensaries that allow members to consume medicine on-site have positive psychosocial health benefits for chronically ill people who are otherwise isolated. On-site consumption encourages dispensary members to take advantage of the support services that can improve their quality of life and, in some cases, even prolong it. Researchers have shown that support groups like those offered by dispensaries are effective for patients with a variety of serious illnesses. Participants active

in support services are less anxious and depressed, make better use of their time, and are more likely to return to work than patients who receive only standardized care, regardless of whether they have serious psychiatric symptoms. On-site consumption is also important for patients who face restrictions to off-site consumption, such as those in subsidized or other housing arrangements that prohibit smoking. In addition, on-site consumption provides an opportunity for patients to share information about effective use of cannabis and of specialized delivery methods, such as vaporizers, which do not require smoking.

Examples of localities that permit on-site consumption (many stipulate ventilation requirements):

- Alameda County
- Berkeley
- Kern County
- Laguna Woods
- Richmond
- San Francisco
- San Mateo County
- South El Monte

DIFFERENTIATING DISPENSARIES FROM PRIVATE PATIENT COLLECTIVES IS IMPORTANT

Reason: Private patient collectives, in which several patients grow their medicine collectively at a private location, should not be required to follow the same restrictions that are placed on retail dispensaries, since they are a different type of operation. A too-broadly written ordinance may inadvertently put untenable restrictions on individual patients and caregivers who are providing either for themselves or a few others.

Example: Santa Rosa's adopted ordinance, provision 10-40.030 (F):

> "Medical cannabis dispensing collective," hereinafter "dispensary," shall be construed to include any association, cooperative, affiliation, or collective of persons where multiple "qualified patients" and/or "primary care givers," are organized to provide education, referral, or network services, and facilitation or assistance in the lawful, "retail" distribution of medical cannabis. "Dispensary" means any facility or location where the primary purpose is to dispense medical cannabis (i.e., marijuana) as a medication that has been recommended by a physician and where medical cannabis is made available to and/or distributed by or to two or more of the following: a primary caregiver and/or a qualified patient, in strict accordance with California Health and Safety Code Section 11362.5 et seq. A "dispensary" shall not include dispensing by primary caregivers to qualified patients in the following locations and uses, as long as the location of such uses are otherwise regulated by this Code or applicable law: a clinic licensed pursuant to Chapter 1 of Division 2 of the Health and Safety Code, a health care facility licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 of Division 2 of the Health and Safety Code, residential care facility for the elderly licensed pursuant to Chapter 3.2 of Division 2 of the Health and Safety Code, a residential hospice, or a home health agency licensed pursuant to Chapter 8 of Division 2 of the Health and Safety Code, as long as any such use complies strictly with applicable law including, but not limited to, Health and Safety Code Section 11362.5 et seq., or a qualified patient's or caregiver's place of residence.

PATIENTS BENEFIT FROM ACCESS TO EDIBLES AND MEDICAL CANNABIS CONSUMPTION DEVICES

Reason: Not all patients can or want to smoke cannabis. Many find tinctures (cannabis extracts) or edibles (such as baked goods containing cannabis) to be more effective for their conditions. Allowing dispensaries to

carry these items is vital to patients getting the best level of care possible. For patients who have existing respiration problems or who otherwise have an aversion to smoking, edibles and extracts are essential.

Conversely, for patients who do choose to smoke or vaporize, they need to procure the tools to do so. Prohibiting dispensaries from carrying medical cannabis consumption devices, often referred to as paraphernalia, forces patients to go elsewhere to procure these items. Additionally, when dispensaries do carry these devices, informed dispensary staff can explain their usage, and different functions, to new patients.

Examples of localities allowing dispensaries to carry edibles and delivery devices:

- Albany
- Angels Camp
- Berkeley
- Cotati
- Citrus Heights
- Eureka
- Laguna Woods
- Long Beach
- Los Angeles (city of)
- Malibu
- Napa
- Palm Springs
- Redding
- Richmond
- Santa Barbara
- Santa Cruz
- Sebastopol
- South El Monte
- Stockton
- Sutter Creek
- West Hollywood
- Alameda County
- Kern County
- Sonoma County

RESOURCES FOR MORE INFORMATION

A downloadable PDF of this report is online at AmericansForSafeAccess.org/DispensaryReport

A model dispensary ordinance can be seen at AmericansForSafeAccess.org/ModelOrdinance.

A regularly updated list of ordinances, moratoriums, and bans adopted by California cities and counties can be found at AmericansForSafeAccess.org/regulations.

You can find ASA chapters in your area at AmericansForSafeAccess.org/Chapters.

ASA Blog
AmericansForSafeAccess.org/blog

ASA Forums
AmericansForSafeAccess.org/forum

Medical and Scientific Information
AmericansForSafeAccess.org/medical

Legal Information
AmericansForSafeAccess.org/legal

Become a member of ASA
AmericansForSafeAccess.org/join

Contact ASA to order the DVD "Medical Cannabis in California"—interviews with elected officials and leaders who are implementing safe and effective regulations.

For more information, see www.AmericansForSafeAccess.org or contact the ASA office at 1-888-929-4367 or 510-251-1856.

APPENDIX A

CALIFORNIA CITIES AND COUNTIES THAT HAVE ADOPTED ORDINANCES REGULATING DISPENSARIES

(as of February 2011)

For an updated list, go to: AmericansForSafeAccess.org/regulations

City Ordinances (42)

- Albany
- Angels Camp
- Berkeley
- Citrus Heights
- Cotati
- Diamond Bar
- Dunsmuir
- Eureka
- Fort Bragg
- Jackson
- La Puente
- Laguna Woods
- Long Beach
- Los Angeles
- Malibu
- Mammoth Lakes
- Martinez
- Napa
- Oakland
- Palm Springs
- Placerville
- Plymouth
- Redding
- Richmond
- Ripon
- Sacramento
- San Carlos
- San Francisco
- San Jose
- San Mateo
- Santa Barbara
- Santa Cruz
- Santa Rosa
- Sebastopol
- Selma
- South El Monte
- Stockton
- Tulare
- Visalia
- West Hollywood
- Whittier
- Yucca Valley

County Ordinances (9)

- Alameda
- Calaveras
- Kern
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Sonoma

APPENDIX B

ASA'S QUICK GUIDE FOR EVALUATING PROPOSED MEDICAL MARIJUANA DISPENSARY ORDINANCES IN CALIFORNIA

This is a quick guide to what should and should not be in city and county ordinances to best support safe access for medical cannabis patients.

What the ordinance MUST include:

- Allowance for over-the-counter/storefront sales (sometimes called reimbursements, contributions, or not-for-profit sales)
- Allowance for patients to medicate on-site
- Allowance for sale of cannabis edibles and concentrated extracts
- Distinction between Medical Cannabis Dispensing Collectives (MCDCs) and private patient collectives or cooperatives

What to look out for in proposed ordinances:

Is the general language and focus framed as a medical or healthcare issue, rather than a criminal justice or law enforcement problem?

Does the ordinance affirm that MCDCs should be organized to serve patients and have a "not-for-profit" business model?

Is there a cap on the number of MCDCs allowed to operate that could negatively impact accessibility, affordability and quality?

- How was the MCDC cap number determined (per capita, per pharmacy)?
- What criteria will be used to approve and license MCDCs?
- Will quality through competition be supported?

Zoning considerations:

- Will each MCDC be required to apply for a conditional use permit, or does the ordinance specify MCDCs as an enumerated business?
- Are there proximity restrictions or "buffer zones" from so-called "sensitive uses" which will make locating a dispensary onerous?
- Has a map been prepared that shows where the ordinance will require MCDCs to locate?

Does the ordinance provide for a community oversight committee tasked with any licensing or appeals processes?

- Will the oversight committee include patients, activists, MCDC operators, and members of the local community?

What are the MCDC requirements for book-keeping and records disclosure?

- Does the ordinance allow MCDCs to keep identifying information about its members off-site, to protect patient identities?
- Does law enforcement have unfettered access to patient records or is a subpoena required?

Are there caps on the number of patient-members an MCDC can serve?

Is on-site cultivation prohibited for MCDCs?

For more information, see www.AmericansForSafeAccess.org or contact the ASA office at 1-888-929-4367 or 510-251-1856.

APPENDIX C

ATTORNEY GENERAL, STATE OF CALIFORNIA, GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE

August 2008

GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may "associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes" (§ 11362.775) .The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

A. **Business Forms**: Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives**: A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members (Corp. Code, § 12201, 12300). No business may call itself a "cooperative" (or "coop") unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code (Id. at § 12311(b)). Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons" (Id. at § 12201). The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (Ibid.) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year (id. at § 12200, et seq). Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers" (Food & Agric. Code, § 54033). Agricultural cooperatives share many characteristics with consumer cooperatives (e.g., id. at § 54002, et seq). Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives**: California law does not define collectives, but they are commonly defined as "a business, farm, etc., jointly owned and operated by the members of a group." Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members—including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions among members.

B. **Guidelines for the Lawful Operation of a Cooperative or Collective**: Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing

operations to help ensure lawful operation. 1. Non-Profit Operation: Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) ["nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit"].

