Canada - Roundtable on Legalization - Submission with respect to the *ACMPR* Opening Provisions and Part 2 Personal or Designated Production

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Interpretation

s.1 (1) Definition of "Adult" means 18 years of age or older

While this may be a good starting point on the age limit question bearing in mind that it is 18 for tobacco, consideration needs to be given as to what approach one is going to take to those who possess or assist in some way who are under 18. If you are going to use the criminal law, then you might want to review the evidence and findings of the Senate Special Committee Report (Nolin) that recommended an age of 16 for that reason. If you are not going to use the criminal law, or some approach that will stigmatize and prejudice young people for the rest of their lives, then a higher age limit such as 18 may be justifiable. At the same time, given that young people (15 to 19) comprise a large segment of the cannabis consuming population, without apparent significant effect, what is the problem with them assisting a parent or brother or other designated person in the production and processing aspects and perhaps even in certain distribution aspects. In a true legalized market surely younger people will be able to assist their elderly friends and relatives as patients. One will need to see what the new "legalization" model looks like in order to this further. Hopefully no illicit markets will be continued.

S. 1 (1) Definition of "cannabis" and "cannabis oil", "dried marihuana", "fresh marihuana" and "marihuana"- these definitions essentially, especially those for "cannabis" and "marihuana", bring in **schedule II of the *Controlled Drugs and Substances Act* (the *CDSA* or the *Act*)** that are broad enough to include "its preparations, derivatives and similar synthetic preparations", followed by a list of specifics, including cannabis resin, cannabis (marihuana), cannabidiol (CBD), cannabinol, THC and others, but not including "nonviable cannabis seed, with the

[1] Significant contributions were received from Arnold Shoichet, Eric Nash and Rielle Capler

exception of its derivatives and mature cannabis stalks that do not include leaves, flowers, seeds, or branches and fiber derived from such stalks (the hemp and bird seed exceptions). Notably, “fresh marihuana” and “dried marihuana” do not include seeds, or plant material that can be used to propagate marihuana but “cannabis” and “marihuana” do.

These definitions are all of importance on the question of “obtaining and providing the substance and its lawful possession”. The Health Canada statements announcing the new regulations indicated that patient or designated persons as producers would have to obtain their original seed or propagation material (clones) from licensed producers. The regulations do not appear to say so directly and appear permissive and not mandatory. If that is what is intended by s.3 and 4(3) and (4) they need to be clarified and reconsidered. While it is understandable that the government may want people to start with a legal seed or clone it is simply not realistic due to the existing market as Health Canada experienced under the *MMAR* when they attempted to get patients to obtain from the Prairie Plant Systems source. Of course, if the definition of licensed producers is expanded and the regulation of dispensaries includes the ability to sell seeds, or clones then a wide range of such products will be available to patients and other producers from a wide range of sources, and this will not be a problem. It must also be remembered that those patients and designated growers that are covered by the Allard injunction that continues, “until further order of the court” will, if they transition to the *ACMPR*, bring with them an established production operation, as well as seeds and clones that they have developed in some cases over years. The government needs to be realistic and appreciate that there are now a wide range of available types of seeds and clones in the market and the propagators and suppliers of such need to be brought into the legal framework not pushed out in order to assist in developing a reasonable market that includes identifying different strains and providing information about them for the benefit of patients and others. In a true legal market one would be able to obtain seeds and startup materials from people like www.richters.com and others who sell medicinal plants and herbs and other vegetables online.

s.1 (1) Definitions of "healthcare practitioner" and "medical practitioner" and "nurse practitioner"[2]

Limiting the gatekeeper role to medical doctors is problematic as most Colleges of Physicians and Surgeons and Medical Associations appear very conservative and restrictive on the issue of "marihuana for medical purposes" though supporting legalization and hoping it will alleviate pressure on the medical profession. They do not want to be the gatekeepers and most members have little or no knowledge or interest in whole plant medicine and Cannabis in particular and prefer to treat their patients with the pharmaceutical alternative solution or pill or prescribed drug that they are of the view is more appropriate because it is an "approved drug" despite the side effects of these alternatives. Cannabis is usually in whole plant form, and only in limited spray or pill form, such as Sativex and Epidiolex (the latter apparently still awaiting Canada and US approval – manufactured by GW Pharmaceuticals UK) derived from the actual plant, and in the past synthetic Marinol (generic Dronabinol) Cesamet (generic Nabilone). These earlier synthetic forms and simple extracts have proved to be not as effective as the whole plant, in which the naturally occurring cannabinoids, flavonoids, terpenes, etc. seem to enhance each other's effects. The nature of this phenomenon has been called the "entourage effect".

