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SENATE OF CANADA

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Special Committee on

Illegal Drugs

Chair:
The Honourable PIERRE CLAUDE NOLIN

Wednesday, August 28, 2002 (*in camera*)

Issue No. 23

Fifty-second meeting on:

Reassessing Canada's anti-drug legislation
and policies

INCLUDING:
THE FINAL REPORT OF THE COMMITTEE
(Cannabis: Our Position for a
Canadian Public Policy)

Première session de la
trente-septième législature, 2001-2002

SÉNAT DU CANADA

Délibérations du
Comité spécial sur les

Drogues illicites

Président:
L'honorable PIERRE CLAUDE NOLIN

Le mercredi 28 août 2002 (à huis clos)

Fascicule n° 23

Cinquante-deuxième réunion concernant:

Le réexamen des lois et des politiques
antidrogue canadiennes

Y COMPRIS:
LE RAPPORT FINAL DU COMITÉ
(Le cannabis: Positions pour un régime de
politique publique pour le Canada)

38799

THE SPECIAL COMMITTEE ON ILLEGAL DRUGS

The Honourable Senator Pierre Claude Nolin, *Chair*

The Honourable Senator Colin Kenny, *Deputy Chair*

and

The Honourable Senators:

Banks
* Carstairs, P.C.
(or Robichaud, P.C.)
Forrestall
* Lynch-Staunton
(or Kinsella)
Maheu

**Ex Officio Members*

(Quorum 3)

LE COMITÉ SPÉCIAL SUR LES DROGUES ILLICITES

L'honorable sénateur Pierre Claude Nolin, *président*

L'honorable sénateur Colin Kenny, *vice-président*

et

Les honorables sénateurs:

Banks
* Carstairs, c.p.
(ou Robichaud, c.p.)
Forrestall
* Lynch-Staunton
(ou Kinsella)
Maheu

**Membres d'office*

(Quorum 3)

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MINUTES OF PROCEEDINGS

OTTAWA, Wednesday, August 28, 2002
(52)

[*English*]

The Special Committee on Illegal Drugs met this day *in camera* in room 256-S, Centre Block, at 9:31 a.m., the Chair, the Honourable Senator Pierre Claude Nolin, presiding.

Members of the committee present: The Honourable Senators Kenny, Nolin and Rossiter (3).

In attendance: Director of Research: Daniel Sansfaçon; from the Committees Directorate: Daniel Charbonneau; from the Library of Parliament: Gérald Lafrenière; from Newman Communications: David Newman; from the Office of Senator Nolin, François Dubois; from the office of Senator Maheu, Philippe Brideau; from the office of Senator Rossitor, Barbara Wheelock; Page: Alexandra Spiess.

Pursuant to the Order of Reference adopted by the Senate on Thursday, March 15, 2001, the committee proceeded to study Canada's anti-drug legislation and policies. *(See Issue No. 1, March 19, 2001, for the full text of the Order of Reference.)*

It was agreed, — That available funds be allocated to the Chair for travel to promote the report following its tabling.

It was agreed, — That the draft report and summary as presented be approved.

It was agreed, — That the Chair be authorized to table the report with the Clerk of the Senate.

It was agreed, — That funds be found within the committee's budget to cover special binding, to a maximum of $ 2,050.55.

It was agreed, — That the Chair be authorized to coordinate the release of the report to the media, as per the draft communication plan as amended.

It was agreed, — That money be reallocated to send summaries by courier to the media.

At 11:20 a.m., the committee adjourned to the call of the Chair.

ATTEST:

PROCÈS-VERBAL

OTTAWA, le mercredi 28 août 2002
(52)

[*Traduction*]

Le Comité spécial sur les drogues illicites se réunit aujourd'hui à huis clos, à 9 h 31, dans la salle 256-S de l'édifice du Centre, sous la présidence de l'honorable sénateur Pierre Claude Nolin (*président*).

Membres du comité présents: Les honorables sénateurs Kenny, Nolin et Rossiter (3).

Également présents: Directeur de la recherche: Daniel Sansfaçon; de la Direction des comités: Daniel\ Charbonneau; de la Bibliothèque du Parlement: Gérald Lafrenière; de Newman Communications: David Newman; du bureau du sénateur Nolin, François Dubois; du bureau du sénateur Maheu, Philippe Brideau; du bureau du sénateur Rossiter, Barbara Wheelock; page: Alexandra Spiess.

En conformité avec l'ordre de renvoi adopté par le Sénat le jeudi 15 mars 2001, le comité poursuit son étude des lois et des politiques antidrogue canadiennes. *(Le texte intégral de l'ordre de renvoi se trouve dans le fascicule n° 1 en date du 19 mars 2001.)*

Il est entendu — Que les fonds disponibles seront mis à la disposition du président pour lui permettre de se déplacer en vue de promouvoir le rapport, après son dépôt.

Il est entendu — Que l'ébauche de rapport et de résumé est approuvée telle quelle.

Il est entendu — Que le président est autorisé à déposer le rapport auprès du greffier du Sénat.

Il est entendu — Que l'on trouvera dans le budget du comité des fonds pour payer la reliure spéciale, jusqu'à concurrence de 2 050,55 $.

Il est entendu — Que le président est autorisé à coordonner la diffusion du rapport aux médias, comme le prévoit l'ébauche modifiée du plan de communications.

Il est entendu — Que les fonds seront réaffectés de manière à envoyer par messager des résumés aux médias.

À 11 h 20, le comité s'ajourne jusqu'à nouvelle convocation de la présidence.

ATTESTÉ:

Le greffier du comité,

Blair Armitage

Clerk of the Committee

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME I : PARTS I AND II

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

ORDER OF REFERENCE

Extract from the Journals of the Senate of March 15, 2001:

Resuming debate on the motion of the Honourable Senator Nolin, seconded by the Honourable Senator Molgat:

That a special committee of the Senate be struck to examine:

- The approach taken by Canada to cannabis, its preparations, derivatives and similar synthetic preparations, in context;

- The effectiveness of this approach, the means used to implement it and the monitoring of its application;

- The related official policies adopted by other countries;

- Canada's international role and obligations under United Nations agreements and conventions on narcotics, in connection with cannabis, the Universal Declaration of Human Rights and other related treaties; and

- The social and health impacts of cannabis and the possible consequences of different policies;

That the special committee consist of five senators, three of whom shall constitute a quorum;

That the Honourable Senators Banks, Kenny, Nolin, Rossiter and (a fifth Senator to be named by the Chief Government Whip) be named to the committee.

That the committee be authorized to send for persons, papers and records, to hear witnesses, to report from time to time, and to print from day to day such papers and evidence as may be ordered by it;

That the briefs and evidence heard during consideration of Bill C-8, *An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof*, by the Standing Senate Committee on Legal and Constitutional Affairs during the Second Session of the Thirty-fifth Parliament be referred to the committee;

That the documents and evidence compiled on this matter and the work accomplished by the Special Senate Committee on Illegal Drugs during the Second Session of the Thirty-sixth Parliament be referred to the committee;

That the committee be empowered to authorize, if deemed appropriate, the broadcasting on radio and/or television and the coverage via electronic media of all or a part of its proceedings and the information it holds;

That the committee present its final report no later than August 31, 2002; and that the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 30 days after the tabling of that report;

That the committee be authorized, notwithstanding customary practice, to table its report to the Clerk of the Senate if the Senate is not sitting, and that a report so tabled be deemed to have been tabled in the Senate.

After debate,

The question then being put on the main motion as amended, it was adopted.

Extract from the Journals of the Senate of May 9, 2002:

The Honourable Senator Nolin moved, seconded by the Honourable Senator Stratton,

That the date of presentation by the Special Senate Committee on Illegal Drugs of the final report on its study into reassessing Canada's anti-drug legislation and policies, which was authorized by the Senate on March 15, 2001, be extended from August 31, 2002 to September 13, 2002.

The question being put on the motion, it was adopted.

ATTEST:

Paul C. Bélisle
Clerk of the Senate

A WORD OF THANKS

I am very proud of the report on cannabis being made public today by the Senate Special Committee on Illegal Drugs. It marks a stage in Canada's public policy on drugs, and I have no doubt that it will find an attentive readership, despite its impressive size.

The report is the product of a team effort over a period of two years. At the risk of leaving anyone out, and I hope I will be pardoned should I do so, I would like to express my gratitude to those most closely involved with the project.

I would first thank all Canadians, who, from near and far, shared in our efforts, by writing us, by attending our hearings and our open forums in the regions, by watching us on television and, quite simply, by taking the time to learn about this important social policy issue. Their contributions, their questions and their comments were a source of inspiration. We will not forget the welcome given us by the Chiefs of the Piapot tribe in Saskatchewan. The ceremony they held for us was truly healing.

The Committee could not have done its work without the immense contribution of its research team. This small group was under the able direction of sociologist Dr Daniel Sansfaçon, whose rigour and devotion enabled the Committee to meet the highest standards of quality in its work and in the drafting of its report. Mr Gérald Lafrenière and Ms Chantal Collin, researchers with the Parliamentary Research Branch of the Library of Parliament working with him, provided invaluable support. I would take the opportunity to thank the Parliamentary Research Branch and its Director General specifically for their diligence and professionalism in responding to our imposing program of work. Finally, I wish to mention the contributions by Ms Barbara Buston Wheelok, assistant to Senator Rossiter, to Mr François Dubois, my research assistant, and to Messrs Jean-Guy Desgagné and David Newman in Communications.

The Committee benefited in its work from the expertise and the generosity of the many experts who testified before it or whom it met privately, and whose names are appended. I would thank them one and all.

We were also able to draw on the competence of the committee clerks and on the efficiency of their administrative personnel in organizing our many working and public meetings. My thanks to Blair Armitage, Daniel Charbonneau and Adam Thompson.

Our report, with its great concern for transparency and rigour, exemplifies the highest standards maintained by the Senate. I would thank my colleagues in the Senate, who entrusted us with this mandate. In concluding, I would like to express my gratitude to my colleagues who took part in our work and especially to each of the members of the Senate Special Committee on Illegal Drugs: its Deputy Chair, Senator Colin Kenny, and Senators Tommy Banks, Shirley Maheu and Eileen Rossiter. They did a remarkable job.

My colleagues, I believe Canadians may rightly be proud of our parliamentary institution.

Pierre Claude Nolin
Senator
Chair, Senate Special Committee on Illegal Drugs

MEMBERS OF THE
SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

1. MEMBERS OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

Honourable Pierre Claude Nolin
(Chair)

Honourable Colin Kenny
(Deputy Chair)

Honourable Tommy Banks

Honourable Eileen Rossiter

Honourable Shirley Maheu

Honourable John Lynch-Staunton *

Honourable Sharon Carstairs, P.C.* **

Honourable Noël A. Kinsella *

Honourable Fernand Robichaud, P.C. *

2. OTHER SENATORS WHO PARTICIPATED IN THE PROCEEDINGS OF THE COMMITTEE

Honourable Michel Biron

Honourable Laurier LaPierre

Honourable Pat Carney, P.C.

Honourable Jean Lapointe

Honourable Thelma Chalifoux

Honourable Edward M. Lawson

Honourable Ione Christensen

Honourable Lorna Milne

Honourable Ethel M. Cochrane

Honourable Yves Morin

Honourable Pierre De Bané, P.C., Q.C.

Honourable Lucie Pépin ***

Honourable Consiglio Di Nino

Honourable Marie-P. Poulin

Honourable Joyce Fairbairn, P.C.

Honourable Marcel Prud'homme, P.C.

Honourable Sheila Finestone, P.C.

Honourable Gerry St. Germain, P.C.

Honourable J. Michael Forrestall

Honourable Peter A. Stollery

Honourable Jerahmiel S. Grafstein, Q.C.

Honourable Terry Stratton

Honourable Mobina S.B. Jaffer

Honourable John Wiebe

Honourable Lois M. Wilson

* *Ex Officio* Members
** The Honourable Sharon Carstairs was a member of the Committee from April 2000 to October 2000
*** The Honourable Lucie Pépin was a member of the Committee from April 2000 to October 2000

TABLE OF CONTENTS

INTRODUCTION **1**

PART I - GENERAL ORIENTATION **5**

CHAPTER 1 - OUR MANDATE **7**
WORDING 7
ORIGINS 9
INTERPRETATION 10

CHAPTER 2 - OUR WORK **13**
TWO WORKING PRINCIPLES 14
STATE OF KNOWLEDGE 15
Research Program 18
Expert Witnesses 19
The Challenge of Synthesis 21
TAKING OPINIONS INTO ACCOUNT 22
INTERPRETING IN LIGHT OF PRINCIPLES 23

CHAPTER 3 - OUR GUIDING PRINCIPLES **25**
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY 28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS 32
Collective governance 34
Governance of the self 35
The role of governance 37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION 38
Requirement for distinctions 38
Criteria for distinction 40
Application to illegal drugs issues 44
SCIENCE OR APPROXIMATE KNOWLEDGE 45
CONCLUSIONS 49

CHAPTER 4 - A CHANGING CONTEXT **51**
CHANGES IN THE INTERNATIONAL SPHERE 51
Globalization and Integration 51
Difficulties of the Security Debate 55
From Anti-Drug Policies to Drug Policies 57
CHANGES IN CANADA 58
Judicial Activism 58
A National Crime Prevention Strategy 59
The Fight Against Organized Crime 59
A SOCIETAL DEBATE 60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES 63

CHAPTER 5 - CANNABIS: FROM PLANT TO JOINT 65
ONE PLANT, VARIOUS DRUGS 66
CANNABIS ROADS 69
PROPERTIES OF CANNABIS 77
Δ^9THC Concentrations 78
Pharmacokinetics 83
CONCLUSIONS 87

CHAPTER 6 - USERS AND USES: FORM, PRACTICE, CONTEXT 89
PATTERNS OF USE 90
Consumption by the population as a whole 91
Consumption among young people 94
Use patterns in other countries 101
To summarize 108
PATTERNS AND CIRCUMSTANCES OF USE 111
Cannabis in History 111
Trajectories of Use 113
Factors Related to Use 119
To summarize 124
STEPPING STONE TOWARDS OTHER DRUGS? 125
CANNABIS, VIOLENCE AND CRIME 127
CONCLUSIONS 128

CHAPTER 7 - CANNABIS: EFFECTS AND CONSEQUENCES 131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD 134
ACUTE EFFECTS OF CANNABIS 139
CONSEQUENCES OF CHRONIC USE 143
Physiological Consequences of Chronic Use 143
Cognitive and Psychological Consequences 148
Behavioural and Social Consequences 152
TOLERANCE AND DEPENDENCE 152
Cannabis Dependence 154
Severity of Dependence 160
Tolerance 162
To summarize 163
CONCLUSIONS 164

CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS 167
FORMS OF TESTING 170
EPIDEMIOLOGICAL DATA 175
Studies not involving accidents 175
Studies where an accident was involved 176
Epidemiological studies on youth 179

Risk assessment 180
EXPERIMENTAL STUDIES 182
Non-driving activities 183
While driving 184
CONCLUSIONS 188

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES 191
HISTORY 196
CONTEMPORARY KNOWLEDGE 197
Therapeutic uses 198
Marijuana as a drug? 200
CURRENT THERAPEUTIC PRACTICES 203
CONCLUSIONS 205

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES 209
THE MEDIA 210
SURVEYS 215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE 221
CONCLUSIONS 224

PART III - POLICIES AND PRACTICES IN CANADA 225

CHAPTER 11 - A NATIONAL DRUG STRATEGY? 227
PHASE I - DEVELOPMENT AND IMPLEMENTATION 228
Creation of the Canadian Centre on Substance Abuse 233
Creation of Canada's Drug Strategy Secretariat 236
PHASE II - RENEWAL 237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING 240
CANADA'S DRUG STRATEGY – A SUCCESS? 241
CONCLUSIONS 243

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT 245
1908-1960: HYSTERIA 248
Opium Act, 1908 252
The Opium and Narcotic Drug Act, 1911 253
Amendments to the Opium and Narcotic Drug Act (1920-1938) 255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954 263
Senate Report of 1955 264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS 268
Narcotic Control Act (1961) 268
An Act respecting Food and Drugs and Barbiturates (1961) 270
The Le Dain Commission (1969-1973) 272
Bill S-19 and Cannabis 283
AFTER LE DAIN: FORGING AHEAD REGARDLESS 284
Controlled Drugs and Substances Act 286
CONCLUSIONS 295

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS **297**
BACKGROUND TO THE RECENT REGULATIONS 298
Section 56 – Controlled Drugs and Substances Act 298
Charter Challenges – Therapeutic Use of Marijuana 299
Government Reaction 302
MARIHUANA MEDICAL ACCESS REGULATIONS 302
Authorization to Possess 303
Licence to Produce 306
Other Provisions 307
COMPASSIONATE ACCESS? 308
Eligibility 309
Access to cannabis 312
Products 316
Costs 316
RESEARCH PLAN 317
Scientific Research 318
Research-Grade Marijuana 320
CONCLUSIONS 321