2. **Business Licenses, Sales Tax, and Sellers' Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual's status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician's identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient's recommendation. Copies should be made of the physician's recommendation or identification card, if any;
b) Have the individual agree not to distribute marijuana to non-members;
c) Have the individual agree not to use the marijuana for other than medical purposes;
d) Maintain membership records on-site or have them reasonably available;
e) Track when members' medical marijuana recommendation and/or identification cards expire; and
f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana**: Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative (§§ 11362.765, 11362.775). The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to nonmedical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited**: State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members (§ 11362.765(c)). Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations**: Marijuana grown at a collective or cooperative for medical purposes may be:

a) Provided free to qualified patients and

primary caregivers who are members of the collective or cooperative;
b) Provided in exchange for services rendered to the entity;
c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or d) Any combination of the above.

7. **Possession and Cultivation Guidelines**: If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

a) Operating a location for cultivation;
b) Transporting the group's medical marijuana; and
c) Operating a location for distribution to members of the collective or cooperative.

8. **Security**: Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines**: Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries**: Although medical marijuana "dispensaries" have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives (§ 11362.775). It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver—and then offering marijuana in exchange for cash "donations" - are likely unlawful (*Peron*, supra, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety]).

2. **Indicia of Unlawful Operation**: When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.

APPENDIX D — MODEL ORDINANCE

MODEL ORDINANCE FOR COLLECTIVES

WHEREAS voters approved Proposition 215 in 1996 to ensure that seriously ill Californians have the right to obtain and use cannabis for medical purposes and to encourage elected officials to implement a plan for the safe and affordable distribution of medicine; and

WHEREAS the California State Legislature adopted Senate Bill 420, the Medical Marijuana Program Act, in 2003 to help clarify and further implement Proposition 215 in part by authorizing qualified patients and primary caregivers to associate within the State of California in order to collectively or cooperatively cultivate cannabis for medical purposes; and

WHEREAS the California Attorney General published "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Purposes" in 2008, acknowledging that "a properly organized and operated collective of cooperative that dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with state law; and

WHEREAS crime statistics and the accounts of local officials surveyed by Americans for Safe Access indicate that crime is actually reduced by the presence of a Medical Cannabis Dispensing Collective (MCDC); and complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of sensible regulations; and

WHEREAS California courts have upheld the legality of MCDCs under state law, including *People v. Hochanadel*, 98 Cal.Rptr.3d 347, and *People v. Urziceanu*, 132 Cal.App.4th 747;

THEREFORE, BE IT RESOLVED That _____ does hereby enact the following:

Purposes and Intent

(1) To implement the provisions of California Health and Safety Code Sections 11362.5 and 11362.7, et seq., as described by the California Attorney General in "Guidelines For The Security And Non-diversion Of Marijuana Grown For Medical Use," published August 2008, which states in Section IV(C)(1) that "a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with the guidelines.

(2) To help ensure that seriously ill _____ residents can obtain and use cannabis for medical purposes where that medical use has been deemed appropriate by a physician in accordance with California law.

(3) To help ensure that the qualified patients and their primary caregivers who obtain or cultivate cannabis solely for the qualified patient's medical treatment are not subject to arrest, criminal prosecution, or sanction.

(4) To protect citizens from the adverse impacts of unregulated medical cannabis distribution, storage, and use practices.

(5) To establish a new section in the _____ code pertaining to the permitted distribution of medical cannabis in _____ consistent with state law.

Nothing in this ordinance purports to permit activities that are otherwise illegal under state or local law.

Definitions

The following phrases, when used in this Chapter, shall be construed as defined in California Health and Safety Code Sections 11362.5 and 11362.7:

"Person with an identification card;"
"Identification card;"
"Primary caregiver;" and
"Qualified patient."

The following phrases, when used in this Chapter, shall be construed as defined below:

"Medical Cannabis Dispensing Collective" or "MCDC". Qualified p atients, persons with identification cards and designated primary caregivers of qualified patients and persons with identification cards who associate, as an incorporated or unincorporated association, within _____, in order to collectively or cooperatively provide medical marijuana from a licensed or permitted location pursuant to this Chapter, for use exclusively by their registered members, in strict accordance with California Health and Safety Code Sections 11362.5 and 11362.7, et seq.

"Director." The Director of Planning or other person authorized to issue a Conditional Use Permit pursuant to _____ code.

Cities and counties may issue a business license or a Conditional Use Permit (CUP) to regulate MCDCs. If a jurisdiction opts for a business license model, the language in the following sections may be replaced with language authorizing the issuance of a business license by amending the appropriate code Sections: Conditional Use Permit Required, Application Procedures, and Findings.

Conditional Use Permit Required

A Conditional Use Permit shall be required to establish or operate a Medical Cannabis Dispensing Collective (MCDC) in compliance with the requirements of this Chapter when located in Commercial, Manufacturing, or Retail Zones.

Application Procedure

(1) In addition to ensuring compliance with the application procedures specified in Section _____, the Director shall send copy of the application and related materials to all other relevant City departments for their review and comment.

(2) A disclaimer shall be put on the MCDC zoning application forms that shall include the following:

a. A warning that the MCDC operators and their employees may be subject to prosecution under federal law; and

b. A disclaimer that the City will not accept any legal liability in the connection with any approval and/or subsequent operation of an MCDC.

Findings

In addition to the findings required to establish compliance with the provisions of Section _____, approval of a Conditional Use Permit for an MCDC shall require the following findings:

(1) That the requested use at the proposed location will not adversely affect the economic welfare of the community in which it is located;

(2) That the requested use at the proposed location is outside a Residential Zone;

(3) That the exterior appearance of the structure will be consistent with the exterior appearance of structures already constructed or under construction within the immediate neighborhood, so as to prevent blight or deterioration, or substantial diminishment or impairment of property values within the neighborhood.

Location

The location at which an MCDC distributes medical cannabis must meet the following requirements:

(1) The location must be in a Non-Residential Zone appropriate for Commercial, Manufacturing, or Retail uses, including health care use;

(2) The location must not be within a 600-foot radius of a school, as measured in Section 11362.768 of the California Health and Safety Code;

(3) The location must not be within 1,000 feet of another MCDC.

Police Department Procedures and Training

(1) Within six months of the date that this Chapter becomes effective, the training materials, handbooks, and printed procedures of the Police Department shall be updated to reflect its provisions. These updated materials shall be made available to police officers in the regular course of their training and service.

(2) Medical cannabis-related activities shall be the lowest possible priority of the Police Department.

(3) Qualified patients, their primary caregivers, and MCDCs who come into contact with law enforcement shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if they are in compliance with the provisions of this Chapter.

(4) Qualified patients, their primary caregivers, and MCDCs who come into contact with law enforcement and cannot establish or demonstrate their status as a qualified patient, primary caregiver, or MCDC, but are otherwise in compliance with the provisions of this Chapter, shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if (1) based on the activity and circumstances, the officer determines that there is no evidence of criminal activity; (2) the claim by a qualified patient, primary caregiver, or MCDC is credible; and (3) proof of status as a qualified patient, primary caregiver, or MCDC can be provided to the Police Department within three (3) business days of the date of contact with law enforcement.

Operational Standards

(1) Signs displayed on the exterior of the property shall conform to existing regulations;

(2) The location shall be monitored at all times by a closed circuit video recording system for security purposes. The camera and recording system must be of adequate quality, color rendition, and resolution to allow the ready identification of any individual committing a crime anywhere on the site;

(3) The location shall have a centrally-monitored alarm system;

(4) Interior building lighting, exterior building lighting and parking area lighting must be in compliance with applicable regulations, and must be of sufficient brightness and color rendition so as to allow the ready identification of any individual committing a crime on site at a distance of no less than 40 feet (a distance that should allow a person reasonable reaction time upon recognition of a viable threat);

(5) Adequate overnight security shall be maintained so as to prevent unauthorized entry;

(6) Absolutely no cannabis product may be visible from the building exterior;

(7) Any beverage or edible produced, provided, or sold at the MCDC containing cannabis shall be so identified, as part of the packaging, with a prominent and clearly legible warning advising that the product contains cannabis and that is it to be consumed only by qualified patients;

(8) No persons under the age of 18 shall be allowed on site, unless the individual is a qualified patient and accompanied by his or her parent or documented legal guardian;

(9) At any given time, no MCDC may possess more cannabis or cannabis plants than would reasonably meet the needs of its registered patient members;

(10) A sign shall be posted in a conspicuous location inside the structure advising: "The diversion of cannabis (marijuana) for non-medical purposes is a violation of state law and will result in membership expulsion. Loitering at the location of a Medical Cannabis Dispensing Collective is also grounds for expulsion. The use of cannabis may impair a person's ability to drive a motor vehicle or operate heavy machinery.;

(11) No MCDC may provide medical cannabis to any persons other than qualified patients and designated primary caregivers who are registered members of the MCDC and whose status to possess cannabis pursuant to state law has been verified. No medical cannabis provided to a primary caregiver may be supplied to any person(s) other than the qualified patient(s) who designated the primary caregiver;

(12) No outdoor cultivation shall occur at an MCDC location unless it is: a) not visible from anywhere outside of the MCDC property and b) secured from public access by means of a locked gate and any other security measures necessary to prevent unauthorized entry;

(13) No MCDC shall cause or permit the establishment or maintenance of the sale or dispensing of alcoholic beverages for consumption on the premises or off-site of the premises;

(14) No dried medical cannabis shall be stored in structures without at least four walls and a roof, or stored in an unlocked vault or safe, or other unsecured storage structure; nor shall any dried medical cannabis be stored in a safe or vault that is not bolted to the floor or structure of the facility; and

(15) Medical cannabis may be consumed on-site only as follows:

a. The smoking or vaporizing of medical cannabis shall be allowed provided that appropriate seating, restrooms, drinking water, ventilation, air purification system, and patient supervision are provided in a room or enclosed area separate from other MCDC service areas.

b. The maximum occupancy of the on-site consumption area shall meet applicable occupancy requirements.

c. The MCDC shall use an activated charcoal filter, or other device sufficient to eliminate all odors associated with medical cannabis use from adjoining businesses and public walkways. The fan used to move air through the filter shall have the capacity sufficient to ventilate the square footage of the separate room or enclosed area in which medical cannabis use is permitted.