The medical profession is prepared to prescribe opiate drugs like OxyContin and others that can kill people by overdose whereas they are reticent to prescribe cannabis that has no lethal dose and there are now existing peer reviewed research studies suggesting that cannabis can assist as an exit strategy drug from opiate addiction. Instead, often due to pressure from Colleges and Medical Associations with respect to prescribing opiates, doctors may cut off the patients before they ,the doctors, get into trouble and forcing the patients to go to the street and get unregulated black market product that often kills due to overdose. See ***Canada (Attorney General) v. PHS Community Services Society*** **2011 SCC 44** **http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do** - with respect to the Vancouver Supervised Injection Site.

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Addiction (in the scientific meaning of the term), as opposed to dependence, needs to be recognized as an illness or disease and treated as such. Fortunately we do not see this type of behavior attributable to addiction characteristic of opiate addicts, among those seeking cannabis even in an illicit market. It has no lethal dose and most adverse events are due to overconsumption of edibles due to not following instructions.

The medical profession's general lack of knowledge with respect to whole plant medicine and the professions attachment to pharmaceutical solutions requires consideration of expansion of the gatekeeper role to include health care professionals such as Naturopaths and Doctors of Traditional Chinese Medicine, and perhaps others, who know something about whole plant medicine, and who should therefore be included under the definition of "healthcare practitioners" both independently and to assist others on the treatment team, including medical doctors, in seeking knowledge in relation to the best solution for their patients. The addition of "nurse practitioners" under the *MMAR* and now carried forward under the *ACMPR* is welcomed, but the problem is that they are limited by the local doctors and Colleges in their ability to participate. Nurse practitioners should be allowed and encouraged to educate themselves and participate and monitor patients accordingly.

The Canadian Medical Association and its provincial counterparts, as well as Colleges of Physicians and Surgeons across the country, while supporting legalization, otherwise appear to be responding in a somewhat alarmist manner suggesting an age limit of 25 or even 21 and a patient review every 3- 6 months and insisting on a "longitudinal relationship" between the patient and the practitioner of cannabis medicine when the latter is brought in much like a specialist to provide that expertise to the ongoing longitudinal treatment team and perhaps then become part of it. While the Colleges are understandably concerned (see the College response in the BC Medical Journal below) that authorization of cannabis use without appropriate assessment and ongoing care of the patient is not good professional care nevertheless informed and responsible practitioners feel intimidated by College statements and expectations that do not seem to be justified by available evidence and feel that the Colleges are unduly restricting them, despite the fact that they are doctors who have informed themselves about

cannabis as medicine and do so responsibly and substantially in compliance with the Standard, but taking note of specific concerns and problems with the incorrect positions and unreliable research relied upon by these Colleges and creating an ongoing dialogue with them.

The physician as ‘gatekeeper’ remains a major obstacle to patients accessing cannabis. A detailed submission on this issue was made in the Health Canada Multi –Stakeholder Consultation Sessions of February 18th, 2004 by Eric Nash but remains unresolved.

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Regular complaints are being deceived with respect to issues/problems with medical doctors signing and clinics taking advantage of the program and patients. Cannabis Consultants are getting lots of phone calls & emails from patients looking for doctors to sign their *ACMPR* forms. Many complaints from patients are regarding clinics charging exorbitant rates for doctor referrals and *ACMPR* home-growing forms to be completed.. Some patients report $400-$2400 for a doctor to do their paperwork for usage/possession. Other patients report clinics charging a new "per-plant" fee for *ACMPR* home-growing forms to be completed, often ranging from $10,000-$20,000.Clinics are getting referral fees and percentage kickbacks from current Licensed Producers and this provides a disincentive to approving the patient to produce for themselves. If the clinics do assist by completing the forms for production they charge exorbitant fees and this is apparently a widespread problem across Canada. The clinic business model is based on a percentage commission fees (15 to 22%) paid by LPs based on the amount of products sold to the patients who were referred by the clinic. A recent example of a complaint from a patient in Ontario is attached to illustrate the problem:

> “Hello. I am a patient from Ontario and am having a very hard time dealing with the referral agency I am with. A few months ago they signed me up for which they charge $650 dollars to get an appointment with a doctor that is willing to sign for more than 5 grams if that is what the patient requires. I opted for that