CHAPTER 14 - POLICE PRACTICES **323**
ENFORCEMENT AGENCIES 323
RCMP 323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999 326
TheCanada Customs and Revenue Agency 326
Provincial and Municipal Police 328
COSTS 328
POLICE POWERS 333
Searches and Seizures 335
Entrapment and Illegal Activity 347
Conclusion 352
STATISTICS 353
Reported Incidents 353
Charges 356
Concerns 359
Customs Act - Fines 361
SEIZURES 362
CONCLUSIONS 364

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM **367**
PROSECUTION 367
COURTS 368
Drug Treatment Courts 369
DISPOSITION AND SENTENCING 372
CORRECTIONS 376
CRIMINAL RECORD 379
COURT CHALLENGES 382
CONCLUSIONS 387

CHAPTER 16 - PREVENTION **389**
INITIATIVES THAT FALL SHORT OF THE MARK 393
Not enough prevention 394
Prevention lacks focus 396
There is not enough evaluation of preventive measures 397
Preventive and social messages in contradiction 398
There is a body of knowledge on which we have to draw 399
PREVENTING WHAT AND HOW? 400
RISK REDUCTION AND HARM REDUCTION 410
CONCLUSIONS 412

CHAPTER 17 - TREATMENT PRACTICES **415**
CANNABIS DEPENDENCY 415
FORMS OF TREATMENT 421
EFFECTIVENESS OF TREATMENT 423
CONCLUSIONS 426

CHAPTER 18 - OBSERVATIONS ON PRACTICES **427**
DIFFICULTIES IN HARMONIZING THE PLAYERS 427
INCONGRUITIES OF APPROACH 429
SIGNIFICANT ECONOMIC AND SOCIAL COSTS 431

PART IV - PUBLIC POLICY OPTIONS **437**

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT **439**
A GENEALOGY 440
The 1909 Shanghai Conference 443
The 1912 Hague International Opium Convention 444
The 1925 Geneva Opium Conventions 446
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement 447
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs 448
The Second World War 449
The 1946 Lake Success Protocol 449
The 1948 Paris Protocol 450
The 1953 New York Opium Protocol 450
THE THREE CURRENT CONVENTIONS 451
The Single Convention on Narcotic Drugs, 1961 451
Convention on Psychotropic Substances 455
Protocol amending the Single Convention on Narcotic Drugs, 1961 460
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 462
SOME LEEWAY? 464
CONCLUSIONS 468

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES **469**
FRANCE 470
Different Forms of Logic 470
An Integrated Public Policy 472
Legislative Framework 474
Key Reports 477
Statistics on Use and Offences 481
Costs 483
THE NETHERLANDS 485
Dutch Pragmatism? 486
Essential Experts Reports 488
Legislation 493
The Coffee Shop System 496
Data on Use 498
UNITED KINGDOM 502
Ten-Year Strategy to Battle Drugs 502
Legislative Framework 503
Other Relevant Legislation in the Field of Drug Misuse 505
Debate in the UK 506
Recent Key Reports and Studies 507
Administration 515
Costs 515
Statistics 516
SWEDEN 518
National Strategy 520
Legislative Framework 523
Debate in Sweden 525
Recent Reports 526
Costs 528
Administration 528
Statistics 529
SWITZERLAND 531
A Harm Reduction Policy 531
The Legal Framework 538
A Bill to Decriminalize Cannabis 539
Administration of Swiss Drug Policy 542
Statistics on Narcotics Use and Offences under the Narcotics Act 544
AUSTRALIA 546
National Drug Strategy 546
Legislative Framework 551
Decriminilization in Australia 554
Administration 556
Statistics 557
UNITED STATES 560
The Federal-State Legislative Framework 560
Current Legislation and Enforcement 563
Federal Drug Policy Goals and Objectives 570
Administration of the Policy 572
Current Issues and Debates 575

Statistics 576

CHAPTER 21 - PUBLIC POLICY OPTIONS 581
INEFFECTIVENESS OF CRIMINAL POLICIES 583
Impact on Consumption 583
Impact on Supply 589
Conclusion 590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS 591
COMPONENTS OF A PUBLIC POLICY 593
Strong Decision-making Body 593
Interconnection 594
A Shared Definition of Shared Objectives 594
Information Tools 594
LEGISLATIVE OPTIONS 595
Clarification of criminology 595
Criteria for a Legal Policy on Cannabis 602

CONCLUSIONS AND RECOMMENDATIONS 607

LE DAIN – ALREADY THIRTY YEARS AGO 607
INEFFECTIVENESS OF THE CURRENT APPROACH 609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES 610
A CLEAR AND COHERENT FEDERAL STRATEGY 611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS 612
A PUBLIC HEALTH POLICY 614
A REGULATORY APPROACH TO CANNABIS 617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE 618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS 619
RESEARCH 620
CANADA'S INTERNATIONAL POSITION 621

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES 623

BIBLIOGRAPHY 627

GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see chapter 7). In the report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence.

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators, THC increasing the liberation of dopamine in nucleus accumbens and cerebral cortex.

At-risk use
Use behaviour which makes users at-risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marihuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic drug, cannabis is a modulator of the central nervous system. It contains over 460 known

chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure decriminalization*, which entails an amendment to criminal legislation, and *de facto decriminalization*, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalisation
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states objective, reliable and comparable information within the EU on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate quickly the tissues. THC is highly fat-soluble.

Gateway (theory)
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then "hard" drugs. The theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate is from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces on inactive THC metabolites can be detected as many as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant and transformed into a paste.

International Conventions
Various international conventions have been adopted by the international community since 1912, first under the Society of Nations and then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organisation responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems resulting from a substance. Pharmacology generally distinguishes four levels: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC are more difficult, especially in trying to determine the therapeutic benefits of cannabis and to examine its effects on driving.

Legalisation
Regulatory system allowing the culture, production, marketing, sale and use of substances. Although none currently exist in relation to « street-drugs » (as opposed to alcohol or tobacco which are regulated products), a legalisation system could take two forms: without any state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become equivalent for cannabis.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of national drug control policy (ONDCP) USA
Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. More neutral than the term “drug” because it does not refer to the legal status of the substance, it is the term we prefer to use.

Psychotropic substance (see also psychoactive)
Much the same as psychoactive substance. More specifically however, the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytic, sedatives, neuroleptics, etc. More specifically, refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
Control system specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Society of Nations (SDN)
International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance
Reduced response of the organisms and increased capacity to support its effects after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs, including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO)
The World Health Organization, the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

INTRODUCTION

The question of illegal drugs is one of the societal issues that can readily become a moral and indeed emotional matter. Who among us does not have an opinion on drugs and "drug addicts"? Who does not have a parent, friend, young cousin or uncle who has had personal problems at school or at work, perhaps even run-ins with the police and the criminal justice system, as a result of using drugs? Who has not heard of drug traffickers, veritable anti-heroes, whom we find both repulsive and fascinating, all of whom we consider the worst kind of scum, who grow rich by selling adulterated and dangerous products to our children? Every day brings its share of newspaper articles and television news reports on anti-drug operations conducted by police forces: sometimes massive, and almost always spectacular arrests, huge seizures of drugs, cash and weapons of all kinds. Every day we also see articles on money laundering and the corruption of honest men through the illegal drug market. Even closer to home, the events of September 11 shed new light on the ambiguous and alleged relations between the drug trafficking world and the financing of "terrorist" networks. Security is now the key buzz word.

The drug issue involves the political values of life in society. In what kind of society do we want to live? What place should, and can, drugs occupy in it? For some, drugs are substances that keep individuals in a state of dependence. Using them weakens their moral fibre, makes them more malleable, more subject in particular to (bad) outside influences, and reduces their ability to be productive individuals in society. If they don't bring about human downfall, drugs do prevent the full achievement and realization of human potential. For others, drugs are tools to achieving greater productivity, being more competitive and thus better positioned in a hyper-competitive world. The obvious example of this is doping among elite athletes. For still others, drugs are a preferred means of entering into contact with other aspects of their being, spiritual, artistic aspects, or simply peace and serenity. The history of art is full of examples. These almost diametrically opposed conceptions often leave little room for dialogue and result in considerable prejudice on all sides.

In the past 20 years, we have introduced stringent anti-tobacco programs. And we have definitely achieved a measure of success. We have also adopted stricter measures to put a stop to impaired driving. Here too, we believe we have made significant inroads. The fight against drugs is a kind of metaphor for the type of social policies we expect of governments: policies based on the improved well-being of citizens.

Of course, everything depends on what each person means by the word "drugs". The term is clearly not neutral: it elicits varying degrees of fear and anxiety. And we do not necessarily all include the same substances under that heading. The examples cited above concern illegal drugs, alcohol, tobacco and performance-enhancing substances. A number of psychotropic drugs could also be included. And yet, when we think of drugs, the first things that come to mind are illegal substances: cocaine and heroin, of course, crack and amphetamines for the more sophisticated among us, and, obviously, cannabis and hashish. However, an increasing number of scientific studies and government policies strive to show the interrelationships between different drugs, discussing at-risk behaviours in relation to each drug. As will be seen below, the mere fact of considering alcohol as one drug among others signifies a genuine cultural revolution in a country such as France, a major producer and consumer of wine. And tobacco companies would certainly object to comparing nicotine to heroine.

The members of the **Senate Special Committee on Illegal Drugs** addressed the question of drugs as everyone else does, that is to say with the same preconceptions, with the same basic attitudes, the same fears and the same anxieties. Of course, we had at our disposal the study which a number of our colleagues had conducted in 1996 on government legislation dealing with illegal drugs, which had enabled them to hear a number of witnesses over several months. We also knew at the outset that research expertise would be available to us, but let there be no mistake, it is nevertheless difficult to go beyond attitudes and opinions that have long been taken for granted. Whether one is in favour of enhanced enforcement or, on the contrary, greater liberalization, opinions tend to resist the facts, particularly since, in a field such as this, the production of facts, even through scientific research, is not necessarily a neutral enterprise. It follows then that we too, like you, have our prejudices and preconceptions. And together we must make the effort to go beyond them. That is one of the objectives of this report.

Our report is divided into four parts. Part I outlines our general orientations and comprises four chapters. Chapter 1 describes the Committee's origins and mandate, while Chapter 2 outlines the work we have undertaken, explaining certain choices we have made. Chapter 3 is central to the entire architecture of the report and, as it were, provides a "reading grid". In it, we state what we have called the **guiding principles** for a public policy on illegal drugs. Lastly, Chapter 4 offers a broad overview of the present situation with regard to illegal drugs, placing our efforts in the context of the changes that are occurring in various countries and on the international scene more generally.

Part II is the heart of our report. It provides a comprehensive outline of scientific research findings and the opinions of the experts we heard. Chapter 5 describes the plant from which smokable cannabis and hashish are derived and the pharmacological properties of the cannabinoids, which are their active ingredient. It also provides some figures on sources of production of cannabis and its main trafficking routes. Chapter 6 contains information on uses and users: who uses cannabis, in what circumstances,

what do we know about their user trajectories and, in particular, the highly controversial question as to whether cannabis use leads to the use of other drugs. Chapter 7 describes the physiological and psychological effects and consequences of cannabis, focusing as well on the important issues of cannabis dependence and tolerance. Chapter 8 deals specifically with the important issue of driving under the influence of cannabis. Given the current debates on the issue of therapeutic uses of cannabis, Chapter 9 reviews existing findings. Chapter 10, the last chapter in the section, addresses public opinion, outlining public opinion polls and surveys, reporting also what we were told in the consultations we held in the regions following the publication of our discussion paper in May 2002.

Part III concerns public policy and practices in Canada. When we think of drugs, we immediately think of the legislation governing them. In so doing, we forget that the law is never more than one of a number of elements involved in a public policy. Chapter 11 focuses on the National Drug Strategy, which was in effect in Canada between 1987 and 1997. It must be considered since only in this period in the history of our public drug policies was an attempt made to adopt a comprehensive and integrated strategy. Chapter 12 then describes the history of Canadian drug legislation. Chapter 13 examines the current regulatory regime for therapeutic uses of cannabis. The following four chapters deal with the various components of the implementation of the public policies on illegal drugs. Chapters 14 and 15 discuss respectively police practices and legal practices central to the implementation of those statutory provisions, while Chapters 16 and 17 briefly examine prevention practices and health care practices. Finally, in Chapter 18, we conclude this third part of our report with a series of three observations on these practices, examining in particular the economic costs and unexpected consequences of current public policies.

Part IV addresses public policy options. When it comes to drugs, we cannot avoid the architecture of the international conventions that have governed these substances since 1912. This is the subject of Chapter 19. However, beyond this global framework, countries have chosen different approaches to respond to drug related issues and problems. Chapter 20 describes in detail the public policy frameworks in seven industrialized countries. Finally, chapter 21 is key to understanding our recommendations and their links with our guiding principles. This chapter shows that the criminal law is but one of the tools of public policy in this field. It then distinguishes between the various legal options and clarifies heavily loaded terms such as decriminalisation and legalisation. Finally, based on the accumulated knowledge, our reading of public opinion and our principles, this chapter explains our framework for a comprehensive public policy on cannabis.

Based on all this knowledge gathered, we state a certain number of conclusions and offer our recommendations, which express the fundamental premise underlying our report: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make***

only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equivalence of others.

We are aware, as much now as we were at the start of our work, that there is no pre-established consensus in Canadian society on public policy choices in the area of drugs. In fact, as we have seen, there are few societies where there is a broadly shared consensus among the general public and between the public and experts. We are also aware, perhaps more so than at the outset, that the question of illegal drugs, viewed from the standpoint of the public policies that govern them, is part of a broader international context and that we cannot think or act in isolation. We are aware that our proposals are provocative, that they may meet with some resistance. However, we are convinced that Canadian society has the maturity and openness to welcome this informed debate.

In this, as in so many other areas of public policy, we say that action must be taken and that the knowledge accumulated fully supports the orientations we propose, but that first and foremost the sharing of knowledge and public debate are both necessary and desirable in the democratic life in our society.

PART I

GENERAL ORIENTATION

CHAPTER 1

OUR MANDATE

WORDING

On April 16, 2000, pursuant to a motion by Senator Pierre Claude Nolin, the Senate adopted the following order of reference:

> *That a Special Committee of the Senate be appointed to reassess Canada's anti-drug legislation and policies, to carry out a broad consultation of the Canadian public to determine the specific needs of various regions of the country, where social problems associated with the trafficking and use of illegal drugs are more in evidence, to develop proposals to disseminate information about Canada's anti-drug policy and, finally, to make recommendations for an anti-drug strategy developed by and for Canadians under which all levels of government work closely together to reduce the harm associated with the use of illegal drugs;*
>
> *That, without being limited in its mandate by the following, the committee be authorized to:*
>
> - *Review the federal government's policy on illegal drugs in Canada, its effectiveness, and the extent to which it is fairly enforced;*
> - *Develop a national harm reduction policy in order to lessen the negative impact of illegal drugs in Canada, and make recommendations regarding the enforcement of this policy,* ***specifically the possibility of focusing on use and abuse of drugs as a social and health problem****;*[1]
> - *Study harm reduction models adopted by other countries and determine if there is a need to implement them wholly or partially in Canada;*
> - *Examine Canada's international role and obligations under United Nations conventions on narcotics and the Universal Declaration of Human Rights and other related treaties in order to determine whether these treaties authorize it to take action other than laying criminal charges and imposing sentences at the international level;*
> - *Explore the effects of cannabis on health and examine whether alternative policy on cannabis would lead to increased harm in the short and long term;*

[1] Emphasis in the original.

- *Examine the possibility of the government using its regulatory power under the Contraventions Act as an additional means of implementing a harm reduction policy, as is done in other jurisdictions;*
- *Examine any other issue respecting Canada's anti-drug policy that the committee considers appropriate to the completion of its mandate.*

Upon adoption of the motion, the Committee chairman asked the Senate to name the members who would form the Committee. The following senators were thus appointed: Pierre Claude Nolin, Chair, Sharon Carstairs, Deputy Chair, Colin Kenny, Lucie Pépin and Eileen Rossiter.

The Committee thus constituted approved a work program and a budget, which it then submitted to its peers in the upper Chamber. The Committee's budget was approved in June 2000, thus making it possible to hire the scientific and administrative personnel who would support its work. The Committee organized its program of hearings of expert witnesses and held its first hearings on October 16, 2000.

