Canadian AIDS Society  Société canadienne du sida

Background Paper to the Canadian AIDS Society's Position Statement on HIV/AIDS and the Therapeutic Use of Cannabis

1. Introduction

The Canadian AIDS Society believes that people living with HIV/AIDS should have access to cannabis for therapeutic [1] purposes in the treatment of HIV/AIDS through a compassionate framework (see **CAS' Position Statement**) Current access through Health Canada's program for medical access to marijuana is severely hindered by the medical community's reluctance to support the program and by the unduly restrictive application process. Measures must be taken to ensure that people living with HIV/AIDS have access to a safe, abundant supply of cannabis for therapeutic purposes without fear of prosecution.

2. Context

2.1 Cannabis

Cannabis is the plant that is more commonly known as "marijuana", "marihuana", "weed" or "pot", to name a few. Its flowering tops (buds) and leaves can be smoked, and its resin can be extracted to produce hashish. Cannabis is a psychotropic drug that modulates the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. The principal active ingredient of cannabis is delta-9-tétrahydrocannabinol, or THC. Other components such as delta-8-tétrahydrocannabinol, cannabinol and cannabidiol, may modulate the overall effects of cannabis[2].

2.2 Effects of Cannabis

Antiretroviral drug therapy has significantly improved the prognosis of AIDS, but has contributed serious side effects such as nausea and loss of appetite. The side effects lead to a person's difficulty in taking the required medication, and the loss of appetite can result in severe weight loss. In addition, people living with HIV/AIDS often live with chronic pain. Living with HIV/AIDS and with the side effects of medication can have an important negative impact on a person's mood and well-being. People living with HIV/AIDS often use cannabis to control nausea, increase appetite, promote weight gain, decrease pain and improve their mood.

---

[1] The term "therapeutic" is often used in this text instead of "medical", as cannabis is not an approved drug in Canada and the medical community is reluctant to support its use at this time. The word "therapeutic" better represents the use of cannabis as part of a person's therapy and care, instead of linking its use to the medical model.

[2] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

2.3 Prevalence of cannabis use in people living with HIV/AIDS

Though data on the prevalence of cannabis use are sparse, surveys reveal that about 23% of Canadians aged 15 years and over have consumed cannabis at least once in their lifetime. In addition, about 7.4% had done so in the 12 months preceding the survey in 1994[3]. It is often cited that there are approximately 400,000 Canadians currently using cannabis for therapeutic purposes. This estimate is based on one study conducted in Ontario that found that 1.9% of the population aged 18 years and over reported that they use marijuana for medical purposes[4]. This is most likely an underestimate. In British Columbia alone, it is estimated that about 7%, or 290,000 people, use cannabis for therapeutic purposes[5].

An increasing number of persons with HIV/AIDS are using cannabis to alleviate their symptoms. Reports from compassion clubs[6] in Canada estimate that 35% of their members are people living with HIV/AIDS who use cannabis to improve their quality of life[7]. Surveys reveal that approximately 28% of people living with HIV/AIDS report using cannabis, mainly to relieve anxiety and/or depression, increase appetite, gain weight, increase pleasure and relieve pain[8,9,10]. Cannabis has been extensively reported to alleviate nausea, stimulate appetite, reduce pain, and improve the mood of people living with HIV/AIDS, and research to this effect is mounting[11,11].

Cannabis is usually consumed in smoked form. For people concerned about the harmful effects of smoking, alternatives such as using a vaporizer may significantly reduce or eliminate toxic substances commonly found in smoked cannabis such as benzene, toluene, naphthalene, carbon monoxide and tars, thereby substantially reducing respiratory damage from smoking[12]. An oral form of synthetic THC (delta-9-tetrahydrocannabinol, cannabis' main active compound) is also available. Baked goods, sublingual sprays and other forms are also available in some compassion clubs.

---

[3] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

[4] Ogborne AC, Smart RG, Adlaf EM. *Self-reported medical use of marijuana: a survey of the general population*. Canadian Medical Association Journal, June 13, 2000;162(12):1685-1686.

[5] Robin O'Brien, Member of Health Canada's Stakeholder Advisory Committee on Medical Marihuana, Personal Communication, February 2004.

[6] Compassion clubs are non-for-profit organizations that provide cannabis to people with serious illnesses. They operate in the 'grey zone' of the law, as they are still illegal, though community support is strong as they provide a compassionate service.