> program since the 5 gram/day limit I had the year before dealing with another referral agency wasn't enough to suppress the symptoms of my IBS and asthma since I eat edibles made from concentrate or vape concentrate rather than smoke. But the edibles don't effect me unless they're very strong and even then the effect is only effective for an hour or two. So after paying $650 a few months ago they told me to pay $475 for them to send my papers to Health Canada which I did. And now they say since I need the original doctor prescription to send to Health Canada, I need to give them another $650 to make that appointment. Then they said that there is so much potential money to be made from the plants that they are charging new patients $20,000 for similar licences and that my renewal cost would be $10,000. All this even though I never stated that I plan to sell anything. I am a legitimate patient I have a legitimate diagnosis for asthma and IBS from my family doctor. I need to grow my medicine because the quality and quantity I need to relieve my symptoms is out of my financial reach and I either have to choose to suffer physically or financially because I can't grow my medicine. Also I plan to breed strains that work for me. I am disgusted by the current state of affairs with legitimate doctors afraid to prescribe and crooked doctors and referral agencies banking off of patients who are only looking to live happy healthy lives without having to have such a heavy financial strain. Every time I bring up medical marijuana with my family doctor he says he is not educated on the subject. I am thinking about going to my doctor with a few articles and my daily intake regimen and seeing if I can convince him that this is a real medicine that works for me, though I doubt anything can convince him. If I have no other option I plan to give these guys the $650 they ask for and seeing where things go from there, although them talking about illegal distribution makes me seriously doubt their legitimacy.“

Consequently, this issue is a major concern because of its impact on those members of the medical profession that are trying to do things correctly and bearing in mind the clear need for the medical profession to be involved because of the nature of some of the patients serious illnesses that are beyond the scope of some of the others in the other healthcare professions mentioned.

Attached is a link to the British Columbia College of Physicians and Surgeons – Professional Standards and Guidelines – Marihuana for Medical Purposes created May 5th, 2015 and revised as of July 30, 2015. https://www.cpsbc.ca/files/pdf/PSG-Marijuana-for-Medical-Purposes.pdf

This Standard (that is not a Guideline) has been of significant concern in terms of the nature of its statements and expectations to a group of doctors in BC who are part of

“Practitioners for Medicinal Cannabis “(PMC)), a nation-wide network of specialists and general practitioners who have taken the time and trouble to educate themselves and their peers about Cannabis,. Their concerns are expressed in their letter of June 1, 2016 published in the BC Medical Journal Issue for September 2016, http://www.bcmj.org/letters/medicinal-cannabis-concern-college-standard together with the reply thereto from the BC College of Physicians and Surgeons in the same BCMJ issue. http://www.bcmj.org/letters/medicinal-cannabis-concern-college-standard-college-replies.

Below is a link to the PMC Summary referred to in their submission that contains specific informed responses to the College Standard on various issues and provides extensive references for the many studies that do in fact exist on these issues. See also www.norml.org for a continuing updates on studies past, present and ongoing.

PMC Response to CPSBC standard - dis

There is even greater concern about several other Colleges (**Saskatchewan, Newfoundland, Alberta**) which insist not only on the prescribing physician having a longitudinal treating relationship with the patient, but also that the “prescribing physician must also be the treating physician for the condition for which marijuana is authorized” (**Saskatchewan**). In other words, if the patient’s regular care providers (GP and/or specialist) are not onside with the medicinal use of cannabis, the patient seeking cannabis must find a whole new care team who ARE supportive or at least open minded. This is an instructive example of how the medical profession's Regulatory Authorities are obstructing patient “reasonable access”.

Here are links to the directives of these regulatory bodies regarding medicinal cannabis:

Sask: http://www.cps.sk.ca/imis/Documents/DocTalk%20Winter-Spring%20Newsletter.pdf - scroll to p.20 “Medical Marihuana” and p.21 the Colleges bylaw;

Newfoundland: http://www.cpsnl.ca/default.asp?com=Policies&m=340&y=&id=98 ;

Alta: http://www.cpsa.ca/standardspractice/marihuana-medical-purposes/

Quebec: http://www.cmq.org/publications-pdf/p-1-2014-04-01-en-directives-concernant-ordonnance-cannabis-seche-fins-medicales.pdf?t=1473640615100

http://www.cmq.org/page/en/cannabis-a-des-fins-medicales.aspx

Note that in relation to the Québec situation you cannot get access to cannabis for medical purposes, unless you agree to participate in this research program (conducted by Vice Chair, of the Task Force Dr. Mark Ware) and doctors are also compelled to participate in it without compensation for their time and effort which has caused some concern. While the collection of this information is laudable and to be encouraged, it is submitted that it would be preferable if this program was voluntary with patients and doctors being encouraged to participate because of the valuable data that will be collected. As a compulsory program it could be argued that it is an unreasonable limitation on "reasonable access" by Québec patients.

See also the link to the CBA (BC) Midwinter presentation entitled **"Social and Medical Cannabis Issues: Past, Present and the Future** below and in particular the sections on medical marihuana and the Bibliography containing links to many studies as well as the Appendices that provides further references with respect to medical marihuana, and in particular the "Handbook of Cannabis" edited by R. Pertwee, Oxford University Press, 2014 for excellent current information. A search of "PubMed" will yield a substantial further number of studies, including some that are double-blind, placebo based and including studies involving larger cohorts that are not funded by proponents of medical cannabis, unlike many small cohort specific pharmaceutical funded studies on specific drugs they are manufacturing.