However, the Committee was dissolved when the general election was called in October 2000, and restruck on March 15, 2001, but with an amended mandate: the scope of its work was now restricted to cannabis. The Committee's mandate in its present form therefore reads as follows:

That a special committee of the Senate be struck to examine:

- *The approach taken by Canada to cannabis, its preparations, derivatives and similar synthetic preparations, in context;*
- *The effectiveness of this approach, the means used to implement it and the monitoring of its application;*
- *The related official policies adopted by other countries;*
- *Canada's international role and obligations under United Nations agreements and conventions on narcotics, in connection with cannabis, the Universal Declaration of Human Rights and other related treaties; and*
- *The social and health impacts of cannabis and the possible consequences of different policies;*

That the special committee consist of five senators, three of whom shall constitute a quorum;

That the Honourable Senators Banks, Kenny, Nolin, Rossiter and (a fifth Senator to be named by the Chief Government Whip) be named to the committee;

That the committee be authorized to send for persons, papers and records, to hear witnesses, to report from time to time, and to print from day to day such papers and evidence as may be ordered by it;

That the briefs and evidence heard during consideration of Bill C-8, An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof, by the Standing Senate Committee on Legal and Constitutional Affairs during the 2nd Session of the 35th Parliament be referred to the committee;

That the documents and evidence compiled on this matter and the work accomplished by the Special Senate Committee on Illegal Drugs during the 2nd Session of the 36th Parliament be referred to the committee;

That the committee be empowered to authorize, if deemed appropriate, the broadcasting on radio and/or television and the coverage via electronic media of all or part of its proceedings and the information it holds;

That the committee present its final report no later than August 31, 2002; and that the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 30 days after the tabling of that report;

That the committee be authorized, notwithstanding customary practice, to table its report to the Clerk of the Senate if the Senate is not sitting, and that a report so tabled be deemed to have been tabled in the Senate.

ORIGINS

The Committee's mandate is a continuation of the history of drug legislation passed by the Parliament of Canada in 1996, the *Controlled Drugs and Substances Act.* That legislation, which revised drug statutes in Canada by repealing the *Narcotic Control Act* and certain sections of the *Food and Drugs Act*, grew out of a relatively lengthy history of which we will provide only a brief overview here, since Chapter 12 is devoted to a detailed history of drug laws in Canada.

Bill C-7, which was tabled by the newly elected government in February 1994, proposed a revision of illegal drug legislation, in particular to make it more coherent and to render national legislation consistent with Canada's obligations under the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* signed in 1988. Following prorogation, it was reintroduced in the House of Commons at the start of the 2nd Session, on March 6, 1996, as Bill C-8. It was adopted by the House on the same day and was referred to the Standing Senate Committee on Legal and Constitutional Affairs which conducted a detailed study of it and heard a number of witnesses.

In its report, the Senate Committee on Legal and Constitutional Affairs proposed 15 amendments as well as the striking of a joint parliamentary committee of the House of Commons and the Senate, which would review Canada's drug policy. Bill C-8 was passed and received Royal Assent on June 20, 1996, and is thus Canada's current illegal drug legislation.

While this legislation was being studied by the Sub-Committee on Bill C-7 of the Standing Committee on Health of the House of Commons in 1994 and 1995, "*the vast majority of witnesses (…) were highly critical of the bill. The most general criticisms concerned three points: first, the lack of basic principles or an express statement as to the purpose of the act; second, the fact that the bill followed the prohibition system of the 1920s, subsequently codified in the Narcotic*

Control Act, and third, the absence of any emphasis on damage reduction and prevention criteria which form the basis of Canada's Drug Strategy."[2] Despite the amendments made by the Sub-Committee of the House, the testimony of the persons heard by the Senate Committee was equally critical. Witnesses noted that the Act did not categorize drugs on the basis of the dangers they represented, that it did not contain any specific, rational criteria and that it was impossible, particularly in view of the Act's complexity, to determine how it would be implemented in practice.

All of these criticisms led the Senate Committee to "*propose energetically*" the creation of a Joint Committee of the House of Commons and the Senate that would review all Canadian drug legislation, policies and programs.[3]

However, the 1997 federal election rendered this suggestion moot. Senator Nolin, convinced of the need for action and faced with the inaction of the House of Commons, thus tabled his first motion in 1999 - that a Senate Committee be struck and given a mandate to examine the legislation, policies and programs on illegal drugs in Canada. The motion was adopted by the Senate in April 2000. In support of the motion, Senator Nolin had commissioned a study on drugs and drug policy in Canada. The purpose of this study, in particular, was "*to assist in analyzing policy on the control of drug use from a new angle, without being influenced by the often unfounded prejudices that Canadian society has of drug addicts*".[4] Senator Nolin wrote further that a Senate Special Committee "*would be charged, first, with transmitting to the Canadian public accurate and objective information on the use of illegal drugs, their effects on individuals and society and control measures in place. Second, it could conduct consultations on desirable amendments that Parliament should make to legislation on the control of drug use in the years to come.*"[5]

INTERPRETATION

Our mandate comprises four components:

1. Examine the federal government policy on cannabis, the means used to implement it, its control and its effectiveness;
2. Examine the policies and approaches followed in other countries;
3. Examine the implications of the international conventions and treaties; and
4. Examine the social and health effects of cannabis and the possible impacts of different policies.

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[2] Allain, J. (1997) *Bill C-8:Controlled Drugs and Substances Act*. Ottawa, Library of Parliament, page 35.
[3] Standing Senate Committee on Legal and Constitutional Affairs, Eleventh rapport, June 1996, page 8.
[4] Nolin, P.C. (1998) Preface. In Riley, D. (1998), *Drugs and Drug Policy in Canada. A Brief Review and Commentary.* Ottawa, page 10.
[5] *Ibid*., page 11.

We chose to interpret our mandate in the broadest manner possible. Some asked us whether it was our ambition to be a second Le Dain Commission.[6] Others told us we did not have the resources to be so exhaustive and rigorous in our examination. Still others regretted the fact that we were restricted in the first phase of our work to cannabis, as though the various substances could be separated and their users classified accordingly.

Chapter 2, on our work program, will show that we were motivated by a desire to be rigorous and to cast our net wide. We are nevertheless aware of the scope and limits of our role as a Senate Committee, all the more so since the means put at our disposal were as limited as our ambition was generous.

The question of the distinction among substances is more problematical for various reasons. First, recent research shows that it is more important to distinguish between user behaviours than between substances. Based on this view, it is thus not so much the drugs themselves that should be distinguished as the different ways in which they are used and the environments in which those uses take place, and hence the risks a certain number of users run. Here we will discuss at-risk behaviours[7], which are not determined so much by the characteristics of the substances as by those of the users and the conditions in which they are used. Second, the distinctions between substances have no clear scientific basis. Thus, entirely different classifications are arrived at depending on how one views the pharmacological properties of the various drugs, their effects on physical health and their origins or cultivation methods. And third, a comprehensive and integrated drug policy cannot be put forward on the basis of this distinction between substances.

However, the result of this decision, which forced us to limit our work to cannabis, was something more than just disadvantages and limits. We should admit, first of all, that embracing the entire field of illegal drugs with so little in the way of resources would have been a monumental undertaking. And as recent commissions of inquiry and international scientific conferences have chosen, as we did, to survey the state of knowledge on cannabis, we were able both to make use of their work and to compare it to our own. Lastly, and more particularly, experiments conducted in other countries, in particular the Netherlands, demonstrate the merit in treating cannabis separately, in a "market separation" approach.

In short, while restricting our work to cannabis, we invited the witnesses not to limit themselves to it alone and to show us the links between it and the various at-risk behaviours of users when they occur. We also bore in mind the necessity of addressing

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[6] The Le Dain Commission, which investigated illegal drugs in the early 1970s, will be discussed more fully in Chapter 12. See Canada (1970), *Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs.* (Le Dain Commission) Ottawa: Queen's Printer.

[7] See among others: Reynaud, M., P.J. Parquet et G. Lagrue (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Rapport préparé à la demande du Directeur général de la Santé. Paris: Secrétariat d'État à la Santé et aux Affaires Sociales.

drugs in the context of an integrated policy, particularly with regard to the major parameters of public policy, legislation or knowledge infrastructure, for example.

CHAPTER 2

OUR WORK

Designing, developing and implementing public policy is the very essence of the role of government, of political life in the broad sense. This fundamental activity presupposes a choice between various alternatives and, in a democratic system, an explanation and justification of the choice that has been made. A public policy, regardless of its object, stands at the confluence of various influences: partisan political considerations of course, economic considerations as well, even increasingly so. However, if it lays claim to a certain degree of rationality and citizen support, a public policy must also be based on rigorous and objective data, preferably from scientific research, and on an understanding of society's expectations and resistance. Lastly, a public policy, in our view, should be founded on, and at the same time promote, guiding principles. By that, we mean a clear and express vision of the principles that guided the choice among various alternatives and that reflect a conception of government and of the relationship between government institutions and civil society.

From the outset, our Committee chose to remain above partisan issues. This is the advantage of belonging to the Senate, which makes it possible to take, on various questions, a more objective view not influenced by concern for re-election. Economic considerations affected us in two different ways. The first, a trivial matter, was related to the budgets allocated to us, which necessarily limited the scope of our work, the second to the economic impact of various public policy options which are discussed in Chapters 18 and 21.

Our work thus focused on the other three sources that should influence a choice of public policy on illegal drugs: knowledge, public opinion and guiding principles.

At the Committee's public hearings, the Chair presented the research program as follows:

> *In order to fully satisfy the mandate conferred upon the committee, the committee has adopted an action plan. This plan centres around three challenges. The first challenge is that of knowledge. We will be hearing from a wide variety of experts, both from Canada and afar, from academic settings, the police, legal specialists, medical specialists, the government sector and social workers. (…)*
> *The second challenge, surely the most noble challenge, is that of sharing knowledge. The committee hopes that Canadians from coast to coast will be able to learn and share the information that we will have collected. In order to meet this challenge, we will work to distribute this knowledge and make it accessible*

to all. We would also like to hear the opinions of Canadians on this topic and in order to do so, we will be holding public hearings in the spring of 2000 throughout Canada.
And finally, the third challenge for this committee will be to examine and identify the guiding principles on which Canada's public policy on drugs should be based. [1]

This chapter describes the various measures we took to ascertain the state of knowledge and public opinion on cannabis and to determine guiding principles. Chapter 3 presents our guiding principles in detail, while Parts II and III outline all the information we were able to gather. First, however, a few words on two working principles which we considered essential to the complete realization of this Committee's mandate.

TWO WORKING PRINCIPLES

In view of the formulation of our mandate, which included an obligation to provide Canadians with objective and rigorous information, we have emphasized rigour and openness throughout the entire process.

It was all the more imperative that we do our work in a rigorous manner since opinions on all sides of the illegal drugs issue are strong and often categorical. Like everyone else, we too had our opinions and preconceptions regarding illegal drugs when we began our work. How could it be otherwise? Like you, we have children. We have had friends and relatives whose lives have been ruined by addiction problems. Our study of the government bill (C-8), which afforded us the opportunity to hear from a certain number of stakeholders and experts, provided us with information, of course, but also revealed major gaps in our knowledge. It then seemed clear to us that opinions were often based on partial and at times incorrect information. On what basis can it be said that cannabis leads to the use of other drugs? What is the empirical basis that supports the notion of cannabis dependence? What leeway does a nation have under the provisions of the international conventions governing the production, trafficking in and possession of illegal drugs?

One cannot assert both one thing and its opposite. However, on the subject of drugs, and specifically cannabis, such very assertions were made to us, and with conviction. How to determine who was right? And to tell opinions from facts?

These findings convinced us that the highest degree of rigour was necessary in the course of our work, as will be seen in the next section.

But rigour is not enough. For this information to reach Canadians, we could not reserve it for our exclusive use, hence the second principle that guided us: openness. From the outset, we insisted that all our work be made available as soon as possible on

[1] Senate of Canada (2001) *The Proceedings of the Special Committee on Illegal Drugs.* Issue No. 1, page 23.

our Web site. There was nothing new in posting witnesses' testimony to a Web site, since this is common practice for most parliamentary committees. However, in addition to this testimony, we also posted a number of studies we had commissioned, many from the Parliamentary Research Branch of the Library of Parliament. These studies, which are often not made public until after a Committee's report is published, were made available to Canadians as they were completed.

Being legislators, we would of course like our work to have an impact on public policy. We also believe it important to provide Canadians with information that is as factual as possible to allow them to benefit from it.

STATE OF KNOWLEDGE

When the Commission of Inquiry into the Non-medical Use of Drugs conducted its work in the early 1970s, like most commissions of inquiry, it had a large staff and budgets enabling it to carry out a vast research program. That was all the more necessary since, at the time, no large pool of knowledge on illegal drugs existed. Virtually nothing was known about the active ingredients of cannabis or even about the pharmacological properties of more traditional drugs, such as heroin and cocaine, and little was known about user trajectories; criminological studies on the relationship between drugs and crime were virtually non-existent, and public policy impact studies were in their earliest stages.

To say the situation has completely changed would be an understatement. In all scientific disciplines, from molecular biology to anthropology, countless studies have been conducted over the past 25 years on illegal drugs in general, and cannabis in particular. They come from the United States, of course, but also from Australia, England, France, Switzerland, Italy, Germany, Sweden, Finland and Denmark to name only a few. They have been conducted by academics interested in these questions on a purely individual basis, by pharmacological laboratories and by research groups within organizations operating in the drug addiction field and in the context of scientific commissions appointed by the governments of various countries.

The Committee asked the Parliamentary Research Branch to prepare a survey of illegal drug research under way or completed in the past five years at the federal level and in the provinces and territories.[2] That survey, which lays no claim to being exhaustive, but offers an overview of the extent and scope of recent research, clearly shows that, despite minuscule budgets compared to those allocated in the United States, research on illegal drugs is doing relatively well in Canada. We can only imagine

[2] Leduc, D., et al., (2001) *Federal Research on Illegal Drugs and Related Issues.* Ottawa: Library of Parliament; and Miller Chenier, N., & S. Norris (2002) *Territorial Research on Illegal Drugs and Related Issues.* Ottawa: Library of Parliament. Reports prepared for the Senate Special Committee on Illegal Drugs. Available at www.parl.gc.ca/illegal-drugs.asp.

that it would be a formidable task to survey the studies under way in the United States on the question of illegal drugs.

Ascertaining the state of knowledge on the subject thus first meant finding the means to prepare a rigorous synthesis. To that end, the Committee adopted a research program focusing on all aspects. However, as it lacked the financial resources to produce an extensive series of studies, and also wishing to ensure that the information was broadly transmitted to the public, the Committee designed a program of public hearings of expert witnesses who would likely be able to assist in more clearly determining the state of current knowledge on the subject.

The Committee approved a research program divided into five major axes of knowledge, sub-dividing each one into specific issues:

- *The socio-historical, geopolitical, anthropological, criminological and economic issues of the use and regulation of cannabis*. This axis of work will establish the context for a better understanding of modern practices in the production and use of cannabis. The main questions are:
    - What are the key historical patterns in the production, use, consumption and circulation of cannabis?
    - Is there a relationship between cannabis use and religious or cultural practices?
    - What are the relationships between the production, use, consumption, and circulation of cannabis and the socio-demographic characteristics of populations? More specifically, what do we know about cannabis users?
    - What are the key domestic and international drug routes and how are they related to national and international political and policy issues?
    - What are the relationships between various drugs and how have current distinctions between licit and illicit drugs been created?
    - What are the relationships between the production, use, consumption, circulation and regulation of drugs and criminality?
    - What are the key economic issues in the production, use, consumption, circulation and regulation of cannabis?

- *The medical and pharmacological aspects of the consumption, use and regulation of cannabis*. The use of cannabis for medicinal purposes occupies an important place in current debates on regulatory systems governing it. The idea here is to produce state of the art reviews on knowledge related to the physiological and psychological effects of various drugs. The key research questions are:
    - How has cannabis been used for medicinal purposes?
    - What is the state of knowledge on the therapeutic properties of cannabis?
    - What is the state of knowledge on the physiological effects of cannabis, especially in respect of addictive capacity?

- What is the state of knowledge on the psychological effects of cannabis, especially in respect of dependence?
- What is the current state of knowledge on the effects of various forms of treatment for dependence and addiction problems, their impacts and their costs?

❖ *The legal aspects from a national perspective*. Federal legislative mechanisms exist in Canada to control the use, consumption, production and circulation of drugs, even though treatment and other areas, for example, are under the jurisdiction of the provinces and territories. Additionally, the courts have interpreted the relevant acts and regulations, particularly regarding policing powers. Overall, this section will examine the legislative and control arsenal, its rationality and objectives, from the standpoints of criminology, law, history, sociology and economics. The key questions guiding this third axis of the research program are:

- What are the history of and logic to the different regulatory and control modes of cannabis in Canada?
- What are the history and logic behind criminalization and penalization in Canada?
- What is the state of case law in respect of the legislative and regulatory arsenal relating to the production, use, consumption and circulation of drugs in Canada?
- What is the state of case law on police powers and sentences in relation to drug issues?
- What are the effects of criminalization and penalization in matters of drugs on the justice system (and its various components), the prison system and the criminal careers of delinquents?
- What are the economic and social costs of the various modes of regulation, control and criminalization in matters of drugs?
- What are the relations among justice and public health policies and government departments in matters of drugs?

❖ *The legal and political issues in an international perspective*. Canada is a party to various treaties and conventions on the production, trafficking and possession of psychoactive substances. It was important to assess how precise and binding these instruments are on domestic legislation. Also, these treaties and conventions are themselves part of a larger array of international instruments, especially on human and political rights; it was essential to determine the interrelationships between these instruments. Finally, drugs are an issue in international relations, in particular in relations between Canada and the United States. Although not legally binding, these factors may influence policy reorientations and will thus be interesting to look at. The key questions are:

- What are the main treaties and conventions in matters of drugs, their history and their provisions?
- What constraints, if any, do these treaties and conventions impose on Canada?
- Beyond treaties and conventions, what other aspects of international relations have implications for Canada in adopting a regulatory mode in matters of drugs?
- What are the regulatory approaches adopted by other countries, what are their impacts, and to what extent are they pertinent for Canada?