[7] Black, Hilary. Founder and Co-Director, BC Compassion Club Society, Personal communication, March 30, 2004.

[8] Prentiss D, Power R, Balmas G, Tzuang G, Israelski DM. *Patterns of marijuana use among patients with HIV/AIDS followed in a public health care setting*. J Acquir Immune Defic Syndr, 2004 Jan 1; 35(1):38-45.

[9] Sidney S. *Marijuana Use in HIV-Positive and AIDS Patients: Results of an Anonymous Mail Survey*. In: Russo E. *Cannabis Therapeutics in HIV/AIDS*, 2001, New York, The Haworth Press, pp 35-41.

[10] Furler M, Walmsley S, Millson P, Einarson T, Bendayan R. *Medical Marijuana Use by Patients with HIV in Ontario*. Unpublished Abstract.

[11] World Health Organization. *Cannabis: a health perspective and research agenda*. 1997.

[12] Russo E (ed). *Cannabis Therapeutics in HIV/AIDS*. The Haworth Integrative Healing Press, Volume 1, Numbers 3/4 , 2001.

2.4 Research

The CAS Board of Directors position on the rights of people living with HIV/AIDS to access treatment that may provide some benefit makes it unnecessary to take a position on whether smoking cannabis has a proven clinical benefit or not. Scientific proof of clinical benefit should not be required to permit the compassionate use of cannabis by people living with HIV/AIDS. However, the CAS Board of Directors supports the need for more clinical studies on all of the active ingredients in cannabis and their effects on health. The CAS Board of Directors strongly supports the development of a Canadian research agenda on cannabis.

Health Canada must expand its research agenda and funding to include compassion societies and university partnerships. This is supported by the Senate Special Committee on Illegal Drugs which states[13]:

- Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs
- The studies that have already been approved by Health Canada must be conducted as quickly as possible.
- The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards.

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

3. Access to Medical Marijuana in Canada

In Canada, cannabis is a controlled substance subject to the *Controlled Drugs and Substances Act (CDSA)*, which prohibits possession, cultivation, trafficking, possession for the purpose of trafficking, importation, and exportation. An exemption can be granted under section 56 of the CDSA for medical or scientific purposes. No notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of cannabis as a drug.

In May 1999, on an interim basis, Health Canada established a process enabling Canadians to apply for an exemption to possess and cultivate cannabis for therapeutic purposes under section 56 of the CDSA, in response to growing demand for access to cannabis and to challenges to the *Canadian Charter of Rights and Freedoms.*

[13] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

3.1 The Marihuana Medical Access Regulations

In 2001, Health Canada introduced the *Marihuana Medical Access Regulations (MMAR)*[14] to enable compassionate access to marijuana for people who are suffering from serious illnesses. The MMAR consist of the Authorization to Possess, an Applicant's Declaration, a Medical Declaration in Part 1. Part 2 consists of either a personal or designated persons' License to Produce. Part 3 addresses Obligations Concerning Documents and Revocation. Part 4 covers the supply by a medical practitioner.

CAS is a member of Health Canada's Stakeholder Advisory Committee on Medical Marihuana. The Committee recently conducted a regulatory review of the MMAR to address some of the concerns that had been expressed by various stakeholders. It should be noted that the Advisory Committee does not currently include a representative from Canada's compassion clubs, despite the Senate Special Committee on Illegal Drugs[15] that states:

- Ensure that the advisory committee on the therapeutic use of cannabis represents all players, including distribution centres and users.

The proposed amendments to the MMAR will be published in the Canada Gazette in the spring of 2004, with a 30-day period for comments. The new MMAR will be in effect sometime in the fall of 2004.

For more information about the MMAR, please visit Health Canada's website[16]. The application package is available[17]. To receive the package by mail, call Health Canada toll-free at 1-866-337-7705.

3.1.1 Categories of Symptoms

There are currently 3 categories of symptoms for which people can apply for authorization to possess and/or license to grow. Category 1 covers terminal illness. Category 2 covers symptoms of cancer or HIV/AIDS such as severe nausea, cachexia (weight loss), anorexia (loss of appetite/inability to eat), persistent muscle spasms due to multiple sclerosis, spinal cord injury or disease, epileptic seizures, and severe pain from cancer, HIV/AIDS, multiple sclerosis, spinal cord injury or disease, or a severe form of arthritis. Category 1 requires the signature of a physician. Category 2 requires the signature of a specialist, and Category 3 requires the confirmation from a second specialist. This model was deemed unnecessarily complex and too prescriptive in terms of medical assessment. To address these issues, there will now be only two categories. The new Category 1 will include all compassionate end-of-life care (former Category 1 for terminal illness), as well as the symptoms currently included in Category 2.