(16) MCDCs must verify that each member (1) is legally entitled to posses or consume medical cannabis pursuant to state law; and (2) is a resident of the State of California.

(17) All MCDC operators, employees, managers, members, or agents shall be qualified patients or the designated primary caregivers of qualified patients. MCDC operators, employees, managers, members, or agents shall not sell, barter, give away, or furnish medicine to anyone who is not a qualified patient or primary caregiver, registered as a member of the MCDC, and entitled to possess cannabis under state law.

(18) MCDCs shall maintain accurate patient records necessary to demonstrate patient eligibility under the law for every MCDC member, including (1) a copy of a valid driver's license or Department of Motor Vehicle identification card, (2) a patient registration form, and (3) a current valid letter of recommendation for the use of medical cannabis written by a state-licensed physician. All patient records shall be kept in a secure location, regarded as strictly confidential, and shall not be provided to law enforcement without a valid subpoena or court order.

(19) Operating hours for MCDCs shall not exceed the hours between 8:00 AM and 10:00 PM daily.

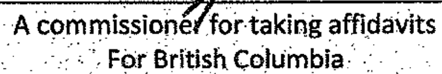
(20) MCDCs must have at least one security guard with a Guard Card issued by the California Department of Consumer Affairs on duty during operating hours.

Severability

If any section, sub-section, paragraph, sentence, or word of this Article is deemed to be invalid, the invalidity of such provision shall not affect the validity of any other sections, sub-sections, paragraphs, sentences, or words of this Article, or the application thereof; and to that end, the sections, sub-sections, paragraphs, sentences, and words of this Article shall be deemed severable.

EXHIBIT "C"

This is Exhibit "C" referred to in the Affidavit
of JAMIE SHAW sworn before me at
Vancouver, BC this 8th day of January, 2015.



A commissioner for taking affidavits
For British Columbia

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Research

Regulating compassion: an overview of Canada's federal medical cannabis policy and practice

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Abstract

Background

In response to a number of court challenges brought forth by Canadian patients who demonstrated that they benefited from the use of medicinal cannabis but remained vulnerable to arrest and persecution as a result of its status as a controlled substance, in 1999 Canada became the second nation in the world to initiate a centralized medicinal cannabis program. Over its six years of existence, this controversial program has been found unconstitutional by a number of courts, and has faced criticism from the medical establishment, law enforcement, as well as the patient/participants themselves.

Methods

This critical policy analysis is an evidence-based review of court decisions, government records, relevant studies and Access to Information Act data related to the three main facets of Health Canada's medicinal cannabis policy – the Marihuana Medical Access Division (MMAD); the Canadians Institute of Health Research Medical Marijuana Research Program; and the federal cannabis production and distribution program. This analysis also examines Canada's network of unregulated community-based dispensaries.

Results

There is a growing body of evidence that Health Canada's program is not meeting the needs of the nation's medical cannabis patient community and that the policies of the Marihuana Medical Access Division may be significantly limiting the potential individual and public health benefits achievable though the therapeutic use of cannabis. Canada's community-based dispensaries supply medical cannabis to a far greater number of patients than the MMAD, but their work is currently unregulated by any level of government, leaving these organizations and their clients vulnerable to arrest and prosecution.

Conclusion

Any future success will depend on the government's ability to better assess and address the needs and legitimate concerns of end-users of this program, to promote and fund an expanded clinical research agenda, and to work in cooperation with community-based medical cannabis dispensaries in order to address the ongoing issue of safe and timely access to this herbal medicine.

1. Introduction

Although modern medicine has only recently begun to rediscover the therapeutic potential of cannabis, written records of medical use date back thousands of years. The first known mention of cannabis as a medicine appears in the world's oldest known medical text, the *Pen Ts'ao Ching*. Apparently composed by Emperor Shen-Nung around 2800 B.C., the oldest written copy dates back to the first century and suggests that cannabis may be useful in treating hundreds of conditions, including rheumatism, menstrual fatigue, and malaria [1,2]. During the 17th and 18th centuries, western medical practitioners learned of its many therapeutic properties from the traditional practices of China and India. By the 19th century, cannabis was common in many widely used pharmaceutical preparations [3], and well-known drug companies like Merck, Burroughs-Wellcome, Bristol-Meyers Squibb, Parke-Davis and Eli Lilly manufactured cannabis-based treatments for pain, digestive conditions, asthma, sleeplessness and depression. With the advent of injection drugs and semi-synthetic analgesics such as acetylsalicylic acid, cannabis fell out of popular use in Western medicine early in the 20th century [4,5].

In Canada, this coincided with the rise of a moral entrepreneur named Emily Murphy who, in 1916, became the first female judge in the British Empire. Four years later MacLean's Magazine published a series of Murphy's sensationalist and xenophobic articles on opium and cannabis use. This not only prompted major legal reform in regards to drug enforcement, but also led to the addition of cannabis to Canada's list of prohibited substances in 1923 without any significant public debate [6,7]. Over the next two decades, the international implementation of cannabis prohibition effectively put an end to nearly all research into its medicinal use.

With the popularization of cannabis as a recreational drug in the 1950's and 1960's, scientific research into its potential harms and therapeutic uses slowly re-emerged [8]. Despite the continued prohibition of its recreational use in most of the world, three countries – the United States, Holland and Canada – have allowed very limited patient access to cannabis through centralized national medical cannabis programs.

This paper examines the origin and evolution of three major components of the Canadian federal medical cannabis program: 1) Health Canada's Marihuana Medical Access Division; 2) the Canadian Institute of Health Research Medical Marijuana Research Program; and 3) Prairie Plant Systems and the federal production contract. In addition, this overview will also examine a community-based alternative to the centralized government monopoly on the production, research, and distribution of cannabis: Canada's informal network of medical cannabis dispensaries.

1.1 Court-Ordered Compassion: Canada's Federal Medicinal Cannabis Program

In 1999 Health Canada initiated a centralized federal medicinal cannabis program in response to an Ontario court challenge. This 1998 court case focused on Jim Wakeford, a person living with HIV/AIDS who faced cannabis possession and cultivation charges for attempting to grow a supply of medical cannabis to treat symptoms of his condition. The Ontario Superior Court recognized his legal right to access cannabis without fear of arrest, and instructed Health Canada to create a process allowing for legal access to this medicine. Health Canada responded by pointing to existing legislation – Section 56 of the *Controlled Drugs and Substances Act* (CDSA) – that would grant qualified applicants a federal exemption from the section of the CDSA addressing cannabis possession (Wakeford v. the Queen, 1999).

The following year, the Ontario Court of Appeals heard the case of a man named Terry Parker, who had been charged with cannabis possession and cultivation while growing a personal supply to alleviate symptoms of his epilepsy. The appellate court struck down the Section 56 program as unconstitutional when it was revealed that the process was not subject to regulatory oversight and instead granted total discretion to approve or reject potential applicants to the Health Minister. The court also struck down Section 4 of the CDSA as it relates to cannabis possession for all Canadians, but suspended the ruling for one year in order to allow the government time to introduce fair and appropriate regulations enabling access to medicinal cannabis for those with a legitimate medical need (Parker v. the Queen, 2000). As a result of these legal challenges, the constitutional validity of Canada's drug control regulations is now legally dependent on the existence of a working federal medicinal cannabis program.

Since these initial developments Health Canada has created the *Marihuana Medical Access Division* (or MMAD, formerly known as the Office of Cannabis Medical Access, or OCMA) to act as the governing body overseeing the implementation of the *Marijuana Medical Access Regulations* (MMAR), which replaced the "Section 56" exemption process in 2001 [9].

On January 9th of 2003 – in a ruling stemming from a lawsuit initiated by medicinal cannabis users and suppliers – the Ontario Supreme Court upheld the right for patients to have access to a safe, legal source of cannabis and once again found the federal program unconstitutional for creating what provincial judge Lederman called the "illusion of access." The court gave the government until July 9th of the same year to put forward a legal supplier for medical users authorized under the Marijuana Medical Access Regulations (Hitzig v. the Queen 2003).