A book that deals with this issue from a plant nutrition perspective and does not deal with cannabis specifically is **"How Not to Die"** by Dr. Michael Greger M.D. of www.nutritionfacts.org that is currently on the New York Times bestseller list and

published by www.Flatironbooks.com in 2015. This book does an excellent example of comparing what is available through plants for nutrition and health, and what is available through prescribed drugs for the same ailment and allows the person or patient to decide for themselves, based on the studies presented accordingly.

Another book for consideration when comparing allopathic medicine and whole plant medicine and the Natural Health Care Products Regulations pursuant to the Food and Drugs Act issue, that has to be addressed, if those regulations are not to apply by default, is **"Medicinal Plants at Home – More Than 100 Easy, Practical and Efficient Natural Remedies** by Mario Transito Lopez Luengo and Carlota Manez Ariso, from Spain and published by Skyhorse Publishing in 2015 (www.skyhorsepublishing.com) Cannabis is not addressed in this book eithers and both are offered for consideration here simply to illustrate the plant versus pill issue that needs to be addressed and by those with expertise in such matters and how that market exists and is regulated or otherwise..

See also again as an example of how these products are marketed and available online via catalogue like www.richters.com .

For ease of reference and understanding, I have attached as Appendix A (http://laws-lois.justice.gc.ca/eng/regulations/sor-2003-196/) **The Food and Drugs Act, Natural Health Products Regulations**, including the definition of a "natural health product" and **schedule I noting item 1** including **plants**, and **schedule II noting item 4** thereunder that excludes **substances** in **schedules I -V of the *CDSA* expressly and item 3 that excludes tobacco.** These provisions need to be addressed when **cannabis is removed from schedule II of the *CDSA*** to either allow them to apply to cannabis for medical purposes that fit within the definitions or to ensure that they make it clear that they still do not apply because Cannabis is being dealt with under the *ACMPR* or a Cannabis Control Act either federally or provincially or both. The NHP Regulations do not deal with self-production but only sales to the public and getting Health Canada approvals. It should be noted that Health Canada has recently announced that it proposes to engage in consultations with respect to "Self-Care Products," including Natural Healthcare

Products based on risk – see http://healthycanadians.gc.ca/health-system-systeme-sante/consultations/selfcare-autosoins/document-eng.php

Presumably, a number of these concerns and restrictions will fall away in a true "legalization" model. Patients would be free to consult not only medical doctors but others in the search for a solution to their particular ailments. It is hard to determine the exact continuing legal requirements in relation to medical cannabis until one knows what the proposed legal model will look like. **ss.3 – 5 - Obtaining Access – these provisions appear to define lawful possession through the lawful obtaining of the substance, whether "cannabis" (that incudes seeds or clones), "fresh marihuana", "dried marihuana" or "cannabis oil".**

See the detailed discussion about this above in relation to the definitions. It appears but perhaps needs clarification that certainly existing *MMAR* Allard injunction patients or designated growers can continue to use the seeds and clones that they have been using and that new growers "may" obtain such starting materials from licensed producers, but are not compelled to do so. As indicated above, if the licensed producer pool is expanded and dispensaries made lawful then obtaining such seeds, clones and other propagation materials will not be a problem but otherwise it will. In a legal market, why not Richter's (www.richters.com) and others online or otherwise as they sell other seeds and plants purporting to have medicinal properties.

s.6 Possession Limits - this section purports to deal with possession limits in setting equivalencies setting out the 30 times the daily quantity provision, but making the limit the least of the amounts listed with the 150 g of dried marihuana in (d) that comes from the Allard injunction.

As submitted in greater detail below, this provision needs to be clarified to indicate that it does not affect the persons production storage allowance, nor possession storage allowance, as per their *MMAR* or *ACMPR* licences, but only applies when out and about from their residence and provision needs to be made for exceptions for those going on holidays or to work out of town, where they will need more than 150 g during the period away and the 30 day provision makes more sense and worked successfully in the early

days under the *MMAR* before the injunction that added this provision. Where is the evidence of a problem with the 30 day limit allowance to justify this 150 gm limit? This limit was found to impact section 6 Charter mobility rights of patients with higher doses and how it impacted their travel or when working out-of-town – **see *Garber v. Canada (Attorney General)*, 2015 BCSC 1797: http://www.courts.gov.bc.ca/jdb-txt/SC/15/17/2015BCSC1797.htm**

s.10 General Provisions – **Application of *Narcotic Control Regulations*** -this section speaks for itself, and should be read together with **Part 4** of these regulations – **Consequential Amendments** - that essentially amends s. 53 once again so that the practitioner can now only prescribe fresh or dried marihuana or cannabis oil **"received from a licensed producer**".