---

[14] Health Canada. *Marihuana Medical Access Regulations.* June 15, 2001. Available at: <http://www.hc-sc.gc.ca/hecs-sesc/controlled_substances/pdf/regulations/marihuana_06-13-01.pdf>.
[15] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.
[16] http://www.hc-sc.gc.ca/hecs-sesc/controlled_substances/pdf/regulations/marihuana_06-13-01.pdf
[17] www.hc-sc.gc.ca/hecs-sesc/ocma/index.htm

The new Category 2 will be for other medical conditions or symptoms not covered under the new Category 1. A physician's signature will be required for Category 1, and will be accepted for Category 2 provided the patient's case has been assessed by a specialist.

3.1.2 Applicant Declaration

The applicant declaration states that the applicant is aware that no notice of compliance has been issued under the Food and Drugs Act concerning the safety and effectiveness of cannabis as a drug, and that the risks and benefits associated with the use of cannabis for medical purposes are not fully understood. The new MMAR will place more emphasis on the patient's responsibility in choosing to use cannabis for therapeutic purposes and that this decision has been discussed with the physician. The language of the declaration will be simpler and will reflect an informed consent.

3.1.3 Medical Declaration

Physicians will no longer be required to sign a declaration that states that they recommend cannabis for their patient's symptom relief. They must now attest that conventional treatments for the symptom have been tried or considered and have been found to be medically inappropriate or ineffective for the treatment of the applicant, and that they are aware that no notice of compliance has been issued regarding the safety and effectiveness of cannabis as a drug. They must identify the maximum quantity of dried cannabis to be authorized, the daily amount, and the form or route of administration that the applicant intends to use.

3.1.4 Renewal of Authorization

Authorization is valid for one year or less, as specified by the physician. Renewals will no longer require filling out the complete application once again. The patient and medical practitioner will now be required to sign a form that states that there are no changes to the applicant's situation, if applicable. The validity period of photo identification will be extended from 2 years to 5 years.

3.1.5 Disclosure to Police

Under the current regulations, consent has to be given in order to disclose information about exemptees/authorized persons[18] to the police. In the proposed amendments to the MMAR, consent will be implied upon application. It should be noted that information will only be provided to the police as needed, in response to a specific request to verify the validity of someone's authorization. The database will remain under the possession and responsibility of Health Canada.

3.1.6 Communication with Applicant's Physician

Under the current regulations consent must be given by the applicant in order for Health Canada to communicate with the person's physician. Under the proposed amendments, authorization to communicate with the physician will be implied upon application to clarify the information provided on the application form.

[18] Exemptees are covered under section 56 of the Controlled Drug and Substances Act, as they applied before the creation of the MMAR Authorized persons are authorized under the MMAR.

3.2 Limitations of the MMAR

Despite the creation of the MMAR to provide access to medical marijuana, there are still many barriers to access marijuana for therapeutic purposes. The Senate Special Committee on Illegal Drugs eluded to the program's limitations[19]:

> "*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. After careful review of the MMAR and thorough consideration of the evidence submitted to us, it is apparent that the MMAR have become a barrier to access. Rather than providing a compassionate framework, the regulations are unduly restricting the availability of cannabis to those who may receive health benefits from its use." (p.308)*

3.2.1 Reluctance of the Medical Community

The most difficult hurdle for people living with HIV/AIDS to overcome is to find a physician that is willing to sign the request for authorization forms. The medical community has been reluctant to support the MMAR program as they feel there is a lack of scientific evidence on the risks and benefits of cannabis to support its use. Cannabis is not an approved drug product. They are also concerned with the use of smoked marijuana and do not accept this form of administration. Their responsibility to support the use of cannabis for medical purposes may be in conflict with their profession's role related to unapproved or alternative medicines. Medical organizations such as the Canadian Medical Association, the Canadian Medical Protective Association, and the 'Collège des médecins du Québec' have issued statements to their members about their concerns and reservations to support such a program. As a result, many physicians do not support their patients' applications for fear of retribution from their professional bodies.