On the eve of July 8th 2003, with the announcement that Health Canada would soon accept written requests by federally-registered users for the cannabis being grown under contract by Prairie Plant Systems (PPS), Canada became the second nation in the world to put in place a system for access to medical cannabis through a centralized, government-administered program (the first was the U.S. Investigational New Drug (IND) program, which began supplying cannabis in 1979, but ceased taking applications in 1989). However, this did not save Health Canada's program from being found constitutionally deficient later that year. On October 7th, the Ontario Court of Appeals declared five specific sections of the MMAR invalid, including the restrictions on production that prevented compassion clubs from operating as legal entities:

[161] We have earlier described the ineffectiveness of the DPL (Designed Production License) provisions of the *MMAR* to ensure a licit supply to [federal license] holders. That ineffectiveness appears to stem very largely from two prohibitions in the *MMAR*. First, a DPL holder cannot be remunerated for growing marihuana and supplying it to the ATP holder. Second, a DPL holder cannot grow marihuana for more than one ATP holder nor combine his or her growing with more than two other DPL holders. These barriers effectively prevent the emergence of lawfully sanctioned "compassion clubs" or any other efficient form of supply to ATP holders. (Hitzig v Canada, 2003)

Although the Ontario Court of Appeals decision immediately struck down these five barriers, on December 17th, 2003 Health Canada re-instated the limits on production verbatim, defending their actions by suggesting that:

...these limits on the production of marihuana are necessary to maintain control over distribution of an unapproved drug product, which has not yet been demonstrated to comply with the requirements of the FDA/FDR; minimize the risk of diversion of marihuana for non-medical use; be consistent with the obligations imposed on Canada as a signatory to the United Nations' *Single Convention on Narcotic Drugs*...; and maintain an approach that is consistent with movement toward a supply model whereby marihuana for medical purposes would be subject to product standards, produced under regulated conditions; and distributed through pharmacies...[10]

To date, a program allowing for pharmacy-based access to medical cannabis has yet to be implemented, and by re-instating the regulations that the Ontario Court of Appeals had recently struck down, Health Canada once again brought this program into questionable constitutional standing.

Despite ongoing controversy surrounding the administration of the federal medical cannabis policy, Canadians overwhelmingly support its use. According to the Project Canada Survey Series conducted by sociologist Reginald Bibby since 1975, recent polling indicates that 93% of Canadians support the legal medical use of cannabis [11].

1.2 A Brief History of North America's Community-Based Medical Cannabis Dispensaries

During the late 1980's, as rates of HIV and AIDS began to rise in San Francisco, a few underground dispensaries offering a safe source of cannabis to those needing it for medical purposes were established by compassionate people living with HIV/AIDS and drug policy reform activists. With the successful passage of a state ballot initiative called "Proposition 215" in 1996, California became the first U.S. state to allow for the legal medical use and distribution of cannabis. Within a few weeks dozens of these "compassion clubs" opened, and although they often had varied policies and practices, their common goal was facilitating access to a safe supply of cannabis for medical users [12]. Since then, over 250 community-based medical cannabis dispensaries have opened up in California, and it is estimated that they currently supply over 200,000 state authorized patients [13]. Similar organizations have emerged all over the world, and in Canada and the U.S. these dispensaries remain the main source of cannabis-based medicines for therapeutic use.

There are currently seven well-established compassion clubs or societies in Canada, the oldest and largest of which is Vancouver's British Columbia Compassion Club Society (BCCCS). The BCCCS opened in 1997 and now serves over 4000 members [14]. Taking a holistic approach to health, this non-profit organization operates a Wellness Center offering alternative treatments such as Traditional Chinese Medicine, acupuncture, counseling, and herbalism at a reduced cost to members of the society. The Vancouver Island Compassion Society (VICS), which has been a registered non-profit society in B.C. since October of 1999, has used its knowledge and experience of cannabis and its therapeutic properties to implement an extensive research agenda.

Although the Canadian federal government has not legally recognized any of the nation's compassion clubs, many of these organizations have had the opportunity to inform the public debate surrounding safe access to medical cannabis. Canadian compassion club operators were invited to present before the Senate Special Committee on Illegal Drugs, which made the following recommendations in Chapter 9 of their final report:

• Measures should be taken to support and encourage the development of alternative practices, such as the establishment of compassion clubs;

• The practices of these organizations are in line with the therapeutic indications arising from clinical studies and meet the strict rules on quality and safety;

• The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards;

• The studies should focus on applications and the specific doses for various medical conditions;

• Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs. [15]

Additionally, Hilary Black (Founder of the BCCCS) and I were invited to represent compassion clubs in a presentation before the OCMA Stakeholder Advisory Committee in the Spring of 2003, and made a number of recommendations to improve the federal program, including the decentralization of medical cannabis access in Canada, and the need to have the end-user costs of this medicine covered by provincial registries [16]. In a broader stakeholder consultation organized by the OCMA in 2004, representatives of the BCCCS and VICS produced and distributed a document titled "Roadmap to Compassion; The Implementation of a Working Medical Cannabis Program in Canada" [17], which examined many of the ongoing issues restricting medical cannabis access through Health Canada's program, and set out a 12-month timeline for the decentralization of this federal policy and practice. In a section titled "Potential Concerns with a Decentralized Program", the authors respond to one of the key objections to decentralization and community-based access to medical cannabis, Canada's oft-cited international treaty obligations:

In the past, Health Canada has implied that the decentralization of this program is restricted by our international treaty obligations, the most significant of which are the Single Convention on Narcotic Drugs [(1961)], the Convention on Psychotropic Substances [(1971)] and the relevant portions of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances [(1988)]. According to section (c) of the original 1961 treaty, a signing country has the right to produce any drug or substance so long as its use and distribution is: "Subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs." In other words, there should be no doubt that the trade, use and possession of drugs for medical or scientific purposes is permitted by the terms of this Convention.

The report concludes that "the future of a successful medicinal cannabis program in this country should focus on the distribution model that has already proven itself to be safe and successful: not-for profit distribution by community-based compassion societies". Health Canada has yet to acknowledge the experience and expertise residing in the compassion clubs, and refuses to consider the incorporation of this successful model into its medical cannabis access program.

Canada's compassion clubs and societies provide over 11,000 critically and chronically ill Canadians access to a safe supply of cannabis within an environment conducive to healing. Since these organizations have developed policies reflective of their local socio-political environment, there can be some significant variation in the scope and quality of services offered by these dispensaries. The VICS and BCCCS have recently attempted to address these operational differences by introducing a set of regulations based on the best-practices of these organizations titled "Guidelines for the Community-Based Distribution of Medical Cannabis in Canada" [18]. This document, released at the 2006 International Harm Reduction Association Conference in Vancouver, addresses the rights of both dispensaries and their clienteles, is designed to inform both local communities and compassion clubs of the roles and responsibilities of such organizations, and aims to:

1. Provide a base-standard for self-regulation of dispensaries based on current best practices in Canadian compassion clubs;

2. Support medical cannabis dispensaries in providing a high standard of care that clients can and should expect;

3. Help both distributors and end-users achieve maximum safety and therapeutic potential within a setting that is conducive to healing;

4. Formalize the good reputation established by compassion clubs, thus ensuring those with medical need have continued access;

5. Promote an understanding of medical cannabis dispensary practices to all levels of government, the justice system, law enforcement, and community partners;

6. Allow for effective cooperation amongst dispensaries utilizing the same base-standards of operation.4

7. Organize participating dispensaries into a more cohesive voice for the legitimization and legal acceptance of community-based cannabis production, research and distribution. (Chapter 4)

These guidelines are an attempt to introduce more transparency and accountability into the compassion club model, and they have been endorsed by over 80% of Canadian compassion clubs. Additionally, they are being used in the development of similar regulations in Washington State, Rhode Island, and many California municipalities.

2. Health Canada's Marihuana Medical Access Division

The federal government's own polling and research suggests that there are currently over 290,000 medical users in the province of British Columbia alone [19], and yet between the introduction of the federal medical cannabis program in January 1999 and September 2004, Health Canada only received 2838 applications from across the nation. According to the MMAD there were 757 registered medical users in Canada in September 2004, suggesting a rejection or drop off rate of nearly 75% in the first year of the program [20].

Although the Ontario Court of Appeals' Hitzig decision was supposed to ease access to Health Canada's "compassionate" program by reducing the bureaucratic burdens of the MMAR, the number of applicants per month declined steadily between April of 2002 and July 2005, with the OCMA only approving 47 of the 299 applications received between January and September of 2004. In fact, participation in the program shrank by 34 people in the three months between July and October of 2004, dropping from 781 down to 747 authorized users [21].

The problem of access was well-noted by the Canadian Senate Special Committee on Illegal Drugs in their final report on cannabis from 2002, which found that:

while a process that authorizes the possession and production of marijuana has been established in Canada, this has not ensured that cannabis is suitably available

to those in need...we have come to the conclusion that the MMAR have become a barrier to access. Rather than providing a compassionate framework, the regulations unduly restrict the availability of cannabis to those who may receive health benefits from its use. [22]

According to this report, one of the main reasons for the small number of applicants to the program is reluctance by physicians to act as gatekeepers to medicinal cannabis. Citing a perceived lack of information on dosage, side effects, and alternate routes of administration to smoking, a number of provincial medical colleges, the Canadian Medical Association (CMA), and the Canadian Medical Protection Agency (which insures nearly 95% of Canada's physicians) have warned against the therapeutic use of cannabis, and have recommended that doctors not participate in the federal program. For example, a CMA press release dated July 9th, 2003, declares:

The CMA has consistently raised concerns about the lack of evidence-based decisions to support the Medical Marijuana Access Regulations," said Dr. Dana Hanson, President of the CMA. "Our unease over use of medical marijuana has been ignored in this new policy. Physicians should not be the gatekeeper for a substance for which we do not have adequate scientific proof of safety or efficacy [23].