❖ *The ethical issues and Canadians' moral and behavioural standards*. Ethical issues and knowledge of the standards adopted by Canadians are also relevant in determining policy and legislative orientations. The key questions are:

- What are the ethical principles relevant to examining issues related to the production, use, consumption, circulation and control of drugs?
- What are the pertinent ethical principles in relation to the medicinal use of cannabis and the medical and psychological treatment of drug addictions and dependence?
- What are the current norms of behaviour of Canadians in relation to cannabis production, consumption, use and circulation?
- What are the norms of tolerance of Canadians?
- To what extent do ethical principles and norms of tolerance in the population accord?

As can be seen, the undertaking was a vast one. In an attempt to answer these questions in the most effective and most economical manner possible, the Committee agreed to perform two tasks concurrently: conduct a research program and hear expert witnesses–complementary activities.

Research program

Lacking both a research budget that would have enabled us to commission studies and a full-time research staff, we asked the Parliamentary Research Branch to produce syntheses and analyses of the relevant literature.[3] The research is divided into three major categories:

[3] A complete list of the studies produced by the Parliamentary Research Branch is provided in Appendix 3. All the research reports are available on line at the Committee's Web site: www.parl.gc.ca/illegal-drugs.asp. The Committee wishes to express its appreciation of the work performed for it by the Parliamentary Research Branch.

- Legal studies: analyses of case law and international conventions and treaties;
- Socio-criminological studies: analyses of the relationship between drugs and crime, of developments in denunciations, charges and sentences; cannabis use practices; economic aspects of drugs;
- Comparative studies: syntheses of public policies in certain countries.

We also received a synthesis of the literature on the physiological and psychological effects of cannabis.[4] Lastly, we commissioned a qualitative study on Canadians' opinions and attitudes by a public survey firm.[5]

In all, the Committee received 23 reports and benefited from summaries of work conducted in other countries, particularly through its attendance at international conferences.

Expert Witnesses

Aware of the research program's limits, and particularly of the need to question some of the researchers whose work was cited in the studies conducted and to compare their analyses with those of other researchers and with the positions of other expert organizations (police forces, for example), we conducted a series of hearings of expert witnesses in Ottawa and certain other cities across the country.[6]

The hearings began on October 16, 2000 during the 36th Parliament and resumed on April 30, 2001, during the 37th. They ended on June 10 of this year with presentations from the principal departments responsible for illegal drug policy in Canada. As far as possible, the Committee maintained a rate of one hearing every two weeks.

In every case, the Committee asked the witnesses to prepare a written brief responding to specific questions. The Committee did not expect the experts to give their opinion or tell it what to think. The expert witness hearings were part of an effort to increase members' knowledge. Knowing that our ability to conduct studies was limited and acknowledging that research data were incomplete, if not contradictory, we wanted to take full advantage of this exceptional opportunity to clarify and better disseminate certain findings.

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[4] Wheelock, B. (2002) *The Physiological and Psychological Effects of Cannabis: A Survey of the Literature*. Document prepared for the Senate Special Committee on Illegal Drugs. (The Committee particularly wishes to thank Senator Rossiter, who made the preparation of this paper possible.)

[5] Léger Marketing (2002) *An Exploratory Study Among Canadians on the Use of Cannabis*. Montréal: author. Report prepared for the Senate Special Committee on Illegal Drugs. Available at www.parl.gc.ca/illegal-drugs.asp.

[6] A complete list of the witnesses heard as well as subjects, places and dates is provided in Appendix 2. All the evidence and certain supplementary documents provided by witnesses are available on line at the Committee's Web Site.

Who were these experts? How did the Committee select them? These are important questions to the extent that a certain number of stakeholders questioned the Committee's credibility as a result of certain choices it made. First, we wanted to cover each of the major fields of investigation. Consequently, we heard sociologists and lawyers, psychologists and physicians, police officers and criminologists. Second, we wanted to hear as many Canadian experts as possible from those various research areas. Third, for the most part, we selected experts known for their publications in the field. The researchers included Professors Harold Kallant and Marie-Andrée Bertrand, who were closely involved in the work of the Le Dain Commission 30 years ago and researchers closely associated with such major institutes as the Ontario Centre on Mental Health and Addiction (the former Addiction Research Foundation) and the Canadian Centre on Substance Abuse. Lastly, we were interested in inviting experts who, in certain cases, could speak on behalf of major institutions such as the Canadian Medical Association, the Federation of Canadian Municipalities, the Canadian Association of Chiefs of Police and the Royal Canadian Mounted Police. It will be seen from a close look at the list of experts heard and the subjects of their presentations that they coincided with all our areas of concern.

When the hearings focused on the situation in other countries, we sought to strike a balance between those persons who could describe public policy and researchers whose work was recognized in their country and internationally. As the number and length of our hearings were limited, we had to make choices. At most we could hear four persons per hearing. As a general rule, we tried to choose a senior government official and three researchers.

One could also question our choice of countries heard: France, the Netherlands and Switzerland. We had initially intended to hear representatives from England, particularly because that country's public drug policies have been examined in many high-quality studies. Unfortunately, changes under way in there prevented us from holding those hearings. Similarly, we did not have enough time to hear from Sweden or Australia. However, we had the Parliamentary Research Branch prepare syntheses on each of those countries.

The case of the United States deserves particular attention. Chapter 20 describes American drug policy. However, at our hearings on the United States, which is much more complex and less monolithic than is often thought, we were unable to hear from those responsible within the U.S. government, although not for lack of trying. The Director of the prestigious National Institute on Drug Abuse (NIDA) had tendered his resignation a week before the scheduled date of the hearings, after accepting our invitation. And the Director of the Office of National Drug Control Policy in Washington declined our invitation. In short, we are dissatisfied at having been unable to hear the senior officials responsible for drug policy in the United States. Nevertheless, on June 10 2002, we held a private meeting with Dr. Hanson, the new Director of NIDA, and on June 11 we had an *in camera* meeting with Mr. Walters, the Director of ONDCP and some of his key advisors in Ottawa.

In all, the Committee held more than 40 days of public hearings in Ottawa and other Canadian cities, hearing more than 100 persons from all backgrounds.

One further note. It can be said that we did not handle the testimony of researchers and those of practising experts in the same way. That is true in part. To the extent that researchers presented data lending itself to critical review, containing verifiable data, which does not mean proof, on specific subjects, making it gradually possible to answer our empirical questions, we attached a certain degree of importance to them, which will be reflected in the passages cited throughout this report. The information from practitioners is not in itself any less significant or important in our view. However, the practitioners more often tended to express opinions than to present study data. They also did not have the same concern to give precise answers to the questions put to them. Those opinions are important, as are those of the Canadians whom we heard and who wrote to us, but they are nevertheless opinions, not cold hard data.

The challenge of synthesis

Faced with this massive amount of information, the greatest challenge was to synthesize it. The scientific literature on all of the topics addressed, particularly those concerning the effects of cannabis and users and types of use, is abundant. Experts reported to us on their research and that of other researchers. The reports prepared at our request are full of information, and our research team stayed on the look-out for recent publications and attended various international scientific conferences. In short, the task was to make sense of all this data, which, in addition, contained contradictory information at times.

At the same time, the data on certain subjects are still fragmentary. This is the case of data on trends in the use of cannabis and other drugs in Canada (Chapter 6), on the specific nature of therapeutic applications of cannabis, evidence of which often does not go beyond the anecdotal (Chapter 9) and simply on police practices (Chapter 14) or the decisions of Canadian courts (Chapter 15).

Synthesizing this information thus also meant making choices. While fully respecting the diverse range of perspectives, we nevertheless had to draw conclusions, accepting that some of the conclusions might be preliminary and that they might be contradicted by subsequent research. It is in the very nature of science that it is constantly in motion, and we accept that state of affairs. As a result, we are aware that we have left ourselves open to criticism. So much the better, we might add, first, because criticism will stimulate public debate, second, because it will undoubtedly pique the curiosity of researchers, who will verify some of our findings empirically, thus improving the state of our present knowledge, and, third, because our choices will be made plain in light of the guiding principles that are outlined in the next chapter.

TAKING OPINIONS INTO ACCOUNT

Public opinion is hard to grasp, first, because it does not exist in itself but is created by the manner in which the pollsters' questions are asked, by the manner in which the media report a debate, and by a broader context of representations the actual determinants of which are never precisely known.

Understanding public opinion on a complex subject such as drugs is not a simple matter such as discovering what type of laundry detergent respondents will buy at the supermarket. A seemingly simple question quickly becomes complex once Pandora's box is opened. A public opinion poll may ask the public whether they are in favour of decriminalizing cannabis. However, do we know whether every respondent understands the term "decriminalization" in the same way? The complex nature of this term is addressed in Chapter 21. Do we know whether respondents are for or against decriminalization for the same reasons? And once it has been determined that a majority is for or against it, do we know how that public policy choice would be implemented?

If it is the case, taking opinions into account is a necessity in a democracy. For us, taking opinions into account meant we had two closely related responsibilities: first, it meant we had a duty to inform, indeed to educate, although we hope those who are offended by that term will pardon us for using it, but we are convinced that on public policy topics, which are societal issues, it is the duty of political leaders to transmit information that educates, not merely convinces. The level of knowledge about drugs, even about cannabis which is the best known drug, is often limited and wrapped up in numerous myths. Our second responsibility in taking public opinion into account was to go and discover it. We did so in three ways.

First, we publicized our work as widely and as openly as possible to enable everyone to learn about it and react to it. Many chose to do so by writing to us, although they were relatively few compared with the number of people in this country.

Second, we commissioned a qualitative public opinion study. The focus groups conducted across the country as part of that study are described in detail in Chapter 9.

Third, we held public hearings in various cities across the country (eight in all), thus enabling a certain number of citizens to come and tell us what they thought, what they knew and what they had experienced.

We are aware that informing and seeking public opinion also means having a hand in forming it. It is thus not a neutral activity.

INTERPRETING IN LIGHT OF PRINCIPLES

All this knowledge, in the form of research and public opinion, still needs to be interpreted. Scientific knowledge is subject to constant verification. It at times contains

contradictions, as will be seen in Chapters 7 and 8 in particular. Knowledge of public opinion necessarily remains fragmentary and evolving. Thus the importance of interpretation.

Beyond this, a public policy, as noted above, is not based on knowledge alone, no matter how rigorous. Guiding principles are necessary, principles that can permit an informed interpretation of data and assist in the establishment of conclusions. This is the subject of the next chapter, which will describe the method we used to determine our guiding principles and the principles themselves.

CHAPTER 3

OUR GUIDING PRINCIPLES

What should public policy on illegal drugs consist of, policy here being understood in the strict sense of the word, as government through public debate and not party politics? As we are part of the Senate of Canada and therefore of Parliament, and having legislative authority, one might wonder why we ask ourselves the question. As legislators, are we not guided by the principles of good government, that is to say by public interest? In fact, what is public interest, and how is it determined? Does our position as Senators give us the *de facto* ability to say what is, or what should be, in the interest of Canada? We do not believe so.

When faced with social issues such as illegal drugs, we are like all Canadians, struggling with our beliefs, our knowledge, our values, our doubts and our myths. Our special access to some one hundred expert witnesses, our reading of numerous research papers and our discussions with dozens of people across the country have forced us to confront our preconceived ideas and images about drugs and to compare them with those of "others", and if not to change them, at least to refine them along the way. However, this is not sufficient to determine what is in the public interest. Experts, no more so than the many citizens we heard from, do not determine what is in the public interest. Studies show only the most superficial aspects of what Canadians think. In addition, when polls that are more sophisticated provide us with a more in-depth picture of public opinion, we will be no further ahead in trying to decide on the direction that public policy on cannabis should take. This is primarily because the greater good is not determined by polling to see which way the winds of public opinion are blowing, and also because, as is the case with our personal opinions, public opinion relies on unverified information, on preconceived ideas that are sometimes biased, and on values that are not always clear.

We heard quite frequently that the public policy decisions should be based on the future of our children, on the kind of society in which we wish to live and that we wish to leave them. Over the last two decades, Canadian society has implemented costly anti-smoking programs. Do we want to be in conflict with these by allowing the smoking of cannabis? Cannabis is a psychoactive substance that can impair certain cognitive abilities linked to learning in young people. Do we want to send the message that it is okay for them to take drugs?

Others said that the fundamental values of Canadian society, values of respect for people's rights and freedoms, of tolerance and openness towards diversity, were compromised by existing legislation on cannabis. They added that these laws are no longer in step with society, reflecting an inter-generational conflict between adults and youth, they bring about more harmful consequences than good, and on top of being ineffective they are iniquitous.

This is an issue of values, therefore, which opposes various ideas about public health, of community health, meaning both the physical well-being of people as well as of the entire community, of its moral fiber as well as the model of inter-relationships that it proposes. However, we do not all share the same values.

In the fragmented, disillusioned world in which we live, a world open to the sharing of cultures and of identities, albeit not always by choice, the issue of values is constantly at stake, and from this the very meaning of social life. Even the transcendental values that we all share, of sacred respect for life and of immanent justice, are not readily turned into public policy: abortion or capital punishment, for example. As for other values, such as freedom, truth or law, they are the subjects of constant debate in democratic societies and they are precisely the kinds of values that are at stake in a public policy on illegal drugs.

It has now been thirty years since the Royal Commission of Inquiry on the Non-Medical Use of Drugs, the Le Dain Commission, named for its Chairman, studied issues similar to those we are studying today. Its report on cannabis, whose scientific conclusions on the effects of the drug were generally accepted by all members of the commission, nevertheless led to … three reports: a majority report by three of the members, and two minority reports. During our first day of public hearings, Professor Line Beauchesne presented the fundamental differences of opinion among the members:

> *The dissension stems primarily from different visions of the values that should underlie a drug policy. I will refer to the report to illustrate the three positions that can be taken on drug use.*
> *The first position, based on legal moralism, is that advocated by Ian Campbell. This public policy approach founded on legal moralism justifies the current prohibition and resulting repression on the grounds that it protects common values. (…) Briefly put, the government is perceived as having the responsibility of establishing common values, which are then imposed on society with a view to achieving optimum social harmony. If everyone thinks the same way, then there will be fewer problems.*
> *(…) The second position, held by the majority of the Le Dain Commission members, is based on legal paternalism. Public policy based on legal paternalism justifies current prohibitions on the grounds that the State has a responsibility to protect non-independent persons, particularly young persons.*
> *(…)*
> *When we come to the third position, that taken by Marie-Andrée Bertrand advocating the legalization of cannabis, this brings us around to the whole question of values (…). Legal liberalism implies that the government maintains some responsibility for preserving individual autonomy to the maximum extent possible. (…) A public drug policy based on legal liberalism is founded on the premise that the*

> *government's role is to maximize opportunities for each individual to be a full citizen and to ensure that criminal law is never used.* [1]

Moralism is an affirmation of a set of shared values. Paternalism is protection of the weak. Liberalism is maximization of the independence of citizens. These three categories do not include all of the possibilities: communitarianism, for example, represents another approach. In some areas of public policy, at certain times, these various approaches can co-exist. Nevertheless, each one expresses a different concept of the role of the State and of criminal law, and the roles of science and ethics in the choices that must be made.

Having examined each of these subjects, we have elected to set down the guiding principles that clarify the concept we have of the roles that the state, criminal law, science and ethics must play in the development of a public policy on cannabis. These principles will then help us in our analysis of the information resulting from the research and current practices in Canada, and most of all, influence our recommendations. In this way, the reader will have the benefit of our attempts to make explicit the principles which all too often remain implicit, therefore giving the opportunity to all to take us to task for inconsistency, or to voice their disagreement with our conclusions, because they do not share these principles. We feel this exercise has the virtue of being both clear and transparent.

In order to assist our preparations for this work on the guiding principles, we asked four Canadian academics, well known both in their respective fields and for their independence, to prepare issue papers on each of the four main themes: governance, criminal law, science and ethics.[2] We strongly encourage Canadians to read these texts, which are of an exceptional richness and quality. We will use these texts freely, without pretending to render the complexity of their thinking, but neither will we simply echo their sentiments. Just as we did not ask witnesses to tell us what to think, but rather to share their knowledge with us while being as rigorous and as precise as possible, whether their knowledge comes from research or from experience, so we asked for issue papers and not for answers to our questions. We must formulate our own responses to the illegal drug issues before us, and that is what is expected of us.

We will begin with a reflection on ethics. We feel that such an examination, insofar as it affects the very bedrock of our values, as it imposes a requirement for

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[1] Professor Line Beauchesne, witness appearing before the Special Committee on Illegal Drugs, Senate of Canada, Second session of the Thirty-sixth Parliament, October 16, 2000, Issue 1, pages 33-36.