If this is limited to the existing relatively few licensed producers under the *ACMPR* then it will be a problem. However, if the ability to become an LP becomes much easier and less costly and includes "craft growers" and other forms of business organizations such as cooperatives and partnerships, so that the patient has a wider choice, then it will not be a problem –all legal sources will fall under the broad category of "licensed producers" and not just the large scale producers.

Currently, the problem is that these new regulations do not address the dispensary/compassion club situation and their growers, nor the problems identified in Allard with respect to the current LP process.

It appears that under the *ACMPR*, one can complete a "medical document" as per section 8. That is the same as the *MMPR* "medical document" or a section 53 *Narcotic Control Regulation* prescription/authorization equivalent and, if not proposing to produce for oneself or have a designated grower do so for one, then either document is redeemable by a "licensed producer". Possession is lawful pursuant to the "medical document" or "prescription/authorization" and that is the document that must be produced to a police officer on demand as proof that one is authorized as an exception to the general law. There is no requirement to register this document with the government, unless applying to produce for oneself and otherwise a record would be

kept by the licensed producer when supplied. Again, in a legal market, while a social user may be faced with other requirements, a medical patient would still require some form of “prescription” simply to indicate their medical as distinct from social situation, if important in the circumstances arising.

Part 2 - Production for Own Medical Purposes and Production by a Designated Person

A. **174(3) Prior Offences** - these provisions (a) through (b) (i) – (ii) appear to preclude a patient from producing for themselves as permitted under subsection (2) if within the preceding 10 years they have been convicted as an adult of a designated Cannabis offense… “that was committed while they were authorized to produce cannabis under the Act, other than under the former *MMAR*; or (b… that was committed while they were authorized to produce marihuana (i) under the Act, other than under these regulations or (ii), by virtue of an injunction order issued by a court.

It is not clear what this means. It appears to mean that if you were convicted of a designated Cannabis offence under the *CDSA* and not the *MMAR* nor these new regulations, which weren’t in effect in any event, but if you were grandfathered under the Allard injunction in relation to the *MMAR* and convicted of such an offense during that period, then you cannot continue to produce for yourself? At the end of the day does this simply mean that if you were convicted of such an offense while you were grandfathered by the injunction to continue under the *MMAR*, then you cannot grow again for yourself until 10 years of gone by? There was no such provision in the *MMAR*. What is the evidence in relation to this to warrant this limitation, not with respect to possession but self-production? Will this be necessary in a legal market? Will prior records not be extinguished?

B. **S.175 – person must not be registered more than once at any time**.

It appears that a person can continue to grow for 2 people and that there can be 4 licences in one place as per the old *MMAR*, as amended, as a result of court decisions

(**see s.184(b)and (c)).** Does this mean that you can only register for yourself and have to come back at a different time to register to grow for the other person? In other words, you can't simply come in and register for both at one time but have to make 2 attendances or applications? What is the rationale behind this rule? The continued need for these provisions again will depend upon what the new legal regime will look like.

C. **177(4)(a)** prohibiting production for one's own medical purposes if the patient has a conviction referred to in 174 (3) (a) or (b)

Does this require a "criminal record" CPIC check to accompany the application and all the delays that that entails? Subsection (5) (e) appears to expressly require such if you are applying to be a DG, but no similar provision appears under subsection (4). So a 'criminal record' is not a restriction to being a patient but producing for oneself if this section applies. It is important that it refers to a "criminal record" and not a "police information check" and patients should be cautioned not to consent to the latter, as it involves a search of all databases and will turn up all sorts of events that do not involve "convictions". With respect to court matters that are stayed or withdrawn please see my article entitled Prejudicial_Consequences_BCCLA12-Conroy.docx and with respect to the problems of the digital databases please see this recent article by Katherine Viner, Editor-in-Chief of the Guardian https://www.theguardian.com/media/2016/jul/12/how-technology-disrupted-the-truth?CMP=share_btn_link. Hopefully in a legal market, these prior records and data bases of all kinds in relation to cannabis will be extinguished or declared to be irrelevant.

D. **177(7) requiring consent of the owner** for the production of marihuana plants, but only if it is not the ordinary place of residence of the applicant or designated person and not owned by either of them.