Although the CMA's position is now more supportive of the program, these initial warnings were a particular deterrent for Canada's medical specialists, whose support was initially necessary for all applicants to the program that were neither terminally ill nor likely to die in the next 12 months, such as those suffering from MS, HIV/AIDS and hepatitis C (terminal patients only required the support of a single physician). In addition, specialists were simply not available in many smaller rural communities. When compounded by the bureaucratic hurdle of filling out a 29-page application that sometimes took in excess of 12 months for Health Canada to process, the challenges to participation in this program ranged from onerous to impossible for many potential applicants.

Health Canada officially amended the MMAR application process in 2005 to remove the requirement of a supportive specialist for most medical cannabis users. However, this new "simplified" application form was now 33 pages long, and potential applicants continued to face resistance from the medical community. The burden of this difficult application process is apparent in comparing the MMAD with the state-run Oregon Medical Marijuana Program (OMMP). Although both programs originated in 1999 and have similar medical requirements for registration, Oregon's simple two page application process has led to the registration of nearly 15,000 participants as of October 1st, 2007 – despite having a population one-tenth that of Canada [24].

The Canadian Senate Special Committee addressed this problem by suggesting that the proper role of the physician in this program should be to make a diagnosis of the patient's medical conditions or symptoms, after which "the patient should be authorized to use...cannabis if the condition or symptom is one where cannabis has potential therapeutic applications" [25]. Health Canada has yet to heed this advice or change its policy accordingly, so as of June 2007 only 1816 Canadians were benefiting from this federal program [26].

Additionally, potential and actual participants in the program have made Health Canada well-aware of their legitimate concerns by filing official complaints with the MMAD. An "Access to Information" request for copies of all "paper letters of complaint received by Health Canada or the OCMA regarding the federal cannabis program" resulted in over 2000 pages of documented complaints over the first six years of the program, which including problems accessing the federal program, unexplained bureaucratic delays in processing applications and yearly renewals, and criticisms of quality of the federal cannabis supply [27].

In a federally-funded report titled "Our Rights, Our Choice" that examined the human rights, ethical and legal challenges faced by people living with HIV/AIDS who choose to use medical cannabis, the Canadian AIDS Society found that although between 14 to 37% of people living with HIV/AIDS used cannabis to address their condition, many had faced hurdles accessing the federal program [28]. The CAS report states that:

...access to the federal program remains hindered by barriers such as a lack of awareness of the program's existence, mistrust in the government, misinformation about the program and difficulty in finding a physician to support their application. Thousands of seriously ill Canadians must therefore choose between breaking the law to use the therapy of their choice, or going without, which in many cases compromises their well-being and quality of life. (p.2)

3. The Canadian Institute of Health Research and the Medical Marihuana Research Program

Since the court-ordered implementation of a federal medical cannabis policy in 1999, Health Canada has actively promoted its program to encourage and fund studies into the safety and effectiveness of medicinal cannabis. With the launch of the Canadian Institute Health Research's (CIHR's) Medical Marijuana Research Program (MMRP) and the establishment of a 5-year, $7.5 million clinical research grant in 2001, Canada had a unique opportunity to become a world leader in cannabis therapeutics; however, the government's research agenda has proven to be rather anemic. Since the introduction of the MMRP, only three clinical research proposals have been approved for CIHR funding: a smoked-cannabis and chronic pain study initiated by McGill's Pain Center, an HIV/AIDS and appetite study by the Community Resource Initiative of Toronto (CRIT) at St. Michael's Hospital, and the recently announced COMPASS (Cannabis for the Management of Pain: Assessment of Safety Study), which is the first project of the CIHR Marijuana Open Label Safety Initiative (MOLSI).

In March of 2003 the OCMA abruptly cancelled the funding for the Toronto-based CRIT research project, despite having already distributed over $800,000 of a $2 million research grant for the study. This led to the resignation of Dr. Gregory Robinson – a physician and patient-representative living with HIV/AIDS – from the OCMA's Stakeholder Advisory Committee. He argued that Health Canada had created a "Catch-22" by insisting on clinical evidence before approving cannabis as a medicine, but then thwarting the clinical trials needed to gather such evidence. As Robinson stated in his resignation letter to then Health Minister McLellan: "I no longer have faith in your ability to understand compassion for seriously and chronically ill patients," adding that "as an AIDS patient, each moment is valued so much at this time in my life. My continuing commitment to the advisory committee would only be a waste of my time and advice" [29].

Likewise, the $260,000 McGill chronic pain and smoked cannabis clinical study – which was approved in 2001 – has suffered delays largely due to bureaucratic problems in accessing a suitable supply of research cannabis from Health Canada. And although Health Canada announced in December 2004 that the large-scale, multi-center MOLSI study was finally underway and in its initial recruiting stage, very little information is available in regards to this research project, and no results have been made public to date.

In June 2004, the CIHR quietly posted a notice indicating that funding for the MMRP was "suspended until further notice" [30]. Louise Dery, a Senior Strategic Science Advisor with the Office of Controlled Drugs and Substances, indicated that with no guarantees of continuing funding past 2006, the OCMA would not accept any more requests for funding until at least early 2005.

However, in September 2006, the ruling Conservative party announced that it was cutting $4 million earmarked for the MMRP, effectively terminating this program and ending all federal financial support for medical cannabis research in Canada. As a result, Health Canada's initial commitment to a five year, $7.5 million dollar research plan has in fact been reduced to a three year, two-study initiative.

A few Canadian compassion clubs have attempted to remedy this paucity of research by designing and implementing their own studies. Since 2001, the Vancouver Island Compassion Society (VICS) and the British Columbia Compassion Club Society (BCCCS) have initiated peer-reviewed, university-associated research into the effects of cannabis on both hepatitis C (with the University of California, San Francisco), and nausea and pregnancy [31]. In addition, the VICS was awarded a $50,000 grant from the U.S.-based Marijuana Policy Project to undertake the first high potency, smoked cannabis and chronic pain double-blind clinical study in North America. This study has received Institutional Review Board approval, but Health Canada approval is still pending. The VICS has also officially participated in

federally-funded research, including a CIHR-funded sociological examination of the patrons of compassion clubs, and the Canadian AIDS Society research project mentioned earlier in this paper. This CAS report states that:

...it is critical that clinical research be conducted, otherwise the federal medical cannabis program will remain a special access program rife with unnecessary regulatory and bureaucratic barriers...research can be greatly enhanced by involving community groups or organizations such as AIDS service organizations or compassion clubs, from the development of the research protocol to the dissemination of results from a clinical trial. [32].

4. Health Canada's Production and Supply Policy and Practice

In December 2000 Health Canada awarded a five-year, $5.7 million contract for the production of a domestic supply of research-grade cannabis to Prairie Plant Systems (PPS), a Winnipeg-based company that proposed to grow the plants at the bottom of a former zinc and copper mine in Flin Flon, Manitoba [33].

This single-source production plan has been a source of much controversy ever since Health Canada reluctantly began the distribution of its product, and as of June 2007 there were only 356 authorized users purchasing their cannabis from PPS, which is less than 20% of Canada's authorized medical cannabis users. By comparison, 1288 of the 1816 medical cannabis users authorized through the MMAD have chosen to produce their own supply of cannabis [34].

Initial concern over this production contract began with investigations into the physical location of the PPS facility. According to research conducted by independent monitoring groups, as well as Environment Canada and Natural Resources Canada, high levels of heavy metal contamination are detectable in air, water and soil samples for over 100 square kilometers around the Flin Flon mine, which is the result of over 80 years of extensive mining and smelting in the area [35]. When concerns over the potential for heavy metal contamination were raised by end-users and advocacy groups like Canadians for Safe Access, Health Canada spokesperson Jirina Vlk responded by suggesting that the levels of heavy metals in the federal cannabis supply were "similar to what one finds in Canadian tobacco and are well within allowable limits." However, when asked what the allowable limits for tobacco were, she conceded that there are currently no Canadian standards limiting heavy metal content in either tobacco or cannabis [36].

The potency of the government-contracted PPS cannabis has also been called into question. In June 2004, Canadians for Safe Access commissioned tetrahydrocannabinol (THC) testing of the PPS product through the Quebec Institute of Public Health Toxicology laboratory. The results showed the product to be under 6%THC, rather than the 10% claimed by Health Canada [37]. In fact, according to a series of 23 Gas Chromatography Mass Spectrometer (GCMS) tests commissioned by Health Canada and conducted by three different federally-licensed laboratories on the cannabis distributed to authorized medical users between August 2003 and May 2004, the THC content of this product never measured above 7.2%, averaging just over 6.2%THC, well below the 10% labeled on the product [38]. No contrary test results have ever been released by the federal government.

A recent study by Ware, Ducruet & Robinson suggests medical cannabis users can readily and reliably distinguish between cannabis products based on THC content, humidity, grind size and smoking characteristics [39]. Comparing four different products – including the PPS cannabis sent to authorized users until May 2004 – the study determined the government-approved cannabis was 6.6%THC rather than the "10% THC blend" suggested by Health Canada. The study found that "Product 3...which had been originally shipped by Health Canada to authorized patients was rated poorly by the [8] subjects in this study", with end-users finding it "worse than their usual cannabis". In May 2004 Health Canada began to distribute a more potent cannabis product to end users containing 12%THC, and additional improvements including increases in grind size and humidity have taken place in subsequent batches. However, the lack of strain selection is a concern that remains unacknowledged and unaddressed by Health Canada.