[2] They are: R. Macdonald, Professor of Public and Constitutional Law, McGill University, *The Governance of Human Agency;* A.P. Pires, Professor of Criminology, University of Ottawa, *Legislative Policy and "Two-Sided" Crimes: Some elements of a pluridimensional theory of the criminal law;* T. de Koninck, Professor of Philosophy, University of Laval, *The Role of Knowledge and Culture in Public Policy on Illegal Drugs*; and J.F. Malherbe, Professor of Social Work, Université du Québec à Montréal, *The Contribution of Ethics in Defining Guiding Principles for a Public Drug Policy.* These texts are available on line at: www.parl.gc.ca/illegal-drugs.asp.

communication and dialogue[3], is the cornerstone upon which the other guidelines are based. Our principles dealing with governance – that is to say the role of the State – and with criminal law as a tool for achieving social conditions, then, hinge on this ethical concept. We will conclude with thoughts on the role of science, or more specifically of knowledge.

ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY

Let us assume that science, with supporting evidence, had shown the harmfulness of a given drug – say tobacco – and that it is a "cause" of serious, indeed fatal illnesses. To what extent are doctors, judges, and in the end, the State, authorized to go to ensure that people do not smoke? What limits are there on intervention? This is the question posed by ethics, more specifically the ethics of "health". Should we simply ban tobacco and punish both its users and its producers? Should we educate people through prevention campaigns? Should we discourage smokers through their pocketbooks, for example with a surtax for the hospital care that their habit could make necessary?

We see that ethical reflections take us through what is, through the realm of facts, to the realm of what should be, of what would be desirable. Moving therefore from recognized facts (that cigarettes "cause" lung cancer) to standards (the majority recognizes that smoking is harmful), but, more important than standards, to values (health is the greater good) and finally to the means of passing on and above all implementing these values (smoking is forbidden and subject to a fine). At any of these steps, one could speak out and say just a minute, I do not agree. I do not agree with the statement of fact: what is the basis of, what studies support this "finding", one might ask. I do not agree with the standard: even though a public opinion poll may show that most people believe cigarettes cause lung cancer, is that reason enough to put an end to the debate? I do not agree with the established values: freedom is the greater good and not health - what is the use of being in good health under a totalitarian regime? Finally, disagreeing with the means chosen to implement the value - it being unacceptable to

[3] On this subject, see the work of the German sociologist and philosopher Jürgen Habermas, particularly *De l'éthique de la discussion*. Paris : Cerf. The author presents the process of ethical discussion as follows: Through debates, all participants must acknowledge that, in principle, each person participates fully, freely and equally, in the cooperative search for truth in which the unlimited strength of the best argument will carry the day. Practical discussion is considered as a demanding form of argumentative training of the will, which (…) must guarantee, through the universal presuppositions on communication, the fairness of all possible normative agreements negotiated under these conditions. (…) Furthermore, practical discussion is considered to be a process of inter-comprehension in which, due to its own nature, all participants ideally adopt a role. Therefore, the individual and ideal adoption of a role played by each person in particular and *privatim* is transformed into a practical public operation by all, intersubjectively and in common. (pages 18-19).

ban cigarettes under the pretext that they cause cancer because the means is disproportionate to the fact.

Anyone who has followed the debates on cannabis to any degree will have drawn a parallel. Because cannabis "causes" health problems (both physical and moral), the standard states that its use is "dangerous" and, under the banner of public health values (and of the protection of the most vulnerable: children, adolescents, etc.), its production, manufacture, sale and use, etc. will be prohibited. This is the basis of the existing public policy.

As Professor Malherbe reminds us, this way of setting out the cannabis problem – as in fact is true for other substances – encourages us to rethink our ideas on health, medicine and science. Moreover, going one step further, it obliges us to consider the issue of risk and of life itself in society.

We live in a risk-taking society, but in a paradoxical manner. On the one hand, we place great value on risk-taking: venture capital, risk management, putting no limits on success. We see this as much in the appreciation of certain kinds of political or corporate decisions, as in the emulation of certain kinds of risky activities, such as Formula 1 racing, paragliding, and other extreme sports. On the other hand, we are becoming intolerant of risks of life in society, of the risks that others represent to our individual lives. It is a search for safety, both individually and collectively, vis-à-vis the smalltime crook or the terrorist. Risk would be in conflict with safety and security as illness would be in conflict with health.

Between these two apparently opposed attitudes towards risk, a subtle change in connotation slips in and partly explains the paradox. In the first sense (risks we like to take or will accept others taking), the issue is clearly risk. Here, risk is seen as being positive, and offers a number of options: when faced with this kind of risk, the person can decide to forge ahead, to wait, or to give up. In any case, there is a broadening of possibilities, therefore of autonomy, an extension that is no doubt linked to the admiration these people elicit, which is also tinged with envy as we observe this action that our position as "mere mortals" rarely permits us. The shift in meaning happens with the second sense, which does not relate to our ideas on safety but rather of danger. Safety is a collective and individual good, as in food or occupational safety. Danger, on the other hand, is usually a loss or a limitation of freedom of action: when faced with danger, most of us stop, and withdraw from the scene. In this sense, danger reduces the range of autonomy. Therefore, it is not safety that is in conflict with risk, but rather danger.[4] The distinction is fundamental, because it refers us to the degree–whether real or perceived–to which we control our own existence. We sense that the "crazy Canuck" bombing down the slopes is at least in relative control of the risks he is taking; danger is different in that it implies loss of control.

We are collectively learning how to manage this risk/danger equation. The "risk" here, if one can put it this way, is thinking of risk as a kind of acquired individual

[4] There is an interesting discussion on the subject in Professor Pires: pages 41 passim.

autonomy, and of danger as a limitation of this very autonomy by "the other", bringing about in its wake withdrawal, intolerance, and concisely, fear. For if risk is the source of intense pleasure, danger generally gives rise to fear. If risk points to the improvement of the means that allow me to be more in control of my safety, danger points to threats coming from the outside, chiefly from the 'other', over which I have little control.

Some concepts in medicine, and in science in general, add to this paradox when they address risk factors, such as when smoking is considered a risk factor for lung cancer. This is also the case with delinquency: dropping out of school is a risk factor as regards delinquency. Within these meanings, risk here becomes a danger factor, the ultimate danger, of course, being death (cancer). This mechanistic and causalist concept of prevention erases the fundamental difference between the body-machine we occupy and the body-subject we are, to use the distinctions proposed by Professor Malherbe. There is, in fact, no direct link between the "objective" characteristics of our environment (including the personal traits of genetic history, family and culture, etc.) and the subjective perception we have of ourselves and of our relationship with our environment. In other words, it is precisely why two children born in a similar environment, in the same era and friends from a very young age, will take two entirely different paths in life. We have a body with a genetic inheritance and pre-dispositions; what we do with it and how we interact with others and our environment is something else entirely. Just as there is no immediate transfer of the recognized fact to the norm, neither is there any direct translating my biopsychological make-up into actions and thoughts.

The scientific approach searching to identify a statistical "norm" – the correlation between two facts – does not take into account the fact that we are not all equal in the face of this risk/danger equation. What for some would constitute a risk – going down an icy mountain on skis – would represent a real danger for another.

> [Translation] *Despite all we think we know about addiction, a considerable number of well-informed subjects "happily continue committing suicide" through their dependencies. While health education is largely thwarted, and not only in the field of toxic substances, it is because human subjects are in fact subjects, that is to say "subjective" beings whose behavioural reactions are linked much more to the meaning they attach to their behaviours than to the objective mechanical-medical consequences which statistical analysis claims to define.*
> *Some risks are no doubt worth taking for life to be worth the trouble of being lived, for it not to dissolve into a maniacal and fearful sequence of endless precautions (…). Lastly, what is most human (the most autonomy, we dare wonder): succumbing to fearful hypochondria and enclosing oneself in a cocoon of universal prevention (to the point of death by asphyxiation and loss of will) or living one's life through risks freely chosen and accepted.* [5]

This is where the central position of the concept of autonomy comes in. Autonomy, however, is to be understood here in a critical manner as *reciprocal autonomy*,

[5] Malherbe, J.F. (2002) *op. cit.*, page 7.

and not as autonomy where isolated individuals establish standards to their own liking. It should be borne in mind that autonomy, etymologically speaking, means "establishing one's own laws". This is not a question of arbitrary legislation, created for oneself, but of laws that permit, whenever possible, the successful interaction with others, which is the very bedrock of society. This autonomy is based on the ability to recognize the existence, the difference, and the equivalence of the other, allowing one to assume solitude, finiteness and uncertainty, respectively, to then move on to practice solidarity, dignity and liberty in return.[6]

The "dependent" person is not autonomous, some would say. Indeed, in their dependency, the drug addict, the alcoholic and the inveterate smoker are not. Neither the emotionally dependent person nor the person addicted to gambling, money or sex is fully autonomous. Next comes the question of the extent to which the state or society can intervene to encourage the slow achievement of this autonomy, and how to go about it. What are the respective roles of collective governance and criminal law as mechanisms of this governance? How can science contribute to this emancipation?

In any case, we note Professor Malherbe's comment, that:

> [Translation] *(…) the fundamental problem of our civilization is not whether it is acceptable to prohibit the trade in cannabis derivatives or even their use, but rather not to repress the expression of anxiety when it arises and, even better, to invent new ways of taming it. On this point, it is useful to recall that every unjustified restriction, which adds to the already heavy burden of civilized individuals, can only increase their sense of being the object of some form of totalitarianism rather than the subject of their own destiny. From this standpoint, anti-drug campaigns seem decidedly like attempts to deny death rather than recognize its presence in collective and individual life. (…) In this respect, we agree with N. Bensaïd, who says that preventive medicine conceals our fear of death by making us die of fear.*[7]

From this base ensues a definition of ethics as "*constant work, to which we can consent and which we perform with one another in order to reduce, as far as possible, the inevitable difference between our values as practiced and our values as stated.*"[8] With one another, indeed, thereby imposing constraints so that reciprocity and equivalence of the 'other' can be realized; this is the role of governance.

As a guideline, we will adopt the principle that an ethical public policy on illegal drugs, and on cannabis in particular, must **promote reciprocal autonomy built through a constant exchange of dialogue within the community.**

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[6] See Malherbe's discussion of the subject on pages 23-26.
[7] *Ibid.*, page 21.
[8] *Ibid.*, pages 27-28.

GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS

We are social beings. It is a trivial assertion, however it must be stated because it means that, *necessarily*, we always find ourselves in paradoxical situations where to a certain degree, each person has the free will to make decisions, and makes free decisions for himself, while at the same time, in order to regulate interactions with others, rules are established, a normativity, that is more or less complex or more or less formal, as is appropriate. This is true of relationships between couples, families, in sports, and at work, as it is of relationships between citizens and the government. Self-governance – acquired through the arrival of liberal democracy – is never complete and inevitably yields in part to the governance of the community.

Governance is relatively easy to develop within simple relationships: within couples, families, or businesses. This is not to say that its practice is easy: anyone with any experience of relationships as a couple will be well aware of how difficult it can be to make implicit rules explicit, and to agree on the rules of a shared life. However, the standards that are established between friends, between lovers, between parents and children, are in fact a set of relatively simple rules, and most importantly, rules whose effectiveness does not require the intervention of other parties, except in the case of a break-up or of abuse.

In feudal, pre-modern or pre-democratic societies, the prevailing rules for even the simplest social relationships were stipulated from the outside: by the sovereign, the lord, the church representative, the father or forefather, the head of the business, each one could issue orders and expect to be obeyed, being all powerful in his domain. The establishment of normativity was largely done without the involvement of "subjects", without their consent, and without any input on their part; they were excluded from the power relationship. Over the centuries, during which our modern-day democracies were built, we have moved on to styles of governance of ourselves and others that allow people to participate more and more in the development of the rules of life, both personal and social. We have also moved on from a situation whereby each person's life was decided by his or her destiny, and limited to the narrow prospects dictated by the place of birth and status, to an "indeterminate" life situation, which is open to the building a personal identity and history.

These are therefore (1) changes in the sources of normativity and their operationalization in society, and (2) changes in our relationship to these norms. In the first case, we are slowly becoming involved in the external formalization of the sources of behavioural norms. As they no longer ensue from divine right, from the sovereign or the church prelate, they are built through the political manifestation of the will of the people. They are entrenched in national constitutions, in legal decisions (in British Common Law) or in legal codes (the Civil Code). It follows that the supra-legal normativity (inherited from divine right) or the infra-legal (not set out in law), lose both their symbolic value and their real influence on social relationships, to the benefit of legal rules that are registered according to a recognized and legitimate procedure in the

social system by means of statutory provisions. Modern societies are legal societies, that is to say societies that base their management of relationships between people and between individuals, groups and institutions, on the rule of law. Never completely incorporated into the legal system, other sources of normativity have not disappeared completely but the pre-legal or infra-legal sources of normativity are less apparent, and sometimes less legitimate.

With this change of source comes a change in operation: while the sovereign or the church representative could convict, or even execute, without challenge to the legitimacy or rationality of their decision – except by risking the same fate – the means of expressing the will of the people, setting it out in the legal system, is now in the hands of judges and the legal system entirely. The legal establishment of norms is set in motion either by the public authority provided in the legislation (civil and criminal cases, for example) or by citizens themselves (private and civil lawsuits) and is put in effect primarily by the courts. Remedies exist, and most importantly, these remedies are theoretically the same for, and accessible to, one and all.

The relationship that a person has to the norms, and through this to all aspects of social life, is the third change. Choice and uncertainty have both increased, to the point that, today, the connection is not so much to the other person, but to the risk represented by being in contact with them. Normativity in and of itself is no longer considered inevitable, nor even a duty. Without being rejected, social normativity is called into question based on personal experience and worldview. The gap between the subject of the norm and the norm itself seems to be widening, while conflict resolution models are being made more formal.

Through the conjunction of these processes, governance becomes more and more instrumental. The mechanisms of formal normativity, i.e. lawyers, judges and the courts, sometimes take on a greater importance than the actual substance of the norms themselves: the immediate personal question is whether I have access to the recognized mechanisms of conflict resolution, or if, through my condition or my actions, I am excluded in one way or another. In other words, the means is replacing the end, the rule of law is replacing the requirement for a connection to the other, which is the very basis of normativity and of social life itself.

Modern societies are therefore faced with a series of sometimes paradoxical injunctions. Collective governance must: (1) allow social relationships to be regulated in the most orderly but least restrictive manner possible, (2) give expression to the norms and values shared by the community and (3) give each person the opportunity to define themselves in relationship to these norms and values. How can these seemingly obvious opposites be reconciled?

Based on Professor Taylor's work[9], we can say that there are two central spheres or preferred means of governance: the governance of relationships with others, and the governance of the self. The governance of collective relations is obviously part of the

[9] Among others: Taylor, C., (1989) *Les sources du moi.* Montréal: Boréal..

traditionally recognized areas of intervention of the state, even if the form and substance change. On the other hand, governance of the self does not come immediately or systematically under the jurisdiction of the state.

Collective governance

The state is far from the only source of normativity. But the fact that democratic states must act in accordance with the law and that most public policies come in the form of legislative texts, produces a kind of short-circuit whereby the source of law and the state appear as one.

Yet, as Professor MacDonald rightly points out, if the actions of the state are subject to the rule of law, the legal sphere is not limited to the State. In all known societies, rules have always been established for the governance of the self and of collective relations. They are implicit or explicit, formal or informal, all-encompassing or limited in their application, codified or recorded in the collective memory, extensive or limited to certain spheres of activity. In every case, whatever the nature or specific form of the rules, they serve to express for members of the community the conditions of collective life. They deal with marriage and parenthood, the ways in which one respects the life and property of others, as well as the connections to the invisible and the beyond. They take the form of prescriptions and bans, are implemented by the bishop or the mullah, by the king or his representative, or by the judge. Much as we might like to believe, we in modern times have not invented the codification of laws because the first legal code goes back to Hammurabi, the King of Babylon. In Roman law, Justinien was the first to suggest a code of laws, not to mention the Ten Commandments "handed down" to Moses.

In this sense, we agree with Professor MacDonald as concerns legal pluralism, according to which there are multiple sources of normativity and therefore of rules of action that are not exhausted by formal legislation. This is the distinction between law and "juridicity". As we mentioned above, juridicity can be derived as much from the family as from business, from school as from the trade union, from political parties as from religion. In this sense, juridicity "is the business of subjecting action to rules-based governance".[10]

Juridicity, of course, co-exists with other ways of governing individual and community actions: the brute exercise of power and war are examples of other forms. One of the main differences, however, between juridicity and other forms comes from the nature and the origin of its legitimacy. The establishment of legal rules of action involves a form of consent, if not of active participation, in the development and implementation of the rule, qualities that are not needed nor sought out in the case of domination by a tyrant or an occupying army.

[10] MacDonald, *op. cit*., page 24 of the English version.

The development of a formal juridicity, in the form of legal texts passed by legislative assemblies prescribing both objective and subjective rights, is at the very heart of modernity. It is in fact around these kinds of issues that the more specific question of the role of the State arises: when and to what extent should formal legal rules be developed, and how should they be enforced?

Modern societies are unique in that they have, amongst other things, given precedence to the formal rule of law over other sources of juridicity as regards the governance of social relationships, established the need for these formal laws to be adopted and implemented by legislative and executive arms of the State, and set up arbitration systems in the form of courts of law born of the State but having an arm's length relationship with the former two.