3.2.2 Barriers in Finding a Supportive Physician

Health Canada does not provide a list of supportive physicians or specialists, due to confidentiality. Patients rely on word of mouth and referrals from others who may have been successful with their applications. People who may not be connected with authorized persons or who live in remote areas have a greater difficulty in finding a supportive physician.

3.2.3 Barriers in the Processing of Applications

There have been many concerns expressed regarding the application forms and the amount of time it takes to complete them. The amendments to the MMAR have addressed some of those concerns. For example, physicians will no longer be required to list the details of all treatments that they have tried or considered before cannabis.

---

[19] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

The renewal process will also be greatly simplified, requiring only to tick a box that states that there have been no changes in the patient's situation. The renewal form still requires a signature from both the patient and the physician. The renewal process is currently long and some authorized persons have expressed high levels of anxiety and worsening of their symptoms during the waiting period. The MMAR process is inherently long and challenging for some applicants.

3.2.4 Barriers in Accessing Cannabis

Once a person has been approved and is now authorized to possess and/or cultivate cannabis, there are still barriers to obtaining a stable, safe, good quality supply of cannabis. Authorized persons have the option of growing their own if they applied for a license, obtaining a designated grower, or ordering the government-produced cannabis.

Financial considerations are a big obstacle for many people living with HIV/AIDS. Growing their own cannabis requires equipment to set up, the facilities to do so, and the expertise to get a good product and a stable crop. There is currently **no compensation**, either through medical insurance, provincial health insurance or income tax credits, for any of these expenses.

The Senate Special Committee on Illegal Drugs suggests the following, though this is still not in place:

- Ensure that expenses relating to the use of cannabis for therapeutic purposes will be eligible for a medical expenses tax credit

In addition, if an insurance company discovers that a property owner is growing cannabis, they revoke the house insurance, leaving the person with **no insurance coverage** in case of theft, fire, or loss of crop.

A **designated grower may be difficult to find**, and usually requires tapping into the street market. The authorized person can buy from their designated grower, though designated growers can only grow for one authorized person despite court challenges. Authorized persons often seek other sources such as the street market, which may charge more for their product. This renders the authorized person vulnerable to the unknown product they obtain, to having to pay whatever the street value of cannabis is, and to the inherent risks of dealing with the street market. They must also live with the fear of prosecution, even when authorized.

An authorized person may choose to obtain cannabis from a **local compassion club.** These clubs are usually operated by people who have a certain expertise when it comes to cannabis, and their prices are usually as low as they can offer on compassionate grounds. Some compassion clubs are very well established and provide not only good quality cannabis but education on how to consume cannabis, and other health-related services. Some offer a variety of products, from cannabis to tinctures, baked goods, sublingual sprays, and they often sell vaporizers and other paraphernalia to offer delivery options. A compassion club also offers a social environment, which may contribute to expanding one's social support network and contribute to their well-being. The compassion clubs are still technically illegal, though they often operate in a 'grey zone' of the law as they collaborate with the surrounding community and law enforcement.

There have been reports of creative ways to obtain cannabis. Some medicinal users have started forming their own **networks to produce marijuana collectively**. The surplus of crops is often donated to others. This system helps them share the cost and responsibility for the crops, although they are doing this at their own risk of prosecution. This type of situation could be avoided with better access to medical marijuana.

Finally, an authorized person may order **cannabis from Prairie Plant Systems Inc**. (PPS), the company contracted by Health Canada to cultivate and produce a supply of standardized cannabis. There have been concerns expressed regarding the quality of the product produced by PPS. First, PPS grinds not only the flowering buds of the cannabis plants, but the leaves and stems as well. This results in a mixture that contains twigs, which contribute to a foul taste and is difficult to roll to smoke it. PPS claims that the THC level of their cannabis is standardized at 10%, although independent lab tests have showed that THC levels may be around 5%[20]. The PPS product is finely ground, which also limits its use. For example, if someone wants to use a vaporizer to minimize the hazards of inhaling combustion by-products, it is difficult to use the PPS product as the bowl in the vaporizer contains holes through which finely ground cannabis can trickle. The numbers reveal that PPS is not the authorized persons' first choice. As of February 6, 2004, there were 717 people authorized to possess cannabis, and only 63 of them currently obtain their cannabis from PPS[21]. In addition, about 30% of people who have ordered the PPS product have sent it back[19].