Additionally, results from biological testing obtained through Health Canada continue to indicate high levels of mold and biological impurities prior to gamma-irradiation. In six microbiological tests from 2004, the levels of aspergillus and penicillium mold averaged 536.66cfus (colony forming units) and 3872.5cfus respectively [40]. According to the U.S. Food and Drug Administration Center for Food Safety and Applied Nutrition, both Aspergillus and Penicillium mold produce dangerous mycotoxins like aflatoxin and ochratoxin that cannot be destroyed by gamma irradiation [41,42]. According to Dr. Dave Abramson, a mycotoxicologist with Agriculture and Agri-Food Canada, the only way to guarantee that a commodity is free from a specific mycotoxin:

...is to sample the crop in a representative manner, and then perform a quantitative assay following a published and validated procedure. Depending on the crop and place of origin, specific assays for several mycotoxins would be necessary to ensure product safety. [43]

When asked specifically about microbial contamination and inhalation as a route of ingestion, Dr. Abramson states that "environmental studies have shown that all mycotoxins pose a very significant inhalation hazard," adding "there is some evidence that certain mycotoxins would survive the high temperatures associated with smoking, and remain potent in the vapor phase [43]."

Although Health Canada states that "the dried marihuana product meets Canadian requirements applicable to Natural Health Products (NHP) [44], these regulations require that all manufacturers of herbal medicines test for the presence of mycotoxins. However, neither Health Canada nor PPS performed or commissioned any such testing on the federal cannabis supply until May 2005 [45], despite having distributed this product to hundreds of critically and chronically ill Canadians for over 20 months. Although the testing that eventually took place revealed that mycotoxins levels on all PPS crops were below detection, the MMAD's misleading or unsupported statements in regards to the potency, safety standards and actual testing of this cannabis supply has caused justifiable concern and mistrust amongst both authorized users and advocacy groups.

Additionally, the biological decontamination technique used on the federal cannabis crop may turn out to be a health concern in its own right. Gamma irradiation is a highly controversial method of decontamination, and this researcher has been unable to find any studies assessing its safety on smoked or inhaled materials anywhere in the world. Research shows that along with molds and bacteria, it destroys beneficial terpenoids like myrcene, caryophyllene and linalool [46,47] that have known therapeutic properties and which may improve the bioavailability of some cannabinoids [48,49].

Further anecdotal evidence of the inadequacy of the government cannabis supply came from the actual end-users of this product, including longtime authorized user Jim Wakeford who stated to the press that the first batch of PPS cannabis was "totally unsuitable for human consumption" [50]. Out of the 93 people who had ordered the initial PPS product as of March 2004, nearly 30% returned it to Health Canada [51]. Although Health Canada cites much lower return rates for subsequent batches of cannabis, this may be the result of changes to their refund policy. Initially, dissatisfied end-users could return what was left of their package to Health Canada/PPS for a partial re-imbursement. However, under the current policy refunds are only offered for unopened packages, therefore if end-users open the sealed foil pouch in order to sample the PPS cannabis, they cannot return the product for a refund.

In February 2005 Canadian Press reported that according to Health Canada, 127 of the 278 patients ordering PPS cannabis from the government at the time were in arrears, for a total of $168,879 in unpaid medical cannabis bills. Health Canada responded by sending collection agencies after those in arrears for more than 180 days, cutting off at least 19 authorized users from ordering medical cannabis from the nation's only legal supplier, and forcing these critically and chronically ill Canadians to resort to accessing their medicine from illicit sources [52]. In light of this, the Canadian AIDS Society has recommended that the federal government give immediate consideration to "mechanisms for reimbursement of the costs of medical cannabis for seriously ill Canadians" [53].

However, this significant impediment to medical cannabis access remains unaddressed, and an internal Health Canada report titled "Audit of the Management Processes for the Medical Marihuana Program" from March 13, 2007 shows that although the federal government is aware of the inability of many authorized users

to pay for the cost of this medicine, the federal response has been to increase pressure by ceasing shipments after 30 days:

The Departmental Audit Committee Risk provided support in 2005 to clarify the supply policy for Marihuana for Medical Purposes and cease shipment to clients in arrears. Senior Management was aware that a client's file may eventually be sent to collections. The Programme Management Committee of DSCSP recently approved further refinement of the supply policy to cease shipment to clients in arrears more than 30 days [54].

Although the long-term impact of this policy change is unclear at this time, the level of debt by end-users of the federal cannabis supply has increased dramatically since 2005. As of April 30th 2007, 229 authorized users who had ordered this cannabis supply had received notices that their accounts were in arrears, representing $297,920 in unpaid debt [55]. Upon receipt of these notices authorized persons are only allowed to order one more shipment of cannabis before being cut-off from Canada's only legal supply for non-payment. Additionally, 29 accounts have already been sent to collection agencies, cutting off these critically and chronically ill Canadians from their supply, and adding unnecessary stress to their health and well-being.

This is particularly vexing in light of recent information revealing that Health Canada significantly increases the retail price of this product as compared to the actual wholesale cost. An examination of the production and supply contract extension between Health Canada and PPS covering the period from January 2006 to September 2007 titled "A Review of the Cannabis Cultivation Contract Between Health Canada and Prairie Plant Systems" suggests that the federal government pays PPS $328.75 per kilogram of cannabis (approximately $10 per ounce), but then charges patients $150 per ounce, constituting a 1500% markup on a product that has already been paid for by Canadian taxpayers through an ongoing six year and nine month contract agreement totaling $10,278,276 [56]. The report goes on to compare the approximate cost of producing and supplying medical cannabis user through PPS/Health Canada vs. the BCCCS for the fiscal year of November 2005-October 2006. According to Table 1, the British Columbia Compassion Club Society supplies a safe source of cannabis to over 3000 sick or suffering Canadians for approximately the same yearly costs as Health Canada currently spends on the PPS production contract to supply just over 700 end-users, meaning that the total operating cost per person supplied through Health Canada/PPS is $3889.49 per person vs. $739.25 through the BCCCS. The report came to the following conclusions:

Table 1. Cost Comparison of PPS Contract Extension for Oct 2006-Sept 2007 to BCCCS Costs for Fiscal year of November 2005-October 2006

The 1500% mark-up on the cannabis charged to patients highlights the risk of Health Canada creating a monopoly over supply. Health Canada is requiring taxpayers and medical cannabis patients to fund inefficient practices, capital upgrades, and equipment for a private contractor. Instead of providing affordable medicine to those in need, Health Canada has chosen a policy and program that seemingly creates a windfall for one monopoly supplier to the detriment of patients and taxpayers. While community-based medical cannabis dispensaries provide a cost-effective alternative to Health Canada's centralized monopoly for cultivation and distribution, the end-cost to patients still remains problematic. The cost of cannabis for those in medical need must be covered under Canada's universal health care system as it is for other medicine. Canada's critically and chronically ill deserve the most affordable and highest quality care.

Furthermore, although nearly 80% of authorized users choose to cultivate their own supply, Health Canada has stated intentions to remove the right of patients to cultivate their medicine or to nominate someone to do so for them [57]. The Canadian AIDS Society found that only 1.7% of the people living with HIV/AIDS whom they consulted obtained their cannabis from Health Canada, compared to 35.9% who obtained it through compassion clubs:

Considering the current public attitude towards the government's cannabis, the fact that the government only provides one strain of cannabis to authorized persons, and the government's expressed intention to eventually phase out licenses to produce, we are concerned that people living with HIV/AIDS will have to continue to break the law to supply themselves with cannabis for their medicinal purposes...offering only one legal source and only one strain of cannabis for distribution to authorized Canadians may not be a constitutionally adequate alternative to the diverse supply currently available to them through license to produce, unauthorized compassion clubs, or within the black market [58].

This is supported by preliminary results from a survey study titled "Quality of Service Assessment of Health Canada's Medical Cannabis Policy and Practice" showing that only 8% of the 90 respondents – a sample size that represents over 5% of legally authorized users in Canada – currently order cannabis from Health Canada, and on a numeric scale from 1 to 10 – with 10 being "Excellent", and 1 being "Very Poor" – 76% of the respondents who had tried the Health Canada cannabis ranked it as being either a 1 or 2 [59].

Additional preliminary data from this study show that over 92% of respondents find that not all strains are equally effective at relieving their symptoms, and 97% say that they would prefer to obtain cannabis from a source that has a "large selection of different strains" rather than a single product. Finally, over 90% state that they'd prefer to purchase cannabis from a source that offers many different forms of ingestion, and given the option, over 81% of respondents would chose organic methods of cultivation for their medical cannabis supply. Unfortunately, Health Canada's current supply policy and practice has been unable or unwilling to address many of these end-user issues, leaving medical users little choice but to obtain their medicine from the black-market or from Canada's network of community-based dispensaries.

5. Community-Based Alternatives to a Centralized Medical Cannabis Program

"As far as the distribution of marijuana to qualified users is concerned, the government might consider creating properly regulated distribution centres or licensing compassion clubs, as proposed in the recent *Report of the Senate Special Committee on Illegal Drugs: Cannabis*."