This formality of the law, or to be more precise, the legal normativity found in the legislative texts passed by the State, in no way signifies the disappearance of the other forms of normativity. Here Professor MacDonald gives us a relevant example of this:

> *For example, activity that the official criminal law sanctions and stigmatizes may be rewarded and valued in certain other normative communities. In socio-economically impoverished neighbourhoods where economic opportunities are limited, the manufacture and sale of illicit drugs may be an attractive means of escaping poverty. For those who are successful in the enterprise, the consequent advancement in social standing may more than offset the potential harms visited by criminal sanctions. Similarly, in an international context, in countries where the raising of traditional crops which are capable of being converted into illicit drugs is an indigenous cultural activity, and where conditions of poverty are such that the attendant economic benefits are necessary for subsistence, the criminal law (whether domestic or international) has little purchase.* [11]

In other words, juridicity is not exhausted in the formal law, and the role of the State is not limited to the processes of passing, enforcing and arbitrating formal legislation.

Governance of the self

Historically, juridicity has often been equated with moral standards, or has tried to model itself on them. These standards could come from religion, from philosophy, from an ethic, or a universal theory of nature as in Plato. In every case, they tried to say what constituted the "good life", how to conform one's life with the immanent rules of life, ending the cycle of reincarnations, or avoiding eternal damnation. In every case as well, the good life corresponded more or less to "life" in the most abstract sense, that is to say the focus was not so much on the destiny of the individual, but on that of the community, the group, the clan.

It is only as of the second half of the second millennium, during what we refer to as the Age of Enlightenment, that individual life slowly began to register as a primary

[11] *Ibid*., page 25.

concern in the governance of the community. This major change resulted in what Taylor calls "ordinary life", that of the "average sensual man", at the heart of which we find his connection to the world and his manner of connecting with it through the agency of family and work, being suddenly recognized. Having had no means by which to participate in the development of juridicity in general until then, the "citizen" acquired some legal authority and right to active participation (to simplify things, we could give as an example the right to vote), not only as a member of the community but as a whole and unique individual.

Up until that time, communities had a juridicity that was largely based on relationships with others, granting strong objective rights (the right to life: you shall not kill; the right to property: you shall not steal; etc.), with a weak cognitive component: while admitting that it continues (unfortunately one might add), to pose certain problems (take racial or sexual inequality) even throughout the twentieth century, - accepting respect for life as a universal norm has not met with great opposition. It is in this sense that we speak here, particularly following Pires' work discussed in the following section, of norms with weak cognitive components. These fundamental norms, which certain philosophers of law have said are natural laws, do not require a strong empirical justification. The same cannot be said of other norms concerning conduct such as homosexuality, abortion… or taking drugs. These norms are an issue of what we might call subjective rights that relate to individual behaviours that express personal choices achieved through a consensual exchange and thus being of little or less direct concern to the community. This is why we could say this is an issue of norms with a strong cognitive component: in order to be imposed as negative laws, that is to say as constraints or prohibitions, these standards need an exogenous justification drawn from the external knowledge of juridicity itself.

In this way, parallel to the process of legal formalization of the norms of governance in the community described in the preceding sub-section, the modern individual has acquired more and more room for governance of the self. This space is no longer, as in the past, entirely dictated by the determinations stemming from one's birth in a given place, in a given family, with given genetic "baggage". Except in some totalitarian regimes, neither is this space for the governance of the self entirely subjected to collective or religious rules. This space consists of a vast area of uncertainty that, in part, precisely explains why it is sometimes called "disenchantment with the world", or more prosaically "loss of sense" or "lack of values". In fact, we would say that neither comes into play, so much as a process of slow and hesitant reinvention of social life, in and through new ways of relating as individuals.

The role of governance

Governance is part of both the spheres of collective governance of the State and of governance of the self. If the State's chosen vehicle is formal law, the passing of legislation does not exhaust all the possibilities in terms of collective governance.

Moreover, governance of the self is the slow discovery – in the strong sense of the term - of the juridicity that underlies human action.

Professor MacDonald addresses the issue eloquently:

> *How ought law and legal institutions to be deployed to achieve the symbolic governance of human agency in a manner that facilitates the just achievement of individual and collective human purposes?* [12]

The issue brings us back to the purposes of community governance, which is to facilitate human relationships and self-realization, with a minimum of interference in such a way as to stimulate individuals' discovery of the source of normativity rather than having it dictated by an external body. It is not the responsibility of State governance to ensure either the health or the happiness of its citizens. It is, however, its duty to ensure that the rules that it enacts and the way in which they are carried out do the least possible harm to the individual's ability to develop his or her own moral code. Not a single morality, or at least a morality for everyone, as the majority position of the Le Dain report maintained, but a facilitation of access to morality for citizens, morality here being understood in the sense of the ethical discovery of fundamental laws regarding relationships with others, as Professor Malherbe pointed out.

Professor MacDonald proposes a definition of governance that is drawn from the work of the Law Reform Commission, which gives guidance: the goal of governance is freedom, and not control. It is a question of defining the goals of society through policies and action programs that are then implemented through systems and processes and upheld by actors, allowing for the encouragement and affirmation of human action. The law, vehicle of choice of governance, does not seek instrumental purposes of simple expressiveness of rules or limitations passed for and on behalf of citizens, but a reciprocal process of building social relationships through which people, citizens and governments, can constantly adjust their expectations in terms of behaviour.

We therefore accept as a guiding principle for governance that **all of the means the State has at its disposal must work towards facilitating human action, particularly the processes allowing for the building of arrangements between collective government and governance of the self.**

CRIMINAL LAW AND THE LIMITS OF PROHIBITION

During the course of this report, we will have plenty of opportunity to describe the degree to which criminal law is at the very heart of any discussion of illegal drugs. It has come to the point that debates between those we refer to as prohibitionists on the one hand, and liberalists on the other, have overshadowed all other considerations. The

[12] MacDonald, *op. cit*., page 78.

Italian sociologist Pareto (1848-1923), quoted by Professor Pires in his issues paper, said of human beings that even if we would like to believe that we are rational, we are above all argumentative beings, that is to say that we want "to give a logical aspect to behaviours that do not have the substance thereof."[13] In the context of the debate on cannabis, this sentiment takes on its fullest meaning: both sides hurling their arguments at the other, claiming they are recognized "truths".

Any discussion on the role and the place of criminal law as concerns illegal drugs, here being a question of cannabis, in effect poses questions regarding principles of the appropriateness of turning to criminal law. In general, both sides are quick to escape this stringent argument on the principles to turn to justifications. As is true of both sides, justification has nothing to do with the mechanism itself, being the criminal law, but with the target, being cannabis. The result is the litany of "proofs" of the effects of cannabis. For some, the effects are significant enough to "justify" turning to the criminal law, and to list the risks associated with the use of cannabis: addiction, learning difficulties, delinquency, and impaired driving. For others, these same risks are so minimal, or are already covered by other criminal legislation (driving under the influence), that they do not justify the use of the criminal law. Whatever the case may be, the debate is no longer in relation to the principles but on justification.

This reflection on the role of criminal legislation is specifically intended to bring us back to principles of the appropriateness of turning to criminal law. The central issue is to attempt to identify the criteria that will help us decide in what circumstances society can–or must–turn to criminal law. It must then be determined if these criteria justify the use of the criminal law in relation to cannabis.

Requirement for distinctions

Raising the question as to whether or not the use of criminal law as concerns cannabis is justified necessarily brings us back to a primary observation: the use of criminal law is not justified in all cases, but, in some cases, it must be. This observation is supported by three findings: (1) that most social relationships are regulated without the use of criminal law; (2) that certain behaviours are forcibly within the sphere of criminal law; and (3) that certain behaviours legislation has criminalized, at certain points in time, have since been excluded from this domain. The possibility of including or excluding human actions from the sphere of criminal legislation rests on the ability to make distinctions.

However, a significant difficulty arises as soon as this principle of distinction is accepted *in practice*, and not simply in theory. Once an act has been recognized as being a "crime", it becomes part of the body of what defines all offences: behaviours against society. According to the internal logic of criminal law, the only eligible distinction would *precede* the decision to incorporate a behaviour into the law or not. If the

[13] Quoted in Pires, A.P. (2002), *op. cit.* page 8.

behaviour at issue is one that goes against the common good, it is a crime. Otherwise, it would be an uncivilized act, perhaps even an immoral one, but certainly not a crime. Once such a decision is taken, the only remaining distinctions to make would be with respect to form: the kind of procedure to follow and the severity of the punishment according to the nature of the offence.

Everything is done as if there were no positive distinctions made within criminal law between offences, as if the distinction was made only from the outside, before making the act an offence. In fact, distinctions between types of offences do exist. These are the distinctions made by Professor Pires, between standard prohibited behaviours and "two-sided" prohibited behaviours. It is more usual to distinguish between "victimless" crimes and crimes "with victims", but this categorization is incorrect. On the one hand, under criminal law, the victim is all of society. There are certainly individual victims, but by some kind of extension, the harm has in fact been done to all of society. This would explain the principle of deterrence, in criminal legal theory: by punishing a guilty party, we try to dissuade all those who might be tempted to behave in the same way.

On the other hand, this categorization brings us back to a single aspect, the subject of the offence, losing view of the other processes by which criminal law distinguishes between different kinds of offences. In this way, another kind of distinction that is intrinsic to criminal law falls under the modes of justification. A decision to criminalize homicide does not require, as Professor Pires stresses, the undertaking of comparative studies in order to determine if one kind of murder is more or less harmful than another to the victim. The cognitive component is weak: here, there is no need to turn to external arguments to justify the criminalization. The act, in and of itself – this is the concept of *malum in se* – is enough to establish the legitimacy of the criminal standard. There is no such thing when the issue is drugs: since the beginning of prohibition, external justifications were needed regarding the harm caused by drug use. These subjects of criminalization have a strong cognitive component, in that they require a higher level of justification.

The distinction between kinds of prohibitive behaviours is therefore an analytical tool that is necessary in order to understand and think about the role of the criminal law as concerns drugs. What then are the criteria we can use in order to make these distinctions? This is the goal of the following sub-section.

Criteria for distinction

Professor Pires proposes seven criteria allowing for distinctions to be made between the various kinds of prohibitive behaviours in criminal law.

Seven criteria to distinguish between offences	
Nature of the offence	Is this an issue of a conflict or an exchange?
Capacity of the law for discernment	Can the law see a victim and distinguish them from the deviant?
Referentiality	Is the actor able to appreciate the consequences of his actions on another person?
Limitation on natural liberty	Is it possible that there could be limitation of the freedom of the person to act?
Justification of the offence	Must the law turn to outside knowledge in order to justify the enacted standard?
Application of the law	Does application of the law require any active intervention?
Effects of the law	Can the effects of applying of the law compromise the standard?

We will briefly examine these, one at a time.

The nature of the offence

In order for there to be an offence, harm must have been done, which brings us to the victim. As we said above, in the broadest sense, criminal law sees society as the ultimate victim of any offence. The direct victim of an assault or theft is a witness, in the technical sense of the law. However, at a concrete level, the law recognizes direct victims. In certain cases, the concept of victim falls somewhere between the two: it is the neighbourhood or the surrounding area, for example, in the case of nuisance caused by solicitation for the purposes of prostitution. However, these nuisance situations are themselves at the limit of criminal law, in a sort of gray area between standard offences and two-sided offences.

What is remarkable is that the criminal law cannot take all three levels into account at the same time. If it recognizes the direct victim, then society becomes invisible. If it considers the neighbourhood, it becomes even more evident that it can no longer recognize a direct victim or society as a whole. Finally, and above all, if it takes the perspective of society as a whole, then it loses sight of not only the direct victim, but what is more, it loses its specificity. In effect, in the latter case, one could say that civil law also protects society: without respect for sales contracts and debts, society would go down the drain.

It is therefore not only the harm caused, nor even the presence of a victim that gives certain acts their criminal character, but the fact that they bear witness to conflict, abuse of power, infringement of one social actor upon another. Obviously, civil law also serves to resolve conflicts, from which comes the need for more criteria.

Capacity of the law for discernment

Is the law able to differentiate a victim from a perpetrator? In the case of standard prohibited behaviours, it generally can. For example, the victim of a homicide can clearly be distinguished from the perpetrator. Of course, there are exceptions to these

standard scenarios, for example, where the victims themselves face criminal charges. A case in point would be where a victim of sexual assault is convicted of contempt of court for refusing to testify against her attacker.

When faced with two-sided prohibited behaviours, criminal law is hard-pressed to distinguish the victim from the perpetrator. Or, it finds the perpetrator to be the victim that must be protected from himself. Consequently the perpetrator becomes the victim of his/her own behaviour.

Alternatively, cognisant of the limitations and difficulty involved in punishing the victim - for example, a prostitute - criminal law shifts from the phenomenological world (the facts) to a different mode of reasoning. It moves from an analysis-based mode of reasoning (evidence enabling deduction) to one based on consequentialism or teleology (the goals underlying behaviour). For instance, criminal law justifies its intervention by the need to protect children. Consequently, it loses, and causes us to lose, sight of the (ultimately inexplicable) reasons why the offence was brought before the courts in the first place.

Referentiality

This term refers to the capacity of perpetrators of the offence to recognize – despite "explanations", denial or other self-justification methods - the harm caused to others by their actions. Even in case of some borderline standard prohibited behaviours, such as cruelty to animals, the perpetrator of the offence – who, for example, has hanged his neighbour's dog from a tree – may recognize the harm caused by his/her action to the animal's owner. The criminal act in the case of two-sided prohibited behaviours may be self-destructive, but is not motivated by maliciousness towards others, since it does not create a direct relationship with others. Indeed, the sociologist A. Ehrenberg raises the issue of the absence of a relationship with others exhibited in all types of drug use when interpreted as a form of withdrawal from the world. However, this is already beyond the issue of criminal law into to the realm of political discussion on democracy.

Limitation on natural liberty

We shall deal only briefly with this issue here since it is discussed at greater length later. Suffice it to say, however, that the law places special restrictions on what Kant called the "unfettered freedom of action": criminal law restricts an individual's liberty to take the life or property of others. Consequently, it institutes specific rights and freedoms, i.e. the right to enjoy life and property. Fundamental problems arise where the law seeks to restrict the very rights and freedoms that it provides. A case in point is prostitution, where the law seeks to restrict the very right to enjoy one's own body and the freedom provided for by the law.

Justification of the offence

Criminal law very seldom uses external sources to justify the criminalization of offences. A good example to illustrate this is our original homicide scenario. Criminal law does not refer to sociology, anthropology, history, economics or medicine to establish the various effects of different types of homicides and various ways of taking life. The same rationale can be applied to sexual assaults, theft, fraud, etc. The cognitive component in the justification process is weak. The rationale underpinning the standard prohibited behaviour is deeply rooted in the social relationship. It is quite clear that any society even considering legalizing homicide would become untenable and would cease to be a society at all. Consequently, our society does not question the validity of the criminalization of homicide. The sole issue that arises in some countries, but which was addressed in Canada a long time ago, is the sentence society imposes on murderers.

Quite the opposite situation exists for two-sided prohibited behaviours. They require empirical demonstration and justification with a strong cognitive component. As one might expect, this issue is central to any debate on drugs. Indeed, this report accords a great deal of importance to this matter.

Below professor Pires deals with this issue in graph form.

Table 5: Illustration of the reversal of direction of the bases for criminalized prohibited behaviours

As professor Pires points out, the criterion here is not to establish whether there is consensus or “dissensus” on the criminal standard or on the terms relating to the type and possibility of democratic debate but rather to determine whether the source of the legitimacy of the standard is endogenous or exogenous. In the case of standard

prohibited behaviours, the source is endogenous. In the case of two-sided prohibited behaviours, it is exogenous. However, the criminal law creation process remains the same, i.e. democratic debate resulting in the adoption of enabling legislation. It is for this reason that it is all too easy to lose sight of the fact that the two types of offences are not in fact of the same nature.

> [Translation] *The important point to remember is that all two-sided prohibited behaviours to which this criterion applies exhibit certain specific problems. (i) They all have a more precarious, more ideological or more fragile endogenous basis because they are not rooted in a concrete, conflictual deviance and because the norms are not sufficiently detached from certain forms of (purely moral or religious) knowledge or are not sufficiently unaffected by knowledge of facts. (ii) They are therefore more subject to a process of selection from the available knowledge and to the actual value of the knowledge that we select or that is available to us in respect of them at a particular point in time. That means that a critical and serious examination of the knowledge is of crucial importance. (iii) They are, to all intents and purposes, more polemical and subject to public debate at a particular point in time, and more likely to be based on major cultural or cognitive misapprehensions.* [14]

Application of the law

In the vast majority of cases involving standard prohibited behaviours, offences are brought to the attention of the police by way of a complaint. Complaints to the police most often involve theft, sexual assault and homicide. Indeed, approximately 90% all offences that come to the attention of the police do so through complaints. In the case of two-sided prohibited behaviours, close to 100% of offences are discovered pro-actively.