So if you are not the owner, but you are ordinarily resident there, presumably as a tenant, you don't need the owner's consent? You only need to have consent if it is not the ordinary place of residence of the patient or DG? What is the rationale for the lack of consent requirement if you are a tenant? Owners do have an interest in what tenants'

do that might impact their interests. I do not suggest that it should be grounds for termination of the tenancy or that prohibition be a condition of the tenancy, but that owners have an interest in ensuring that local government rules with respect to fire and electrical safety and good production practices with respect to mold and odors are complied with to minimize the chances of damage to their property and upsetting the neighborhood. In a legal market presumably this would simply be a matter between the landlords and the tenants unless the production obviously is causing damage to the premises or causes a nuisance in the neighborhood, usually by smell that would bring in the local government inspectors. These considerations should apply to any medical or otherwise legal production facility.

E. 178(2)(f)(i) and (ii) limiting possession by the registered person to the lesser of 30 times the daily quantity of dried marihuana (as the old *MMAR* provided without any apparent problems) or 150 g of dried marihuana (that was imposed on patients by the Allard injunction).

It is my recollection that the justification for this limitation to 150 g, was imposed because of the concern expressed about patients being accosted and having their cannabis stolen. I cannot recall any evidence of any actual thefts having occurred, just an expression of fear of it possibly happening by the police. We sought to have this clarified several times with the Department of Justice and the Court without success. Confusion arises between this provision and the “storage” provision that allows patients or DG’s to possess more than that at their production or storage site. It complicates the situation for the DG who needs to ship to the patient so that he can continued to store an appropriate amount from the next crop and for the patient who may receive it at the post office and then may have to make multiple trips from the post office to their residence because they can’t carry more than 150g on them at a time in doing so. Further, this means when people go out of town to work for more than 2 weeks if they are a 3g a day patient and less if the dosage is greater, have to have somebody mail or otherwise deliver a further 150g to them when needed and that person doing the shipping would have to be authorized to possess or to assist the patient by doing so. Similar problems occur if a patient goes on holidays for more than 2 weeks, and in

some cases, it would preclude a patient from leaving their house for any significant period of time. Going back to the 30 day supply would solve the problem in the absence of any evidence of problems having occurred. I would submit that the 150g limit is not reasonable or at least that certain exceptions need to be made and the rule clarified. I assume section 187 (c) – (e) and 189 regarding DG's are designed to alleviate this problem, at least to get a supply to the production site or from the production site to the residence and between an old and a new site, but these latter provisions otherwise do not deal with the other problems arising with respect to the 150g possession limit. Presumably this limitation will no longer apply in a legal market as being unnecessary unless recreational/social purchasers are so limited as well. See the reference above to Garber where the BC Supreme Court found this limitation to violate the s.6 mobility rights of higher dosage patients.

F. **184 and 185 Grounds for Refusal** - these are the provisions with respect to the patient and DG's that appear to carry forward from the *MMAR* the limitation to growing for no more than 2 people and having no more than 4 licences at one site.

The history of the litigation in relation to those limitations involved the courts agreeing that limiting a person to grow for only one other person and only having 2 or 3 at one site were not reasonable limitations and the government's response was to allow production for 2 and to have 4 licences at one site. It is submitted that at least a DG growing for a Club like the BC Compassion Club Society should be able to obtain a licence to produce for the Club and its members so as to limit the number of production sites and designated growers required in such circumstances. Perhaps this can be dealt with under Part 1 Commercial Production to enable small and craft growers in relation to such clubs and/or legitimate dispensaries. See also section 197(2) regarding registrations in excess of 4 licences at a site. These provisions may have to be revisited in the context of a legal model with distinctions being made between production for medical purposes or for social/recreational purposes.

G. 188 permits a patient who has a DG to participate in the activities that the DG is authorized to conduct.

While this is an improvement for a patient who has a DG, allowing them to assist, provision needs to be made to allow others to assist patients producing for themselves or with the DG and not limit it to the patient. It is an offense under the Criminal Code of Canada to aid and abet or be a party to an offense but it is not an offense to assist somebody who is doing something lawful. Sometimes people need help from perhaps a spouse, relative, friend, or hired person, during the production to process the cannabis appropriately. Why can't there at least be a provision that a designated person or patient can designate others in writing to assist them during a certain event or period? The problem also arises when a patient wants to go on holidays and needs somebody to look after their production facility in their absence, or if they have to go and work out of town away from their production site. It is respectfully submitted that the patient or DG should be able to designate someone in writing for that temporary period. Presumably in a legal model anyone could assist the patient or otherwise lawful producer and these restrictions will be unnecessary.

H. 193(1)(c) - this is the limitation that **precludes** being able to cultivate, harvest or propagate **partly indoors and partly outdoors simultaneously**.