- Ontario Supreme Court Judge Lederman (Hitzig v. the Queen, January 2003)

The Canadian Senate Special Committee on Illegal Drugs and the Ontario Court of Appeals have both suggested that Health Canada should seek to work with the nation's compassion societies with the goal of improving access to a safe supply of cannabis for legitimate users. Despite these recommendations and court orders, the MMAD has resisted opportunities to decentralize this program, forcing compassionate distributors and their suppliers to continue risking arrest and prosecution in an unregulated market. This risk is hardly theoretical; of the seven major clubs in Canada, more than half have been subjected to raids and arrests by law enforcement.

Although police raids continue to significantly disrupt safe access to cannabis by medical users, the federal prosecution of compassion clubs in Canada has been largely unsuccessful. Following a raid on the VICS in 2000 and a lengthy legal battle, B.C. provincial judge Higinbotham granted this author an absolute discharge for trafficking in recognition that:

...while there is no doubt that Mr. Lucas offended against the law by providing marijuana to others, his actions were intended to ameliorate the suffering of others. His conduct did ameliorate the suffering of others. By this Court's analysis, Mr. Lucas enhanced other people's lives at minimal or no risk to society, although he did it outside any legal framework. He provided that which the Government was unable to provide – a safe and high quality supply of marijuana to those needing it for medicinal purposes. (R. v. Lucas, July 5th, 2002)

There are some clear philosophical differences between the federal program and the work of compassionate distributors (Table 1). Most of Canada's compassion clubs focus on holistic care and harm-reduction, and many have used their unique experience and expertise to enhance consumer options in cannabis-based therapies. So while Health Canada currently offers medical patients a single strain of pre-ground raw plant material, compassion clubs distribute numerous different

symptom-specific strains and offer many alternative methods of ingestion to smoking, including edibles, oils, tinctures, vaporizers, and sublingual sprays.

After an intensive investigation of medical cannabis access in Canada conducted by the Canadian AIDS Society, their final report supported the licensing of compassion clubs, stating:

...we favour a not-for-profit, community-based model of distribution of medicinal cannabis and its related services...these organizations also offer a number of different strains and alternatives to smoking, and are currently serving more than 10,000 Canadians...we recommend that the government authorize compassion clubs that meet defined operational standards and recognize them as legal dispensaries for medicinal cannabis [60].

Despite the significant potential to decrease the overall operational costs of this federal program, and to increase efficiency and end-user satisfaction through community-based access, Health Canada's Marihuana Medical Access Division continues to resist regulating and licensing Canada's compassion clubs and societies.

6. Discussion and Conclusion

Since 1999 the Canadian government has spent over $30 million in funding for the research, production and distribution of medicinal cannabis [61], yet there is a growing body of evidence that Health Canada's program is not meeting the needs of Canada's medical cannabis patient community, and that it may actually be acting as an impediment to safe and timely access. As a result, the policies of the Marihuana Medical Access Division may be significantly limiting the potential individual and public health benefits achievable though the timely and effective therapeutic use of cannabis by sick and suffering Canadians.

Originally implemented to ensure legal access to medicinal cannabis for the critically and chronically ill who might benefit from its use, Health Canada's MMAD has instead limited participation in the federal program through obstructive and arguably unconstitutional regulations, and restricted options to a safe supply of raw cannabis and alternative methods of ingestions by entrenching a restrictive, non-beneficial monopoly on production and distribution. Despite Health Canada's insistence that more research needs to be conducted on the safety and effectiveness of cannabis, the government has only funded two clinical cannabis studies since 1999, and has recently terminated all other federal financing for this emerging area of health research. Disturbingly, over the last six years fewer than 1900 applicants have been able to negotiate the cumbersome bureaucratic obstacles allowing them to participate in this federal program, and preliminary results from a quality of service assessment of Health Canada's medical cannabis policy and practice show that over 72% of the study's respondents cited that they are "somewhat" or "totally unsatisfied" with Health Canada's program [62]. In response to these ongoing problems, Canadian Member of Parliament Libby Davies (Vancouver East), Senator Pierre-Claude Nolin, and the Canadian AIDS Society have all called for a performance audit of the MMAD by the Auditor General of Canada.

Meanwhile, Canada's compassion clubs and societies continue to supply cannabis to more medical users than the MMAD, to initiate and participate in more medical cannabis research than CIHR, and to produce a more varied cannabis supply than Health Canada; all at no cost to the nation's taxpayers. The following are five steps that could significantly improve medical cannabis access in Canada:

1. An immediate audit and review of entire federal medical cannabis policy and practice.

2. Cost coverage of medical cannabis by federal/provincial healthcare programs, and debt forgiveness for current authorized users.

3. The re-implementation of the Ontario Court of Appeals changes to the MMAR in order for it to meet its minimum constitutional obligations.

4. The decentralization of the program to allow for immediate access and legal protection with a health care practitioner's recommendation.

5. The development of a cooperative relationship between Health Canada and compassion clubs to improve access, increase supply/ingestions options, and jump-start research into the therapeutic potential of cannabis.

While the fate of the federal program remains unclear, evidence suggests that any future success will likely depend on the government's ability to better assess the concerns and needs of the nation's critically and chronically ill, to promote and fund an expanded clinical research agenda, and to work in cooperation with Canada's established network of community-based medical cannabis compassion clubs in order to address and remedy the ongoing issue of safe and timely access to this herbal medicine.

Competing interests

The author is the founder and director of the Vancouver Island Compassion Society, and receives a salary from this organization for research, communications and administrative work. The author is also the founder of Canadians for Safe Access and continues to do work on behalf of this non-profit organization, but as an unpaid volunteer.

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The author would like to thank Susan Boyd, Michael Prince, Rielle Capler and Ken Tupper; their helpful advice was invaluable to this policy overview. I'd also like to express my gratitude to the researchers at Health Canada's Access to Information and Privacy Division, without their good work this public interest research would not be possible.

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EXHIBIT "D"

This is Exhibit "D" referred to in the Affidavit
of JAMIE SHAW sworn before me at
Vancouver, BC this 8th day of January, 2015.

A commissioner for taking affidavits
For British Columbia

CAMCD Directors

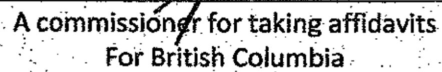
Jamie Shaw - President, Treasurer, COO
Dana Larsen - Vice President
Shega Amula - Director
Kathryn Dalton - Director
Neev Tapiero - Director

Advisory Board

Rielle Capler
Hilary Black
Adolfo Gonzales
Blaine Dowdle

EXHIBIT "E"

This is Exhibit "E" referred to in the Affidavit of JAMIE SHAW sworn before me at Vancouver, BC this 8th day of January, 2015.



A commissioner for taking affidavits
For British Columbia

CAMCD ACDCM
CANADIAN ASSOCIATION OF MEDICAL CANNABIS DISPENSARIES
ASSOCIATION CANADIENNE DES DISPENSAIRES DE CANNABIS MÉDICAL

CAMCD Mission

Promoting a regulated community-based approach to medical cannabis access and supporting medical cannabis dispensaries to provide the highest quality of patient care.

CAMCD Vision

Legally permitted community-based medical cannabis dispensaries providing access to a wide range of high quality cannabis medicines to those in need and regulated in a manner consistent with the highest standard of patient care.

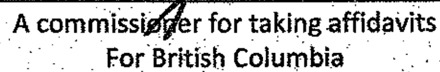
CAMCD Objectives

In support of CAMCD's mission, vision and values, the objectives of CAMCD are:

- To establish and uphold standards for the certification of medical cannabis dispensaries;
- To support medical cannabis dispensaries in providing a high standard of care through education, research and the promotion of best practices;
- To provide clients of medical cannabis dispensaries a mechanism to log and address complaints about dispensaries;
- To conduct, encourage and facilitate research into the medical use of cannabis and methods for its production, distribution and regulation;
- To work with the public, government, educational institutions, health care providers and law enforcement agencies to increase understanding of medical cannabis dispensaries.

EXHIBIT "F"

This is Exhibit "F" referred to in the Affidavit
of JAMIE SHAW sworn before me at
Vancouver, BC this 8th day of January, 2015.



A commissioner for taking affidavits
For British Columbia

CAMCD ACDCM
CANADIAN ASSOCIATION OF MEDICAL CANNABIS DISPENSARIES
ASSOCIATION CANADIENNE DES DISPENSAIRES DE CANNABIS MÉDICAL

DISPENSARY CERTIFICATION STANDARDS

The Certification Standards are organized into 7 key areas of dispensary operations and practices.

SECTIONS

I. PATIENT ELIGIBILITY

II. PATIENT INTAKE

III. PRODUCTS AND SERVICES

IV. DISPENSING

V. SUPPLY

VI. SAFETY, SECURITY AND PRIVACY

VII. EFFECTIVE ORGANIZATION

Each Section contains multiple standards related to that area of dispensary operation and practice.