3.3 Use of Health Canada's Program

Are people using the program? It is often cited that there are approximately 400,000 Canadians, and this may be an underestimate as reported earlier as there may be 290,000 medical users in British Columbia alone (see section on Prevalence of Cannabis Use). Compassion clubs across Canada report that they serve approximately 7000 therapeutic users, while Health Canada has issued 717 licenses. We can conclude that the vast majority of people who use cannabis for therapeutic purposes obtain cannabis through their own source, illegally for the most part.

---

[20] Vancouver Island Compassion Society. *VICS Newsletter*. Volume 1, Issue 9, May 2004.
[21] Health Canada, Office of Cannabis Medical Access. *Marihuana for Medical Purposes – Statistics.* February 6, 2004. Available at <www.hc-sc.gc.ca/hecs-sesc/ocma/stats/2004/feb/stats_feb-04.htm>.

3.4 Phasing Out of Licenses to Produce

Health Canada currently plans on phasing out the issuance of licenses to grow by the year 2007. They plan on being the sole supplier of cannabis for all therapeutic users. They are exploring the feasibility of distribution of cannabis through pharmacies, and plans are underway for a pilot project in a pharmacy in British Columbia. If cannabis is made available through Canadian pharmacies, Health Canada claims that licenses to grow will no longer be necessary.

CAS has concerns about this long-term vision as the current product produced under contract for Health Canada has not been well received. Prairie Plant Systems has heard the concerns expressed by CAS and by several therapeutic users. PPS have plans to improve their product, and are considering providing buds to authorized persons. However, they are not considering producing other strains of cannabis. Therapeutic users claim that certain strains of cannabis are better at relieving specific symptoms. Anecdotal evidence and extensive experience in compassion clubs suggest that the cannabis sativa strain is best for stimulating, uplifting, energizing and creativity enhancing effects, while the cannabis indica strain is best for relaxing, sedating, and pain reducing. Many hybrids of these strains exist, and are usually sativa-dominant or indica-dominant. More research is needed to acquire scientific evidence of the specific effects of strains. It is however common for therapeutic users to find a strain that works best for them, after some trial and error. There is also the issue of potency, or the level of THC in cannabis. A higher potency means that less cannabis is required to achieve the same effect. PPS' product claims a THC level of 10%. The Netherlands currently offer cannabis through pharmacies. They offer two strains – Bedrocan, which contains 18% THC, and SIMM 18, which contains 15% THC[22].

If the plan is to only make one strain available, and no longer allow people to grow their own, they may no longer have access to the therapy of their choice, or will be forced to obtain it from other sources. Authorized persons have expressed their concerns to CAS regarding their fear of police surveillance and prosecution once their license is not renewed.

CAS is also concerned about PPS' chosen site to grow cannabis. Though they do adhere to agricultural standards, the physical location of the site has raised concerns, as the cannabis is grown in a mine shaft. Even with PPS' reassurance that the space is sealed and that the product is standardized and rigorously tested for cannabinoid levels and for toxic substances, the risk perception is prevalent and support for the PPS product is low. CAS feels that people living with HIV/AIDS should have a choice as to the product they want to consume, and should have access to a safe, affordable, and fresh source qith an organic option. A certified organic source of cannabis provides extra reassurance to people living with HIV/AIDS who have a compromised immune system.

[22] Scholten WK. *Medicinal cannabis now available in the Netherlands.* Article submitted to Health Canada's Stakeholder Advisory Committee on Medical Marihuana, October 7, 2003.

3.5 Proposal for a Distribution Model

CAS has concerns that the current distribution model by Health Canada is not enabling access to therapeutic users of cannabis.

3.5.1 Role of Pharmacies

CAS supports the pilot project for distribution in a pharmacy in British Columbia and hopes that this project will extend into pharmacies across Canada. It is CAS' hope that Health Canada will provide a few varieties of cannabis strains, with an option for an organic source. CAS also encourages Health Canada to extend growing contracts to a variety of growers that currently have years of experience and expertise. This will ensure an abundant supply of a variety of strains, and will enable people living with HIV/AIDS to choose the source that works best for them.

3.5.2 Role of Compassion Clubs

In addition to the pharmacy model, CAS supports the inclusion of compassion club in a distribution model for cannabis, as dedicated cannabis distribution centres.