While this may work in some places in Canada it is difficult to understand the rationale for this limitation. Why can't a patient or DG start the seedlings are clones indoors and then move them at an appropriate time either into a green house or outdoors and certainly have them outdoors to maximize natural sunlight for as long as possible, reducing hydro costs, but then be able to bring them back indoors to finish them off to avoid the mold or mildew they would otherwise get from leaving them outdoors due to the heavy dew that can occur as early as mid-August in BC. What is the rationale for this rule and evidence to support it? Presumably it would not be necessary in a legal model.

I. 195(1) and (2) - these provisions essentially incorporate parts of sections **30 through 32 the Act** with respect to **inspections**, but preclude inspectors from

inspecting a dwelling house without consent and make no provision for them obtaining a warrant in the absence of consent.

These are the provisions in the *MMAR* that are thrown up as hurdles to inspection and enforcement by the police and others. I do not understand why the warrant requirement has been removed that existed in the *MMAR*. Persons who apply to make modifications to their residence or outbuilding are usually required by local government by laws or provincial fire, electrical safety regulations to apply for permits to have these things done and to allow for inspections to ensure that they have been done properly. It is not uncommon for a production site to emit an odor in the neighborhood and local government officials are contacted and should be able to attend and inspect and advise the producer on what to do to remedy this problem. In my submission the inspection process can be delegated to local government to ensure that patients or a DG producing in a residence or residential area in particular, and perhaps otherwise, have the power to ensure that local government bylaws and provincial safety regulations are being complied with to protect not only the residents and neighbors, but the owners if a tenancy situation. Producing cannabis under these regulations is a lawful activity and participants should be encouraged to comply with these laws and not take the shortcuts resulting in the various problems that occurred in the illicit grow op market. Reasonable notice should be required, and if reasonable grounds exist to believe that there are breaches ongoing and the owner/tenant will not consent, then the inspectors should be able to enter with an administrative warrant in my opinion, in the interests of all concerned. In my opinion, sections 31(1) through (5) of the Act should also apply at least until the legalization model is determined, and then maybe will no longer be necessary as local by laws and regulations will apply and provide for enforcement.

J. **S.199 and 200 - destruction** of cannabis by registered person or designated person.

It would be helpful to self-growing patients, in relation to the cost of production, that instead of destroying the excess they be permitted to sell it or donate it to a nonprofit society, such as a Compassion Club to assist them in providing access to cannabis for

medical purposes to those who cannot afford to produce for themselves or have someone do so for them, and either have no insurance or insufficient insurance. This assumes that the clubs would be licensed and that they could continue to have special programs for those who can't afford to purchase cannabis for themselves. Stories abound of patients who can't afford their prescribed drugs, even with insurance plans, and don't buy them and end up clogging up the emergency departments of hospitals simply because they can't afford their prescribed medication. If the patient is authorized to sell the excess to a Compassion Club or dispensary, that has to ensure it meets certain standards before being available to the public, this would also help patient producers in terms of lowering their production costs.

Conclusion

The bottom line is to ensure that medically approved patients have "reasonable access" to the amount of medication that they require for their medical condition as per the dosage set out in their "medical document".

The *ACMPR* process continues to permit patients to produce for themselves for affordability and control as well as therapeutic reasons or to have a designated person do so for them if they are unable to do so.

The majority of patients do not wish to grow for themselves or have a designated person do so for them. They want to be able to go to a store like a dispensary or Compassion Club where they can talk to somebody about the product and see what product information is available and recommended to alleviate different symptoms depending upon their condition. While some Compassion Clubs and Dispensaries have been doing this for a long time without any significant risk to the health of the patients and the public, nevertheless, in a legal regulated regime, they can expect certain legislated standards and requirements and perhaps certifications. The ability to test the product grown by the producer and to include that information on the packages and labels would be required. In relation to edibles the packages require a clear warning as to the long time before taking effect because it has to go through the digestive system, including the liver where it apparently gets approximately 4 times stronger then spreads

throughout the body in a totally different sensation to rapid onset smoking. As discussed, there is a need for there to be rules with respect to some packaging not being too attractive to children (persons under the age of 12). If an age limit has to be set with respect to the ability to purchase, what it is will in turn depend upon what approach is taken to those who violate the age limit and engage in possession, distribution, or even production outside the legal framework. Most importantly, the criminal law should not be used as the method of enforcement. If it is then the Senate recommendation that 16 years of age be the limit would be appropriate but if the criminal law is not used then a higher age limit, such as 18 for tobacco and used to define an "adult" in these regulations may be appropriate, with parental/guardian permission for use under that age for medical or otherwise. Some thought also needs to be given to providing for and the regulation of "online dispensaries" that service outlying areas where there are no dispensaries.