For example:

I. **PATIENT ELIGIBILITY**

1. AGE OF PATIENT
2. MEDICAL CONDITIONS AND SYMPTOMS
    - A. DIAGNOSIS AND RECOMMENDATION FOR USE
    - B. SPECIAL CONSIDERATIONS
3. DOCUMENTATION
    - A. HEALTHCARE PRACTITIONERS
    - B. REQUIRED INFORMATION
    - C. DATE OF DOCUMENTATION
        - i. EXPIRY OF...
        - ii. RENEWAL OF...
    - D. DOCUMENT VERIFICATION
    - E. TYPES OF DOCUMENTATION
4. INELIGIBLE APPLICATIONS

1. Age of Patient

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Focus: Addressing requirements related to age of patient

Background:
Typically, the parents or legal guardian provide consent to treatment on behalf of patients under the age of majority and must be guided by what is in the best interest of the minor. However, legislation for consent to medical treatment in a number of provinces and territories in Canada is based on the person's capacity to consent to or refuse the treatment regardless of age [1]. Despite the fact that a minor may consent to treatment, dispensaries must balance patient need for medicine with the current legal status of cannabis and public concerns about age. Except for specific instances where the need for medicine outweighs the public concerns, for example palliative care, it is prudent for dispensaries to abide by the legal age of majority in their province or territory for all patients. (Note: this does not apply to emancipated persons).

Standard:
The dispensary accepts patients who have reached the age of majority in their province/territory and minors who have written consent from a parent or legal guardian.

Tests for Compliance:
1. The dispensary has documented policies and procedures to verify the age of patients.
2. The dispensary has documented policies and procedures to obtain parent or legal guardian consent for applicants under the age of majority in their respective provinces.
3. Dispensary personnel verify the age of patients and obtain parent or legal guardian consent if applicable before registering a patient.

Examples:
- *The dispensary's application and intake forms include patient's date of birth.*
- *The dispensary will ensure that visitors from other provinces are of the age of majority in the dispensary province.*
- *Photo identification with birth date is obtained from new patients and a photocopy is kept on record.*
- *For any patients under the age of majority, the parent or legal guardian initials any place where the patient is asked to sign or initial.*
- *The parent or legal guardian will sign and initial documents in the presence of two dispensary personnel or have their signature witnessed by a legally accredited professional.*
- *The parent or legal guardian will provide documentation of their relationship to the patient and a photocopy is kept on record.*

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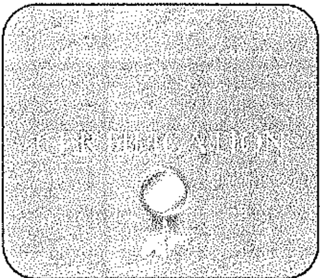
[1] For example, http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96223_01

- *The dispensary utilizes a verification checklist for each patient that includes age, date of birth, and whether on not a written consent was obtained for those under the age of majority.*

STEPS TO CERTIFICATION



*A Dispensary meeting 90% of Standards and all ROP's on either the first On-Site Survey Attempt, or on a Full Certification Survey Attempt achieves full Certification.

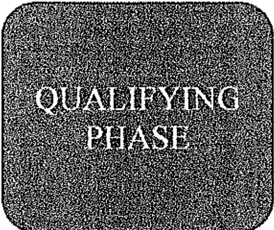
*CAMCD lists dispensary on website as a 'Certified Dispensary', and provides a decal, a certificate, and a badge for the dispensary's own website, all valid for 3 years.

5 - Dispensary must submit a Re-Certification Survey Request, and Survey Fee, between 30-33 months after certification issued.

*A Dispensary meeting over 50% of Standards and all ROP's on either of their two attempts at the first On-Site Survey achieves Provisional Certification.

*CAMCD lists dispensary on website as a 'Provisionally Certified Dispensary', and provides a decal, a certificate, and a badge for the dispensary's own website, all valid for 1 year.

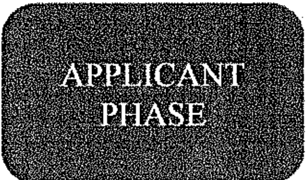
4 - Dispensary must submit a Full Survey Request, and Survey Fee between 6-9 months after issue of Provisional Certification.



*CAMCD will send Patient Surveys, Survey Prep Guide, and Self-Assessment Survey, and will list the dispensary as a 'Qualifying Dispensary' on the CAMCD website.

3 - Submit completed Patient Surveys, Self-Assessment Survey, First On-Site Survey Request, and Survey Fee (within 3-6 months).

*Dispensary has two on-site Survey Attempts to achieve Provisional Certification.



1- Submit Application Form, $1600 (including $150 non-refundable Processing Fee)

*CAMCD will list Dispensary as an 'Applicant Dispensary' on its website and will send the Baseline Survey.

2 - Return the completed Baseline Survey within 2 weeks of receipt to enter Qualifying Phase.

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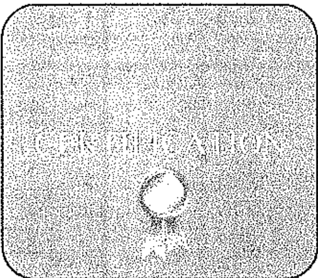
EXHIBIT "G"

This is Exhibit "G" referred to in the Affidavit of JAMIE SHAW sworn before me at Vancouver, BC this 8th day of January, 2015.

A commissioner for taking affidavits
For British Columbia

STEPS TO CERTIFICATION



*A Dispensary meeting 90% of Standards and all ROP's on either the first On-Site Survey Attempt, or on a Full Certification Survey Attempt achieves full Certification.

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EXHIBIT "H"

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CERTIFICATION TIMELINE & COST BREAKDOWN

PHASE	DURATION	ASSOCIATED FEES
APPLICANT PHASE	2-3 WEEKS	$1600 APPLICATION FEE
QUALIFYING PHASE	3-9 MONTHS	$2000 Primary Survey Fee* Due between 6-9 months after entering Qualifying Phase.
PROVISIONAL CERTIFICATION	1 YEAR	$2000 Full Survey Fee* Due between 9-12 months after issue of Provisional Certification.
CERTIFICATION	3 YEARS	$2000 Re-certification Survey Fee* Due between 33-36 months after issue of Certification.

*Survey Fee does not include travel and accommodation if required.

Eg. 1 - A dispensary that has the waiting period waived, and passes its first On-Site Survey at a Certification level, can have a location certified for a total of $3600 within 5 months time.

Eg. 2 - A dispensary requiring the maximum time allowed could have a location fully certified for $5600 within 22 months.

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EXHIBIT "I"

This is Exhibit "I" referred to in the Affidavit
of JAMIE SHAW sworn before me at
Vancouver, BC this 8th day of January, 2015.

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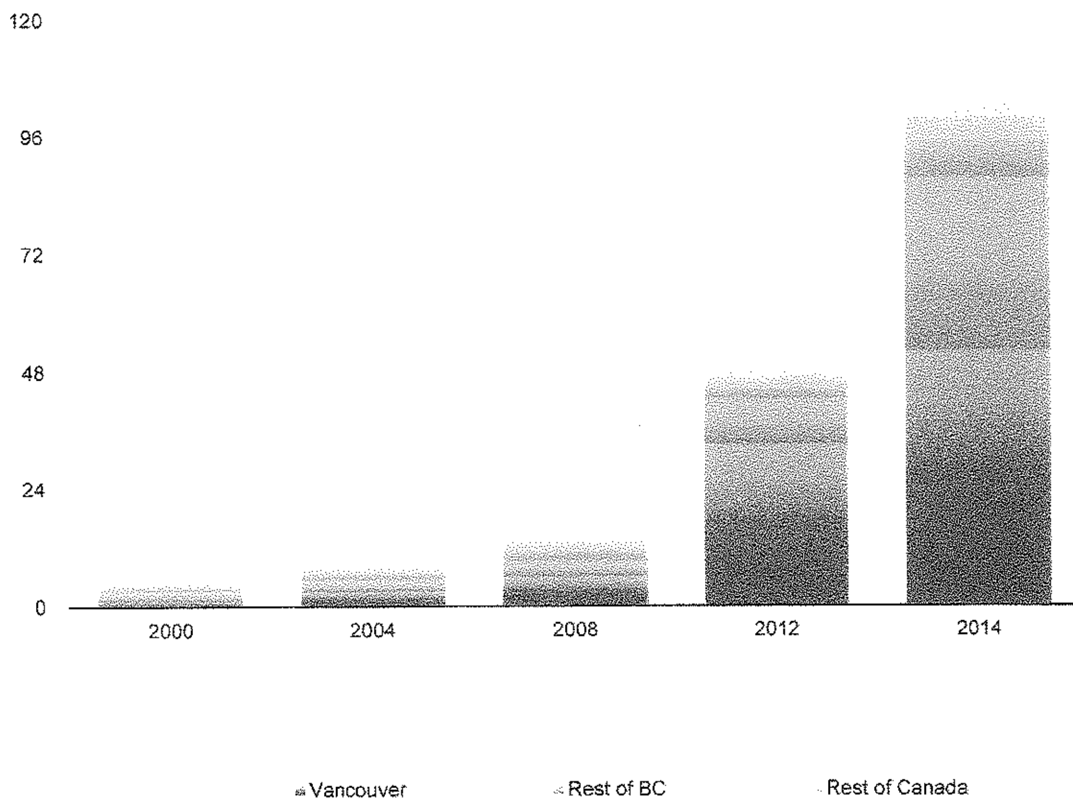
Estimated Number of Medical Cannabis Dispensaries in Canada*

CAMCI
CANADIAN ASSOCIAT
ASSOCIATION CANADIEN



* NB: These numbers were complied from various sources, including personal communications, news articles, and Internet sites such as Best Leaf, Leafly, and LiftMJ. It is important to note that Dispensaries currently exist outside a legal framework, so there is no central registry, and the exact number of dispensaries fluctuates. These numbers do not include dispensaries that may be operating out of the public eye.

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