Health Canada does not recognize compassion clubs, and compassion clubs currently do not have a voice on Health Canada's Advisory Committee. Compassion clubs operate in the "grey zone" of the law. They have the support of the public, communities, the courts, the Senate Special Committee on Illegal Drugs, community organizations, and even law enforcers in some areas. The Senate Special Committee on Illegal Drugs[23] states:

- 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.

Compassion clubs currently serve approximately 7000 people with various illnesses, 35% of whom have HIV/AIDS[24]. More than 350 of Health Canada's authorized/exempted persons currently frequent compassion clubs to obtain their cannabis[22]. In addition, clubs can provide education regarding the use of cannabis, and a social support network. The clubs offer a variety of products. They encourage self-sufficiency by selling clones of any of their strains, and offer cultivation expertise and advice. They sometimes have other services such as massage and alternative therapies. They host meetings and presentations. They have donation programs when available and conduct public outreach, which includes working with the local medical community. After such outreach, many physicians refer their patients to the clubs. They provide education on the safety and efficacy of cannabis. They even welcome students for practicums[25].

---

[23] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

[24] Hilary Black. Founder and Co-Director, BC Compassion Club Society, Personal communication, March 30, 2004.

[25] The Vancouver Island Compassion Society (VICS) is receiving a nursing student who is actually getting university credit for working at the VICS.

Their inclusion into a cannabis distribution model makes sense. Tapping into existing resources is cost-effective. Some clubs are registered non-profit organizations and have to follow clear guidelines of behaviour and accountability. Canada's most established and largest compassion club, the British Columbia Compassion Club Society, has developed operational standards for the distribution of cannabis[26], which could easily be used to standardized compassion clubs across Canada. The quality of compassion clubs currently varies throughout the country, and recognizing them as designated cannabis distribution centres and including them in the distribution model would legitimize their services and raise their level of quality. People living with HIV/AIDS should be allowed to obtain cannabis in a safe place without police harassment or criminal prosecution.

3.6 Effect of Phasing Out Licenses to Produce

An important part of a cannabis distribution model includes an abundant, reliable, safe supply of cannabis. Health Canada plans to phase out licenses to grow, for both authorized persons and designated growers. This plan will force authorized persons to go underground or to obtain their cannabis from Prairie Plans Systems, currently the only contracted source for Health Canada.

People with HIV/AIDS that currently grow their own cannabis or that obtain it from their designated grower have had to invest an initial amount of money to get set up, and to develop a steady, reliable supply of the cannabis of their choice. CAS suggests that these people be allowed to continue to be self-sufficient for their supply of cannabis.

In addition, CAS proposes that Health Canada put out a call for tender for various contractors to be included in Canada's supply of cannabis for therapeutic purposes. This would enable the experienced, established medical marijuana growers to be involved, including established certified organic growers. The growers, however, have some issues with bidding on such a tender. They don't want to be limited by THC limits and the medical model, they don't want to gamma-irradiate their product (as PPS does) and want to grow organically. A workable solution would need to be negotiated.

4. Stigma and Discrimination

To this day, people living with HIV/AIDS are subjected to stigma and discrimination due to fear and misunderstanding about HIV and AIDS. The epidemic in Canada often affects people that are already marginalized in other ways, such as gay and bisexual men, transgender people, injection drug users, aboriginal people, sex workers and prisoners. The disease, however, does not discriminate and affects anyone who is exposed to it – women, heterosexual men, children, youth.

[26] British Columbia Compassion Club Society. *Operational Standards for the Distribution of Medicinal Cannabis.* 2003.

Stigma and discrimination against people living with HIV/AIDS appears in many forms, from lack of resources and systemic neglect restrictive assessments of disability, disclosure of their HIV status, discrimination in the workplace, inequitable access to therapies, and failure to observe guidelines with regard to informed choice in HIV testing and treatment[27]. People living with HIV/AIDS can be at a cultural disadvantage due to others' fear of differences and intolerance, may be living in poverty, may be on disability, and may also be isolated. They may be subjected to homophobia and racism.

A person living with HIV/AIDS who chooses to integrated marijuana into their treatment and care will also be associated with the drug culture and be subjected to the stigma that comes with that. Marijuana users can be seen as drug addicts, unmotivated "potheads", and criminals.

The information provided to the general public regarding marijuana is often biased, with some exaggerating the risks, and others celebrating it as a magical herb. Coverage in the media is usually related to police operations showing raids, seizures and dealer arrests. Scientific information is sparse, though growing. The medical profession has strong reservations about using cannabis for therapeutic purposes, especially in smoked form.

