



Policy commentary

Medical Marijuana programs: Implications for cannabis control policy – Observations from Canada



Benedikt Fischer^{a,b,c,*}, Sharan Kuganesan^b, Robin Room^{d,e,f}

^a Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University, 2400 – 515 West Hastings St., Vancouver, Canada V6B 5K3

^b Social & Epidemiological Research Department, Centre for Addiction and Mental Health, 33 Russell St., Toronto, Canada M5S 2S1

^c Department of Psychiatry, University of Toronto, 250 College St., Toronto, Canada M5T 1R8

^d Centre for Alcohol Policy Research, Turning Point, Fitzroy, Victoria 3065, Australia

^e Melbourne School of Population and Global Health, University of Melbourne, 207 Bouverie Street, Victoria 3010, Australia

^f Centre for Social Research on Alcohol & Drugs, Stockholm University, SE-106 91 Stockholm, Sweden

ARTICLE INFO

Article history:

Received 11 August 2014

Received in revised form

12 September 2014

Accepted 13 September 2014

Keywords:

Medical marijuana

Canada

Cannabis control

Medicalization

Policy

ABSTRACT

While prohibition has been the dominant regime of cannabis control in most countries for decades, an increasing number of countries have been implementing cannabis control reforms recently, including decriminalization or even legalization frameworks. Canada has held out from this trend, although it has among the highest cannabis use rates in the world. Cannabis use is universally criminalized, and the current (conservative) federal government has vowed not to implement any softening reforms to cannabis control. As a result of several higher court decisions, the then federal government was forced to implement a 'medical marijuana access regulations' program in 2001 to allow severely ill patients therapeutic use and access to therapeutic cannabis while shielding them from prosecution. The program's regulations and approval processes were complex and subject to extensive criticism; initial uptake was low and most medical marijuana users continued their use and supply outside the program's auspices. This year, the government introduced new 'marijuana for medical purposes regulations', which allow physicians to 'authorize' medical marijuana use for virtually any health condition for which this is considered beneficial; supply is facilitated by licensed commercial producers. It is expected that some 500,000 users, and dozens of commercial producers will soon be approved under the program, arguably constituting – as with medical marijuana schemes elsewhere, e.g. in California – de facto 'legalization'. We discuss the question whether the evolving scope and realities of 'medical cannabis' provisions in Canada offer a 'sneaky side door' or a 'better third way' to cannabis control reform, and what the potential wider implications are of these developments.

© 2014 Published by Elsevier B.V.

Introduction

In many jurisdictions around the world, cannabis control and policy are subject to intensive current debate. These debates relate to the general control of cannabis for 'recreational' purposes, but also increasingly to provisions for 'medical cannabis' use, i.e., the use of cannabis for therapeutic purposes. While these are generally examined as two separate matters, few analyses have examined the interactive potential or implications of developments in these

arenas for cannabis policy reform overall. In the below, we do exactly this, based on recent developments in Canada.

Cannabis control: history

Cannabis became included in the scope of international drug control in 1925, and total criminal prohibition – even for personal (i.e., non-scientific or -medical) use – as dictated by the international treaties since the 1961 Convention has been the control framework of choice in most industrialized countries (European Monitoring Centre for Drugs and Drug Addiction, 2008; Levine, 2003; Room, Fischer, Hall, Lenton, & Reuter, 2010). Pushes to reform prohibition as the main control mode are almost as old as prohibition itself, yet gained in variety and vigour since the 1970s, as, for example, triggered by national drug policy commission or

* Corresponding author at: Centre for Applied Research in Mental Health and Addictions (CARMHA), Faculty of Health Sciences, Simon Fraser University, 2400 – 515 W Hasting St., Vancouver V6B 5K3, Canada. Tel.: +1 778 782 5148; fax: +1 778 782 7768.

E-mail address: bfischer@sfu.ca (B. Fischer).

inquiries (e.g., in Europe, North America and Australia) (EMCDDA, 2008; Room et al., 2010). In subsequent years, well-known cannabis reform efforts occurred in the Netherlands, as well as several US and Australian states, largely implementing different versions of 'decriminalization' regimes of recreational cannabis use, based on changes in either law ('de jure') or enforcement practice ('de facto') (Hall, 2001; Korf, 2002; MacCoun & Reuter, 2001; NORML, 2014; Single, Christie, & Ali, 2000). The extent and momentum of international cannabis control reform appear to have culminated in new peaks in the recent present. Several jurisdictions – including Uruguay and the two US states Colorado and Washington – have approved the implementation of 'legalization' regimes, including both legal use and supply/distribution frameworks for recreational use (Room, 2014); other jurisdictions in Europe and Latin America (e.g., Germany, Belgium, Spain, Portugal, Argentina, Colombia, Jamaica) have or are in the process of moving towards liberalizing their cannabis control regimes (Hawken, Caulkins, Kilmer, & Kleiman, 2013; Pudney, Adda, & Boone, 2010; Room et al., 2010; Room, 2014; Van Ours, 2012).