One might point to the increase in complaints from people living near cannabis plantations in British Columbia. However, these people's complaints perhaps deal either with the very real danger of fire – since the illegal nature of cannabis production forces producers to illegally tap into electricity lines – or with pressure on them from criminals to keep quiet – also because producers are forced to operate illegally.

The pro-active application of the criminal law in the case of two-sided prohibited behaviours has harmful consequences, including social and human costs but also the possibility of discriminatory application of the law or police corruption. This raises the question of whether the endogenous basis of the offence warrants these consequences.

Effects of the law

The effects of the law stem, to a certain extent, from the previous criterion and all the others before it. This criterion relates to the legitimacy of the standard. The difficulties and criticism arising from pro-active police action, changes in social normativity or in the knowledge base, make the law counter-productive, which, in turn, raises questions *sui generis* as to its basic tenets and legitimacy.

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[14] Pires, A.P., (2002) *op. cit.*, page 59.

We have compiled Professor Pires' suggested criteria under three headings. Each criterion includes an "action-related" and a "law-related" element, which can be used in distinguishing between various criminal offences.

Nature of the offence. The action here refers to the relationship between the "victim" and the "perpetrator", i.e. are they in a conflict or exchange-type situation? The law-related criterion focuses on establishing whether criminal law is able to distinguish between the victim and the perpetrator.

Justification. The action in this case is to determine whether perpetrators are able to recognize the harm caused to others by their actions. The legal aspect of the equation deals with determining the basis of the legitimacy of the standard.

Operativity. The action relates to identifying whether the application of the appropriate standard is triggered by the victim or witness or whether pro-active action is required by law-enforcement agencies. The legal side of the equation is to establish whether the enforcement of the standard could potentially sabotage itself.

It is our view that the analysis of *Criminal Code* offences based on these three criteria addresses the fundamental issue of whether limiting the liberty of an individual to act is justified in the criminal law. It is for this reason that we are less concerned about the criteria themselves than about the result of the application of theses criteria to the criminal law standard.

Application to illegal drugs issues

Are illegal-drug-related offences two-sided prohibited behaviours under criminal law? Undoubtedly so.

The offence created implies an exchange-type situation and it is relatively unimportant whether the subject of the transaction is a prohibited substance or not. It is deemed to be a consented exchange between two parties. In the case of cannabis use – or the personal use of the opium or cocaine that just happens to be growing in my garden, - no exchange with another party takes place. Nevertheless, possession is prohibited in Canada, as is use in certain other countries.

Criminal law is hard pressed to find a victim. With respect to impaired driving endangering the lives of others, the *Criminal Code* contains a provision for the punishment of an individual operating a vehicle under the influence of any substance. The argument that cannabis poses enforcement difficulties is not valid. The same difficulties apply to driving under the influence of prescription drugs. What about the issue of children? It is difficult to see how cannabis use harms children, except where an "uncontrolled" market, brought about either by a lack of regulations or by the current illegality of cannabis fostering illegal markets, does cause harm to children.

In relation to referentiality, a user or even a seller does not see himself or herself as causing harm to others. At least, this is the case for cannabis derivatives. Of course, a situation where "grass" is mixed with other substances and adulterated substances are sold to users is reminiscent of the era of prohibition and is one of the reasons why

prohibition was scrapped. To justify behavioural standards and the offence, criminal law has to refer to external sources over which – and the interpretation of which – it exerts no control.

The operativity of the standard raises both application problems and on-going questions as to the legitimacy of the standard itself.

On the whole, the legal basis of the criminal law is weak where the prescribed standard (1) does not concern a relationship with others and where the characteristics of the relationship do not create a victim and a perpetrator able to recognize his/her actions; (2) has to find its justification outside fundamental social relationships; and (3) results in a form of enforcement, the harmful effects of which, undermine and challenge the very legitimacy of the law. (Where criminal law is involved in these issues, the very standard prescribed by the law makes the perpetrator the victim and tries to protect him from himself, which it can do only by producing a never-ending stream of knowledge, which remains constantly out of his reach.)

This analysis indicates to us that **only offences involving significant direct danger to others should be matters of criminal law**.

SCIENCE OR APPROXIMATE KNOWLEDGE

> *The public is generally willing to leave the choice of control methods to the interaction between health care experts and government agencies because they recognize that the drug is being used essentially for their well-being and they rely on expert knowledge to decide the best way to protect that.*
> *(…)*
> *Therefore, in formulating social policy on non-medical use, you must consider not only at the harm done by the law or at the harm done by the drug, but as far as possible a full cost/benefit analysis of drug use and the control measures, and any change in control measures that you may contemplate. This is a matter for all of society to decide - not for experts to decide as a matter of scientific knowledge.* [15]

From the very outset of the Committee's proceedings, we have been aware that knowledge - even science-based, is not of itself a sufficient basis for the development of public policy on illegal drugs, in particular cannabis. One might be tempted to think that a Special Committee on Illegal Drugs - in this case, cannabis - should base its conclusions and recommendations solely on knowledge. However, no amount of knowledge alone could determine public policy. There are several reasons for this.

Firstly, the process of knowledge development is ongoing. This process is by definition a continuing study of the unknown. The pursuit of knowledge, in view of the scale and complexity of the task, is always approximate - or, as the French

[15] Evidence by Dr. Harold Kalant, professor at the University of Toronto, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, issue no 4, pages 69 and 78.

anthropologist Claude Lévi-Strauss would have put it, cobbled-together. To search for knowledge is to acknowledge our ignorance of fundamental questions, which by definition remain open-ended. According to Professor de Koninck:

> [Translation] *It is appropriate for us to celebrate the ignorance we have at last discovered because it is now part of our known ignorance (ordinary ignorance, in the classical vocabulary), as opposed to unknown ignorance (twofold ignorance) - thanks to neuroscience, oceanography, astrophysics, but also to depth psychology, the history of religion (to cite only two of the advanced "humanities") and to other disciplines which have particularly progressed in our era. We must celebrate it with the wonder and puzzlement which are still the necessary prerequisite of all discovery.* [16]

This situation might seem ironic, since never at any other time has such a wealth of information been produced – in all areas of human culture but also specifically on the issue of drugs – than in the modern era. So much knowledge has been gained in fact, that experts, such as economists, sociologists, criminologists, psychologists, and geneticists have become necessary players in the whole public policy justification process. It is only thanks to the ability of a team of scientists to successfully influence decision-makers that the greenhouse effect and the global warming phenomena have been acknowledged as real and that action has been taken to protect our environment. Governments' macro-economic decisions will be explained to the public on the nightly news by a senior economist. Where urban violence occurs or a serial killer is on the rampage, psychologists and criminologists are brought in to explain what is taking place, or to justify the thrust of criminal policy. The mass production of information and reference to experts in policy development give the public decision-making process at least credibility, if not legitimacy. Consequently, people who feel disenfranchized or even disillusioned by what they perceive as the disparity between the real world and the world presented to them in the media, will feel less inclined to challenge political decisions which are based on the "authority of knowledge". Information is becoming knowledge, the learned are becoming experts and politicians, (who are increasingly allergic to independent reflection on principles and fundamental issues), have come to rely on this handy army of "experts", who are ever ready to proffer advice.

However, information is not knowledge. Indeed, knowledge cannot be reduced to mere information. The Internet teams with information, but no one would dare contend that all of it could be deemed knowledge.

Secondly, the knowledge production process is fragmented and, like modern life itself, has difficulty addressing the issue of meaning. No better knowledge is produced with the addition of academic disciplines all studying issues through the lens of their own field of expertise than is produced when one of these disciplines works in isolation. The promotion of inter-disciplinary and trans-disciplinary approaches will remain as meaningless as calls for a social "partnership", until there is genuine resolve to grasp the issues of meaning and comprehension. Prestigious institutes such as NIDA

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[16] De Koninck, T., (2002) *op. cit.*, page 25.

may have huge research budgets and conduct research, which in itself, is both fascinating and useful, but they function as if their sole goal were to demonstrate the bio-psychological mechanisms of "drug addiction" and the dangerous abuse that results from the consumption of "drugs of abuse", as they call them.

However, the reasons for particular practices cannot be reduced to the sum of their constituent parts, or a jumble of re-enactments. Remarkable knowledge about cell mechanisms and genetics does not provide answers to the ethical and political issues raised by cloning. In the same way, knowledge about the mechanisms of the atom and nuclear fission did not provide answers to the issue of the manufacture and use of nuclear weapons. The highly abstract and math-based discipline of economic "science" is so far removed from reality that it is no longer able to explain the gulf that exists between nations or between extravagant wealth and human misery.

Researchers seem more concerned with mathematical equations and abstractions, and as a result, fail to ask fundamental questions. Their fields of knowledge are patchy and highly compartmentalized and there often remains a confusion between knowledge, information and technology. To ask fundamental questions, is to link issues and to re-acknowledge the complex nature of these issues in an attempt to identify the underlying reasons. There are on-going debates between scientists and philosophers over linking issues and over the shift towards an integrated knowledge base of human beings.[17]

Thirdly, this raises the whole issue of the so-called "learned idiot" "experts".

> [Translation] Idiots *is the right word (from the Latin* idiota*, meaning "ignorant person", borrowed from the Greek* idiôtês*, of the same meaning, as opposed to* pepaideumenos*, "cultivated man"). What is unfortunate is that their unearned reputation as experts extends all the more the influence of this "idiocy" in societies such as ours where "science" exercises a magic power and "that power appears increasingly legitimized by 'learned' experts," as Jacques Testart notes. "Indeed, the expert provides reassurances and citizens are reluctant to decry the absurdity or cynicism of a political decision approved by 'the most qualified experts'.* [18]

We are not trying to take issue with science but rather to challenge the difficulty scientists have in reflecting on their research. It is one thing to conduct cutting-edge research on specific issues, but it is quite another to claim to use the resultant fragmented knowledge to provide "explanations". It is yet another to attempt to provide answers that science is quite simply not able to provide. It is one thing to conduct studies of the behaviour of laboratory rats, which have been administered a dose of Delta 9-THC (the principal active component in cannabis), but it is quite

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[17] Based on a very eloquent exchange between a philosopher and a neurobiologist: Changeux, J.P. et P. Ricoeur (1998) *What makes us Think* (translation of: *Ce qui nous fait penser. La nature et la règle.* Paris: Odile Jacob), pages 77-78

[18] De Koninck, T. (2002) *op. cit.*, page 6.

another to claim that this type of experiment is useful in understanding cannabis use and its effects on human beings. It is still another issue to contend that this research can provide an answer to cannabis public policy-related issues.

Drug use is a social action and forms part of a particular individual's behavioural pattern and as such, cannot be reduced to mere neuro-psychological mechanisms. It might be useful to understand the mechanisms involved but this knowledge alone will not explain the reasons underlying drug use in our society.

Fourthly, the colonization of the mind by the authority of experts-acting as mediators between politicians and the community – equates to the dangerous colonization of social sciences by natural sciences. This is nothing new. This process began in the 19th century but significantly accelerated during the 20th century. The most significant manifestation of this process is the ever-closer links between psychology and neuro-science. Consequently, a transposition of methods and problem-approach systems has taken place. As a result, human sciences have now taken on a quantitivist-reductionist approach, which in turn has led to a knowledge crisis. A sample of 100 young people chosen at random to undergo a battery of psychological tests aimed at determining why they use cannabis will provide apparently serious anecdotal research and a series of correlations, which are unlikely to reveal the reasons behind drug use.

In some academic and decision-making circles, it is fashionable to refer to "*evidence-based*" policies. By this, we mean policies based on "scientific" evidence of approaches that work. One of the most striking examples of this approach was the Crime Reduction Strategy implemented in the United Kingdom in 1998 by the then newly-elected Labour government. Under this scheme, considerable money was earmarked to support those crime prevention initiatives that studies had shown to be effective with the goal of reducing various types of crime by a specified percentage over a five-year period.[19] Despite this scheme, the United Kingdom is currently facing a crime "crisis", in part because crime rates have risen, and the Crime Reduction Strategy is a shambles.

It is tempting to ask how the outcome could have been any different. Social engineering strategies in areas such as population control and crime prevention date back to the 19th century and have rarely provided tangible results. These initiatives, which are built on one or two "formulae", themselves drawn from a small number of controlled experiments, do not take account of the complex nature of the modern world, with its ever-growing, increasingly fluid and intangible interdependent and multi-level relationships. Is it in an attempt to flee this reality that we seek refuge in the mathematical abstraction of correlations between supposedly predictive variables?

The Committee' report - especially the second part - has put great emphasis on research-based knowledge. This focus is an attempt to do justice to the knowledge that

[19] Chapter 20 discusses this issue in greater detail since the strategy includes a drug-related initiative.

has been developed over the past few decades. We considered it important and indeed necessary to give it detailed consideration. Indeed, the Committee recommends that the drive for knowledge acquisition on specific issues that we deem to be important be continued.

We do not claim, however, to have answered the fundamental question of why people consume psychoactive substances, such as alcohol, drugs or medication. We were indeed surprised, given the quantity of studies conducted each year on drugs, that this area has not been covered. It is almost as if the quest for answers to technical questions has caused science to lose sight of the basic issue!

Scientific knowledge cannot replace either reflection or the political decision-making process. It supports the process. Indeed, we consider that its greatest contribution to public drug policy is in doing so. Our guiding principle is that **science, which must continue to explore specific areas of key issues and reflect on overarching questions, supports the public policy-development process**. No more, but no less.

CONCLUSIONS

One of the greatest challenges for modern societies is to collectively invent new forms of social life and community belonging that stretch beyond the tools of formal law. As individuals with objective and subjective rights, people can participate fully in the development – we would even go as far as to say the conquest – of the collective project of creating a society. It is no longer sufficient just to develop legislation and for people to automatically accept this legislation just because it was democratically decided by Parliament. We need to promote ethical participation - through discussion - in the development of collective and individual governance. The groups from civil society, whether they oppose the "behind-closed-doors" globalization process or support promoting fair and sustainable development, are asking how we can collectively develop a joint-participation normativity process, in which collective governance and individual governance are mutually supportive.

This discussion brings us to the conclusion that **public policy on illegal drugs, specifically cannabis, ought to be based on an ethic of reciprocal autonomy and a resolve to foster human action. It ought to defer to criminal law only where the behaviour involved poses a significant direct danger to others. It ought to promote the development of knowledge conducive to guiding and fostering reflection and action**.

CHAPTER 4

A CHANGING CONTEXT

Our work is being conducted at a time in history, in a given historical period. That history is not simply a field external to us, something outside us, exercising no influence on what we do. It is closely bound up with our actions, influencing them in various subtle ways. At the same time, because we are living through and making that history, we do not have the necessary distance from it to reconstitute all its elements or to understand all its implications. However, to re-situate our work in its complexity and uncertainty, we have a responsibility to attempt to ascertain certain elements of this history-in-the-making. This brief chapter is an attempt to identify certain historical elements we think are relevant to our effort. We have identified six elements which we have divided into two spheres, international and national, recognizing that those two spheres necessarily interact with each other. The international elements are: the globalization of markets and the trend toward economic and even political integration; the spiralling increase in discourse on safety and the drug-crime equation; and the aspects of change becoming apparent in certain countries with regard to drug policies. The national elements are judicial activism, which is reflected in significant court decisions at least with regard to the therapeutic use of cannabis; the adoption of the National Strategy on Community Safety and Crime Prevention; and the fight against organized crime.

CHANGES IN THE INTERNATIONAL SPHERE

The last two decades have witnessed significant changes in the international arena and in the structure of national states. The idea here is not to write the history of or to analyze this period. A few of those changes, however, have had a definite impact on drugs.

Globalization and integration

Since the early 1980s, with market deregulation, we have witnessed a globalization of trade and a more significant degree of continental integration. The end of the Cold

War and the disappearance of the Soviet Bloc, as well as the opening of China to capitalist markets, have merely increased the pace of these movements. As a result, we have seen, in particular, an increasing degree of integration of the European economy under the Maastricht accords and in the North American Free Trade Agreement between Canada, the United States and Mexico.

At the same time, rapid technological change, particularly through the Internet and satellite communications, has helped to further open borders, although in varying ways and to various degrees, depending on the level of development in the various countries, to the movement of goods and capital. Similarly, the increase in population flows and travel has led, at times by default or even against the will of certain states, to freer movement of people.

These changes have had a significant impact on the illegal drug markets. The opening of markets and borders has of course created new money laundering opportunities, while making it more difficult to monitor borders and transportation. However, we all too often forget certain effects of macro-economic policies governing global capital flows and expected structural adjustments, particularly in developing countries. One study produced for the United Nations International Drug Control Program clearly shows this.