It has been reported that some people living with HIV/AIDS are even concerned about disclosing their HIV status to their health care professionals for fear of receiving less-than-optimum health care[28]. Approaching the subject of marijuana for therapeutic purposes with their physician is often very difficult, as time with a physician is limited during a visit and they fear their physician's reaction.

Finally, even with their physician's support and authorization from Health Canada's MMAR program, people living with HIV/AIDS make decisions regarding their treatment based on the availability of sufficient income, government funding, or insurance coverage for the medications, to the degree of social support that is available to people, and to their geographic location[29]. There is currently no government funding or insurance coverage for medical marijuana, and people in remote locations may have difficulty finding a supply.

CAS strongly supports the development of measures to minimize stigma and discrimination against people living with HIV/AIDS who choose to use marijuana as part of their treatment and care. CAS strongly urges that public education campaigns be developed to educate and raise awareness regarding cannabis as a therapeutic product. Health professionals also need to be aware and gain knowledge regarding the compassionate use of cannabis for therapeutic purposes.

---

[27] Canadian HIV/AIDS Legal Network, Canadian AIDS Society. *HIV/AIDS and Discrimination: A Discussion Paper*. Prepared by Theodore de Bruyn, March 1998.
[28] Canadian Treatment Action Council. Newsletter, Volume 6, Issue 1, March 2004.
[29] Cain R. *Thinking about Treatments*. Canadian Treatment Action Council.Newsletter, Volume 6, Issue 1, March 2004.

5. Alternatives to Facilitate Access to Cannabis for Therapeutic Purposes

5.1 Changes to the MMAR Application Process

The CAS Board of Directors acknowledges that the MMAR is meant to provide access to people for therapeutic purposes "legally", although the implementation of such a program has been challenging and most therapeutic users must still rely on illicit sources. The CAS Board of Directors feels that this approach is not in the best interest of people living with HIV/AIDS (and Canadians in general).

Why force physicians into a program they are not comfortable participating in? Health Canada currently requires a physician's signature on the authorization forms to access the medical marijuana program. CAS proposes that a physician's diagnosis and a patient's completion of the forms should suffice to obtain authorization to possess and/or grow cannabis. Physicians are not comfortable signing the authorization forms as their professional bodies do not support them. The new proposed forms, as per the MMAR, have been amended so that the responsibility to choose cannabis as a therapeutic product falls mostly on the patient. Physicians must still attest that conventional treatments for the symptom have been tried or considered and have been found to be medically inappropriate or ineffective for the treatment of the applicant, and that they are aware that no notice of compliance has been issued regarding the safety and effectiveness of cannabis as a drug. They must identify the maximum quantity of dried cannabis to be authorized, the daily amount, and the form or route of administration that the applicant intends to use. It is understandable that physicians will have reservations about signing these forms. Health Canada has a list of illnesses for which they approve access to medicinal marijuana. Physicians diagnose their patients' illnesses. Proof of diagnosis should suffice to authorize the use of cannabis for therapeutic purposes.
Compassion clubs are currently requiring a diagnosis from a health professional to distribute cannabis, including health practitioners most experienced with herbal medicine. Pharmacies could adopt the same model. Patients could then present themselves at a pharmacy or a compassion club and obtain cannabis. Health Canada can play a role in ensuring that the process is standardized. Health Canada can supply pharmacies and compassion clubs with a list of illnesses for which cannabis can be distributed for therapeutic purposes.

5.2 Decriminalization

CAS views drug use in general as a health and social issue rather than as a criminal issue. The CAS Board of Directors supports a re-examination of Canada's drug laws and policies within the framework of substance use as a health and social issue (see position statement on **Drug Laws and HIV/AIDS**).

Decriminalization removes a behaviour or activity from the scope of the criminal justice system, either by amending the criminal legislation (*de jure*) or by not prosecuting acts that remain against the law (*de facto*)[30].