Canada features a distinct national profile regarding cannabis use, control and reform efforts. Cannabis was added to the Canadian drug prohibition law in 1923, defining any use (by way of use-related acts, i.e. 'simple possession') as well as production/supply as criminal offenses (Giffen, Endicott, & Lambert, 1991). In the 1960s, cannabis users became drug law enforcement's primary target, suddenly resulting in thousands of criminal arrests each year (Boyd, 1991; Bryan, 1979). The ensuing social controversy over the zealous scope and punitive consequences of cannabis use enforcement – which included many young, middle-class offenders now marred by criminal convictions and records – triggered formal recommendations from a national inquiry ('Le Dain Commission') to decriminalize cannabis use control as early as 1972 (Giffen et al., 1991; Le Dain Commission, 1972). Numerous similar recommendations and proposals for cannabis control reform were launched in the years following, but all essentially failed to materialize; these included, more recently, formal recommendations from a Senate and a Parliamentary Committee formally proposing legalization and decriminalization of cannabis use, respectively (Fischer, Ala-Leppilampi, Single, & Robins, 2003; Solomon, Single, & Erickson, 1983). In recent years, Canada has reported among the highest cannabis use rates in the world; some 10–15% of all adults and 20–30% of young adults are current cannabis users (Health Canada, 2014a; Ialomiteanu & Adlaf, 2012; UNDCP, 2014). While there are some variations between (e.g., inter-provincial or between urban/non-urban) jurisdictions, approximately 60,000 cannabis-related criminal arrests occur across Canada each year, mostly for personal cannabis possession/use; 500,000 to 1.5 million Canadians are estimated to carry cannabis offense-related criminal records (Beeby, 2014; Cannabis Facts, 2014; Dauvergne, 2009; Government of Canada, 2014). While public opinion support for cannabis control reform has been steadily increasing over the past decades, with now at least a majority of Canadians in favour of at least decriminalization, the current (conservative) government has categorically vowed that it will not revise the current universal criminal prohibition approach to cannabis (Drews, 2013; Grenier, 2013).

Evolution of Canada's 'medical marijuana' program

In the years leading up to 2000, a series of higher court decisions responding to constitutional challenges resulted in the Canadian federal government being forced by the courts to establish provisions that would allow for severely ill individuals to freely use and access cannabis for therapeutic purposes without punitive consequences (Belle-Isle et al., 2014; Bogdanoski, 2010; Lucas, 2009). Consequently, in 2001, the then (Liberal) federal government

established the 'Medical Marihuana Access Regulations' (MMAR). With an 'authorization' based on a physician's confirmation for one of a list of federally sanctioned, severe/chronic medical conditions, an individual could become an authorized medical marijuana user; these could obtain their medical cannabis supplies directly from Health Canada, grow it themselves or rely on 'designated' suppliers growing it on their behalf (Belle-Isle et al., 2014; Eggertson, 2013; Fischer et al., 2003; Lucas, 2009). Given the complex bureaucratic processes and requirements involved, as well as the program's inherent selectiveness, the MMAR's initial uptake was highly limited, extending to only a few hundred authorized users in the initial years, although the number of individuals who characterized their cannabis use as 'medical' in Canada was estimated at 400,000–1,000,000 (Belle-Isle & Hathaway, 2007; Lucas, 2009; Ogborne, Smart, Weber, & Birchmore-Timney, 2000; Walsh et al., 2013). Thus, the vast majority of self-described medical marijuana users continued to use and source their product outside of the auspices of the federal program (Belle-Isle et al., 2014).

While the MMAR went through several revisions over the coming years, and its pool of authorized user participants started to gradually increase, it remained subject to considerable criticism; much related to onerous process and barriers to access issues for program applicants, as well as concern about potential criminal abuses of the 'designated grower' system (Belle-Isle & Hathaway, 2007; Comeau, 2007; Jones & Hathaway, 2008). Following a long process of deliberations and consultations, the federal government announced (2013) and implemented the new – and distinctly different – 'Marihuana for Medical Purposes Regulations' (MMPR) in 2014 (Government of Canada, 2014; Belle-Isle et al., 2014). Under the MMPR, the government is no longer involved in 'authorizing' individuals for medical cannabis use; rather, the crucial decision of approval needs to come from (any) doctor who formally assesses and endorses – similar to a prescription – that an individual will 'therapeutically' benefit from cannabis use, thereby authorizing the patient as a medical marijuana user (Health Canada, 2013). Eligibility is also no longer tied to a limited catalogue of health problems, yet extends to any adult residing in Canada who has received a physician's authorization for symptoms pertaining to a list of standard severe/chronic and or terminal medical conditions, or for "a debilitating symptom that is associated with a medical condition or with the medical treatment of that condition" (Health Canada, 2014b). In essence, any symptom a physician is prepared to confirm as 'medical' and as benefiting from cannabis use is sufficient for authorization for medical marijuana use.

While the gatekeeper role to authorize medical marijuana use under the MMPR has been delegated to physicians, the government's decision-maker role is now mainly limited to supply regulation (Eggertson, 2013). Specifically, the federal government selects and licenses commercial cannabis producers – based on an extensive catalogue of criteria – as retail suppliers for authorized medical marijuana users, offering their product at government-regulated prices (The Canadian Press, 2014). These commercial suppliers come in addition to the existing community-based 'cannabis dispensaries'. Dispensaries have proliferated across Canada as the primary providers of cannabis product to the growing numbers of – authorized and un-authorized – medical cannabis users in recent years (Canadian Association of Medical Cannabis Dispensaries, 2013; Capler & Lucas, 2006; Walsh et al., 2013). However, virtually all of these dispensaries have remained unsanctioned and operate in a legally ambiguous state (some have been raided and/or closed), and are excluded from authorization as licensed cannabis suppliers under the MMPR (Belle-Isle et al., 2014; Hopper, 2014; Penn, 2013). Canadian physicians – like their US colleagues – have expressed concern and discomfort with their designated 'gatekeeper' role as the decision-making authority for medical cannabis use (Hoffmann & Weber, 2010; Kahan & Srivastava, 2014; Leaf

Download English Version:

<https://daneshyari.com/en/article/1075279>

Download Persian Version:

<https://daneshyari.com/article/1075279>

[Daneshyari.com](https://daneshyari.com)