Apart from "homegrown production" for oneself or through a designated person the source of supply to the dispensaries/Compassion clubs under the *ACMPR* will be the "licenced producers", if dispensaries and clubs are addressed in these regulations or the new legal model. The cumbersome, lengthy and costly process endured by the current 34 such licenced producers that appears to be carried forward in **Part 1 Commercial Production** of the *ACMPR* needs to be reduced as unnecessary in a legal market and the doors need to be opened to "craft growers" and combinations thereof, whether by partnerships are cooperatives or other business arrangements to ensure a wide variety of options for the patient consumers. This may require significant amendments to **Part 1 Commercial Production and Part 3 the Transitional Provisions** between the *MMPR* and *ACMPR* regarding licensed producers.

As indicated above, provision should be made for patient growers or designated persons to sell or donate their excess product to Compassion clubs or dispensaries and if able to sell to thereby reduce their cost of production accordingly. It may be that some rules with respect to testing might be required as this would be entering the public market, but it should be remembered that this product has no lethal dose (LD50) and what we do with other fruits and vegetables that are homegrown and provided to

neighbors or friends or the public through local farmers markets do not require anything more than visual inspection and washing. It should also be remembered that many of the Compassion clubs and some of the dispensaries have been around for a long time, and some for only a couple of years and there do not appear to be any significant health or other safety issues arising from the way that the product they market has been grown, processed and distributed to date.

Making provision that cannabis is sufficiently recognized as a medicine to be covered by insurance plans that exist through government and/or the private sector without it having to be an “approved drug” with a DIN number and subject to zero taxation, unlike the social/recreational market, is desirable

For a further detailed discussion of the issues around the provision and supply of cannabis for medical purposes. I refer you to the paper **“Social and Medical Cannabis Issues: Past, Present and the Future’,** that I prepared and co-presented with Kirk Tousaw at the Canadian Bar Association, British Columbia Branch Conference in April 2016 at Whistler, BC at pages 19 through 26.

CBA Whistler #1 Presentation.pdf

The possession limits and plant counts placed on people in Washington State and their impaired driving presumptive non-rebuttable per se limit, clearly interferes with “reasonable access” by patients to the amounts that they need as determined between them and their doctors and fails to take into account that, unlike alcohol, the more cannabis one consumes as a chronic user the greater tolerance develops and the less likely that one’s ability to drive (motor coordination skills) are impaired and patients should at least be able to rebut the presumption. I hope this detailed critique and commentary will be of assistance to you.

John W. Conroy QC

APPENDIX A

Natural Health Products Regulations

SOR/2003-196

FOOD AND DRUGS ACT

Natural health product means **a substance set out in Schedule 1** or a combination of substances in which all the medicinal ingredients are substances set out in Schedule 1, a homeopathic medicine or a traditional medicine that is manufactured, sold or represented for use in

- **(a)** the diagnosis, treatment, mitigation or prevention of a disease, disorder or abnormal physical state or its symptoms in humans;
- **(b)** restoring or correcting organic functions in humans; or
- **(c)** modifying organic functions in humans, such as modifying those functions in a manner that maintains or promotes health.

However, a natural health product **does not include a substance set out in Schedule 2**, any combination of substances that includes a substance set out in Schedule 2 or a homeopathic medicine or a traditional medicine that is or includes a substance set out in Schedule 2. (produit de santé naturel)

SCHEDULE 1(Subsection 1(1))

INCLUDED NATURAL HEALTH PRODUCT SUBSTANCES

Item	Substances
1	A plant or a plant material, an alga, a bacterium, a fungus or a non-human animal material
2	An extract or isolate of a substance described in item 1, the primary molecular

Item	Substances
	structure of which is identical to that which it had prior to its extraction or isolation
3	Any of the following vitamins: • biotin • folate • niacin • pantothenic acid • riboflavin • thiamine • vitamin A • vitamin B_6 • vitamin B_{12} • vitamin C • vitamin D • vitamin E • vitamin K_1 • vitamin K_2
4	An amino acid
5	An essential fatty acid
6	A synthetic duplicate of a substance described in any of items 2 to 5
7	A mineral

Item	Substances
8	A probiotic

SCHEDULE 2(Subsection 1(1))

EXCLUDED NATURAL HEALTH PRODUCT SUBSTANCES

Item	Substances
1	A substance set out in Schedule C to the Act
2	A substance set out in Schedule D to the Act, except for the following: • **(a)** a drug that is prepared from any of the following micro-organisms, namely, an alga, a bacterium or a fungus; and • **(b)** any substance set out on Schedule D when it is prepared in accordance with the practices of homeopathic pharmacy
3	A substance regulated under the Tobacco Act
4	A substance set out in any of Schedules I to V of the Controlled Drugs and Substances Act
5	A substance that is administered by puncturing the dermis
6	An antibiotic prepared from an alga, a bacterium or a fungus or a synthetic duplicate of that antibiotic