[30] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

Bill C-10, a decriminalization Act to amend the *Contraventions Act* and the *Controlled Drugs and Substances Act*, is still awaiting a final vote in the House of Commons. The election on June 28th, 2004 may change the course of this Bill. The proposed Bill would allow fines for small amounts of cannabis possession, from $100 to $500 for amounts under 15 grams of cannabis or 1 gram of resin (hashish), and a cultivation fine of $500 for 3 plants or less. Current law enforcement practices are such that possession and cultivation of small amounts of cannabis may result only in confiscation, with no criminal charge. In 1997, for example, about 60% of possession offenses lead to prosecution, and this number is falling[28]. While the proposed Bill may help some Canadians who would otherwise face criminal charges, it would result in a greater number of Canadians, including people living with HIV/AIDS who use cannabis for therapeutic purposes, being punished by fine. In addition, cultivators of over 50 plants will face double the punishment, up to 14 years imprisonment, under the proposed Bill. This possible sentence is greater than for some violent crimes.

The Senate Special Committee on Illegal Drugs commented on decriminalization as an approach:

> "[Decriminalization] is in fact the worst-case scenario, depriving the State of a regulatory tool needed in dealing with the entire production, distribution, and consumption network, and delivering a rather hypocritical message at the same time". (p.598)

Bill C-10 has been met with some resistance by community groups advocating for access to medical marijuana. They are concerned that the fine scale proposed in Bill C-10 discriminates against low-income Canadians[31]. The Senate Special Committee on Illegal Drugs agrees, and adds that a young or disadvantaged person that is unable to pay the fine may face a greater risk of imprisonment than a more affluent person. The CAS Board of Directors shares these concerns as most people living with HIV/AIDS who choose to use cannabis for therapeutic purposes would be affected by these changes, as they continue to obtain cannabis illegally due to the difficulties in accessing the government's medical marijuana access program. The decriminalization bill only perpetuates the prohibition of marijuana and maintains the illegal market.

5.3 Controlled Legalization and Regulation

The AIDS movement has been at the forefront of harm reduction approaches to drug use introduced in the twentieth century. Prohibitionist policies have had little impact on levels of drug use or on the availability of drugs[32,33,34]. Instead, current laws have made

---

[31] Canadian Cannabis Coalition. *Reaction to Canada's New Marijuana Laws*. Cannabis Health, May/June 2004; 2(4): 19-20.
[32] Reuband K. *Drug use and drug policy in Western Europe.* European Addiction Research, 1995;1:32-41.
[33] Cesoni LL. « *Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'incrimination. Analyse comparative de l'usage de drogues illicites de sept législations européennes* ». In : Conseil fédéral suisse, « *Message concernant la révision de la loi sur les stupéfiants* ». 2001
[34] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.

criminals out of many Canadians, including people who use cannabis for therapeutic purposes.

Public policy regarding cannabis must be based on public health considerations and harm reduction approaches, encouraging cannabis users to assume more responsibility and providing information and emphasizing the ability to make an informed choice.

The CAS Board of Directors recognizes that drug use has social and economic costs such as lower productivity and business loss, hospitalizations, medical treatments, disrupted lives, and deaths. Under a prohibitionist framework, police costs and prison costs are added to those costs. Cannabis, however, has been associated with less social and health costs than alcohol or tobacco. The Senate Special Committee on Illegal Drugs goes even further by stating: "In fact, more than any other illegal drug, we can safely state that its criminalization is the principal source of social and economic costs." (p.582)

The CAS Board of Directors also feels that policy and law should reflect the public attitudes and opinions. Public opinion[35] regarding marijuana is more liberal now than 10 years ago. The public does not view marijuana as a dangerous drug, and strongly support its use for therapeutic purposes. The public is, however, concerned about organized crime, and also about use among children and youth.

The CAS Board of Directors favours a controlled legalization system for cannabis in Canada, where the production, distribution and consumption are regulated. There is currently no such system in the world for cannabis. This type of system already exists for alcohol, tobacco and psychotropic medications in Canada. Establishments such as compassion clubs and pharmacies would be regulated as designated cannabis distribution centres and would have to meet operational standards for the distribution of cannabis. Appropriate prevention messages and harm reduction strategies could accompany such a system to ensure that the population has the tools to make informed choices about cannabis.

The CAS Board of Directors recognizes that Canada must respect its international obligations under current conventions. However the CAS Board of Directors encourages Canadian officials to officially request the declassification of cannabis and its derivatives from the international conventions as part of a public health approach, while including rigorous monitoring and evaluation of cannabis distribution in Canada.

[35] Nolin, P.C.; Kenny, C. *Cannabis: Our Position for a Canadian Public Policy. Report of the Senate Special Committee on Illegal Drugs.* September 2002.