> *Efforts to achieve (balance of payments) stability often aim to reduce the external deficit by reducing the level of domestic consumption. Macroeconomic stabilization often requires a reduction in expenditure by government and/or the private sector.*
> *In situations of reduced money growth, an infusion of hard currency can bolster a country's foreign reserves, ease the hardship associated with expenditure-related policies, and moderate foreign indebtedness. Drug money could in this light be perceived as a potentially stabilizing force, a source of capital without the strings of conditionality attached. Clearly, there are "benefits" which accrue to countries which serve as reservoirs of the revenues from the international drug trade.* [1]

In addition, the trend toward the privatization of entire sectors of national economies, particularly in Eastern European countries after the fall of the Berlin Wall, but also in a number of Latin American and Asian countries, in an environment in which internal regulation measures are weak and bank credit tight, fosters the inflow of money from organized crime particularly through the laundering of drug money. It has been observed moreover that the concentration of industrial production in those countries is not necessarily reduced following privatization, thus further favouring penetration by organized crime.[2]

Observers also too often forget the role of investors from the developed countries, where the push for deregulation and market liberalization originates. In those countries, as Campodònico has noted, "*(r)are indeed are prosecutions against drug traffickers or*

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[1] Keh, D.I. (1996) *Drug Money in a Changing World. Economic Reform and Criminal Finance.* Vienna: UNDCP, technical paper no. 4.
[2] *Ibid*., pages 11-13.

financial institutions of the industrialized world, which is precisely where most of the proceeds of drug trafficking are kept."[3] The result is a kind of dual discourse in which the necessity of liberalization of capital for multinationals makes it impossible to distinguish between clean and dirty money. The example of Peru developed by Campodònico and that of Russia examined by Keh show striking structural similarities.

The end of the Cold War also meant that the countries allied to the Soviet Bloc, or internal guerrilla groups, had to turn to other sources of financing. This is the analysis of the Geopolitical Drug Watch and its founder Alain Labrousse, who appeared before the Committee on May 28, 2001, citing the example of Kosovo:

> *What happened in Kosovo is a good example in this regard. The creation of the KLA was financed by intense heroin traffic from Istanbul. The heroin was sold in Switzerland to buy Kalashnikovs and handguns. They were more or less freely available and were stored in the Albanian part of Macedonia.* [4]

And as though to make the connection with the perverse effects of liberalization and the involvement of macroeconomics, Mr. Labrousse wrote in an earlier book:

> [Translation] *According to estimates, drug trafficking in the world generates between 420 and 577 billion francs in business annually. The growing role that these funds play in the democratization and economic restructuring process is leading to an explosion in drug production and trafficking in Asia, Africa and the East. It is this windfall, drawn on by local powers of all kinds, that fuels nationalist, ethnic and religious conflicts in the Third World and countries of the former Communist Bloc. Drugs, an economic issue and a tool of power, are now a given in international relations. Apart from a few major traffickers, the banking systems of the rich countries, the IMF and the major international organizations are involved.* [5]

Like other analysts, Mr. Labrousse observes that the developed countries are not immune to criticism since they "close their eyes" when their interests, particularly strategic and economic, are at stake.

> [Translation] *An incident occurred and was reported by the press when the international financial action group prepared a list of countries suspected of engaging in money laundering; it did not include either the Anglo-Norman island of Jersey or the Principality of Monaco, which surprised everyone. It was subsequently discovered that France and England had negotiated with each other to ensure neither appeared on the relatively infamous list.* [6]

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[3] Campodònico, H. (1996) "Drug trafficking, laundering and neo-liberal economics: Perverse effects for a developing country." in Dorn, N. *et al.* (eds) *European Drug Policies and Enforcement*. London: Macmillan Press, page 231.

[4] Senate of Canada (2001) Proceedings of the Special Committee on Illegal Drugs, Ottawa: Senate of Canada, Issue No. 3, page 27. The reports of the OGD may also be consulted at: www.ogd.fr.

[5] Labrousse A. and A. Wallon (1993) *La Planète des drogues: organisations criminelles, guerres et blanchiment*. Paris: Seuil.

[6] Labrousse, *op. cit.*, pages 28-29.

This is also the case of European interests in Morocco and Africa more generally, as well as American interests elsewhere, in tax havens.

Chapter 1 of the 2001 report of the International Narcotics Control Board (INCB), a UN agency responsible for monitoring implementation of international drug control treaties, concerns the effects of globalization and new technologies. The agency writes that, apart from their "innumerable benefits" globalization and new technologies have had perverse effects: undermined cultural identities, political and social itemization, marginalization and growing poverty in certain sectors. According to the Board, "*these disparities are exploited by drug dealers and traffickers in their attempts to develop new markets. Moreover, in the course of the last decade, the growth in trade and financial activity has provided criminals with greater possibilities for concealing the illicit transfer of goods such as internationally controlled drugs and precursor chemicals and for disguising the proceedings therefrom.*"[7] According to the report, drug traffickers use new technologies to enhance the effectiveness of product delivery and distribution, to protect themselves and their illegal activities and to commit conventional offences using new methods or to commit new types of offences.[8] Among other things, the Board also notes:

- The Inter-American Drug Abuse Control Commission noted for 1999-2000 that the Internet had become the most widely used medium for expanding the production of synthetic drugs in some countries of that region;
- According to the International Criminal Police Organization (Interpol), in 2000, over 1,000 Web sites world-wide offered to sell illicit drugs, mostly cannabis;
- Increasing recourse to electronic means of financial transfer, together with a massive growth in the volume and speed of monetary flows, lead to reduced capability for detecting illicit capital movements; and
- The Financial Action Task Force on Money Laundering (FATF) has warned that there are three characteristics of Internet use that could aggravate certain conventional money-laundering risks: ease of access, depersonalization of contact and rapidity of electronic transactions.[9]

In short, while the search for greater coherence, and indeed for better predictability of international markets, is highly promising, particularly as regards the developing countries, it also has untoward effects, regardless of all other geopolitical considerations. Moreover, these characteristics also afford “unexpected” benefits… for organized criminal groups.

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[7] *Report of the International Narcotics Control Board for 2001*. Vienna: author, page 1.
[8] *Ibid*., page 2.
[9] *Ibid*., pages 2-4.

Difficulties of the security debate

Over the same period, in various Western countries, a preoccupation for domestic security has gradually arisen in response to the perceived or actual increase in crime and to the public's feelings of insecurity. The effects of this have been observed in election campaigns based on law and order and in a shift toward measures considered repressive by some, such as zero-tolerance policies.[10]

With regard to drugs, this social discourse has had two main components. The first, starting in the early 1980s under Ronald Reagan's presidency, was the "war on drugs", which went far beyond U.S. borders. The second, starting in the late 1980s, an attitude increasingly emerged that equated drugs with crime.

The war on drugs made it possible to allocate unprecedented resources to the effort. It was at this time, it will be remembered, that Canada launched the first phase of its anti-drug strategy with a budget of $210 million over five years. In its "war on drugs" the United States allocated 17 times that amount, increasing federal spending alone from $100 million in the early 1970s to more than $17 billion in 2002. The combined spending of the federal government and the states on the war against drugs was estimated at more than $40 billion in 2002.[11] As a result, that war led to a quadrupling of the American prison population, from 500,000 inmates in the early 1980s to more than two million in the late 1990s.

> *During the 1990s, corrections constituted one of the fastest growing line items in state budgets. On average, corrections consumed 7 percent of state budgets in 2000. Today, it is costing states, counties and the federal government nearly $40 billion to imprison approximately two million state and local inmates, up from $5 billion in combined prison and jail expenditures in 1978. Twenty-four billion of that was spent on the incarceration of non-violent offenders. Despite the modest recent decline in state prison populations, the massive growth in state prisoners over the past two decades has meant that* ***one out of every 14 general fund dollars spent in 2000 was spent on prisons.*** *(…) The expansion of America's prisons has been largely driven by the incarceration of non-violent offenders. The percentage of violent offenders held in state prisons declined from 57 percent in 1978 to 48 percent in 1999. From 1980 to 1997, the number of violent offenders committed to state prison nearly doubled (up 82 percent), the number of non-violent offenders tripled (up 207 percent) while the number of drug offenders increased 11-fold (up 1040 percent).*[12]

In Canada, as will be seen in Chapter 14, while the overall crime rate has been declining regularly in the past 10 years, the percentage of drug-related incidents has constantly increased, and the overall prison population has remained stable. There are

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[10] On this point, see, for example, the work of Wacquant, L. (2000) Les prisons de la misère. Paris.

[11] McNamara, J.D. (2000) "Commentary: Criminalization of Drug Use." *Psychiatric Times*, Vol. XVII, No. 9.

[12] Greene, J. and V. Schiraldi (2002) *Cutting Correctly: New Prison Policies for Times of Fiscal Crisis.* Washington, D.C.: The Justice Policy Institute. See also Schiraldi, V., Holman, B. and P. Beatty (2000) *Poor Prescription: The Costs of Imprisoning Drug Offenders in the United States.* Washington, D.C.: Justice Policy Institute. Available on line at: www.cjcj.org.

even grounds to suggest that the percentage of inmates with addiction-related problems has in fact risen.

This discourse has resulted in a host of national and international measures, in particular increased policing powers in the war against drugs in various countries, a reinforced international police infrastructure, use of the war against drugs in international diplomacy and its reflection in UN proceedings, particularly at the United Nations' extraordinary session on drugs in 1998.

The other aspect of the debate is the drug-crime equation. For a significant proportion of citizens, drug use is associated with crime, when it is not simply reduced to one of its major causes. Witness the following comments:

> *We cannot continue to apply policies and programs that do not deal with the root causes of substance abuse and attendant crime.* [13]

> *In countries that have adopted permissive policies toward drug use, violent crime and organized criminal activity have increased proportionately to the drug trade.* [14]

> *The social harm from other illicit drugs (such as cannabis - ed.) presents a different picture. In some communities or neighbourhoods across the country, the harm caused to innocent victims of violent crime and property crime is very great. (…) This results from drug-addicted users committing crimes to get money to feed their habit.* [15]

Deeply rooted in perceptions and attitudes, this belief, which is discussed later in Chapter 6, and which research data support only in part, has resulted in a series of measures including the creation of special drug treatment courts and the introduction of treatment orders for offenders with known dependence problems, the spread of urine testing programs in the work place and in prisons, as well as the remodelling of socio-community intake systems.

This association of drugs and crime sprang from fertile ground, for a number of reasons: changes caused by globalization and the realignment of the role of the state, which explain at least in part the increased social and economic inequalities between North and South, but also within countries, in the North and in the South; the increased insecurity of general living conditions following the 30 years, from 1945 to 1975, of unprecedented prosperity and employment security; divisions within communities caused by uncertainty and inability to manage mixed populations. For all these reasons the increase in "ordinary" crime (break and enter, car theft, vandalism and so on) has become the perfect metaphor for the insecurity of living conditions. Being

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13 McCaffrey, B.R., Remarks before the First Annual Criminal Justice and Substance Abuse Conference, Albany, New York, June 29, 1999.

14 Testimony of Mr. Dale Orban, for the Canadian Police Association, before the Senate Special Committee on Illegal Drugs, in Senate of Canada, Issue No. 3, May 28, 2001, page 49.

15 Testimony of Mr. Michael J. Boyd, for the Canadian Association of Chiefs of Police, before the Senate Special Committee on Illegal Drugs, Senate of Canada, Issue No. 14, March 11, 2002, page 76.

an easy target that has considerable, very real impact on everyday life in neighbourhoods already subject to other social and economic problems, minor crime now elicited a stern, repressive response. Hence, in all Western countries, the number of prison terms and length of sentences increased starting in the mid-1980s. In addition to this collective security "crisis", there was a division between generations, as a result of which youths as a group came to be viewed as a source of concern, if not simply potential criminals. For example, during that period, Canada experienced an unprecedented increase in its reliance on detention for minors, placing it at the top of the list of industrialized countries in that regard.[16] Since young people are the principal drug users, the rest of equation was quickly established.

From anti-drug policies to drug policies

However, the advent of AIDS in the 1980s helped to cast doubt on prohibitionist policies on illegal drugs. Toward the end of the decade, it was discovered that intravenous drug users had a high rate of HIV and other pathologies such as hepatitis. In fact, intravenous drug use was the second leading cause of infection among men, after homosexual and bisexual practices, and the second leading cause as well among heterosexual women.[17] Repressive policies, based on prohibition of use, do not make it possible to adequately inform users or to adopt risk reduction and preventive measures, such as needle exchanges or supervised injection sites. The increase in harm reduction practices in a number of countries would be based on this new reality.

The creation of agencies monitoring illegal drug use trends was another factor in the questioning of drug policies. Until the mid-1980s, the U.S.A., England and Australia were virtually the only countries with systems for regular and repeated epidemiological surveying of drug use trends in the population. Starting in 1993, the European Union developed its tools to monitor trends in use and policy responses with the establishment of the European Monitoring Centre for Drugs and Drug Addiction and its focal points in individual EU countries. This regular monitoring system showed, among other things, that drug use trends may not vary so much with public policies as with social, cultural and symbolic factors.

Lastly, some states began to question their public policies on the basis of impact assessment studies. That was the case in particular of Australia and Switzerland as well as certain American states. Apart from the often emotional rhetoric, it was discovered in those studies that, in addition to having little impact on drug use, policies had significant untoward effects and high economic costs. It was moreover the results of certain cost benefit studies that led California and other U.S. states to review their

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[16] On this point, see, *inter alia*, the work of Bala, N. (2002) *Juvenile Justice Systems. An International Comparison of Problems and Solutions.* Toronto: Thompson Educational Publishing.

[17] Riley, D., *op. cit.*, page 14.

highly repressive approaches (involving, for example, automatic incarceration on the third offence, whatever it might be).[18]

While national legislation on illegal drugs, particularly cannabis, did not in fact change, there was nevertheless a distinct trend toward questioning practices, particularly legal practices, and seeking alternatives while still complying with the international conventions. That was the case of Spain, Italy, certain Australian states, Belgium and, more recently, Portugal and Switzerland.

CHANGES IN CANADA

We have identified three major causes of change in Canada over the same period which have had at times paradoxical effects: the judicial activism resulting from the coming into force of the Canadian Charter of Rights and Freedoms in 1982, the adoption of the National Strategy on Community Safety and Crime Prevention and the fight against organized crime. Since we will be discussing each of these causes more fully in subsequent chapters of this report, we will only briefly sketch out the broader context here.

Judicial activism

With regard to cannabis, there is undoubtedly no better example than the decision by the Ontario Court of Appeal in the *R.* v. *Parker.*[19] In that case, the Ontario Appeal Court considered the constitutional validity of the prohibition against marijuana under the *Controlled Drugs and Substances Act* in the context of its use for medicinal purposes. The Court unanimously held that Terrance Parker's allegations that the prohibition violated his fundamental rights under section 7 of the Canadian Charter of Rights and Freedoms were founded. Rosenberg J.A., writing for the majority, found that Mr. Parker needed marijuana to control the symptoms of his epilepsy and that the prohibition against marijuana possession was accordingly unconstitutional. The Court thus held that the statutory provision was null and void. However, they suspended the declaration of invalidity for one year, thus giving the government time to amend the act accordingly. In July 2001, as a result of that decision, the government made regulations circumscribing the use of cannabis for medicinal purposes.

Other judicial decisions altered the applicability of drug legislation in various ways, particularly regarding police powers. Certain of these decisions are briefly reviewed in Chapters 14 and 15.

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[18] See, for example, the study by Rydell, C.P. and S.S. Everingham (1994) *Controlling Cocaine: Supply vs. Demand Programs.* Rand: Santa Monica.

[19] R. v. Parker 49 O.R. (3d) 481.

Generally speaking, it has been observed that, since the Charter came into force, the courts have played an increasingly significant role in Canadian political life, and the drug issue has not fallen outside the scope of this judicial activism. Moreover, a decision on the issue of the use of cannabis for non-medicinal purposes is to be rendered by the Supreme Court of Canada in the coming months.

A national crime prevention strategy

In 1999, as a result of the work of the National Crime Prevention Council, the federal government introduced the National Strategy on Community Safety and Crime Prevention. The purpose of this national strategy, originally allocated an annual budget of $35 million, which increased to approximately $65 million this year, is to prevent crime through social development actions in the communities by taking action in particular on risk factors among children and youths. While the Strategy does not specifically mention prevention of drug use, a certain number of its projects and activities have focused on that issue in various ways.

The Centre has seen fit to fund two special drug treatment court pilot projects, in Toronto and Vancouver, for the purpose of preventing repeat drug abuse and related criminality. The Centre also supports an initiative of the Federation of Canadian Municipalities to introduce drug-free communities in a certain number of cities. It is also supporting the evaluation of alternative measures programs for youths accused of cannabis possession.

The fight against organized crime

If there is one legal subject that has given rise to extensive public debate, led to the passage of new legislation granting greater powers to police forces and resulted in spectacular police operations and no less spectacular trials, it is organized crime, in particular criminalized motorcycle gangs in Quebec, the Italian-Canadian Mafia in Montreal and the Asian heroin rings on the West Coast.

In 1995, Parliament passed Bill C-95 granting police officers more effective tools for investigating and prosecuting individuals taking part in gang activities. Four years later, three problems led the government to propose amendments to the *Criminal Code* and other statutes: the problems involved in implementing the act, the growing influence of organized crime in Canada and the illegal activities committed by police officers in undercover operations. In 1999, in passing Bill C-51 (an omnibus bill amending the *Criminal Code*), Parliament granted immunity from prosecution to police officers who had to commit offences related to money laundering in the course of an investigation or in performing other duties. According to the government, the purpose of that amendment was to support police officers in the fight against organized crime and money laundering.

In addition, on October 19, 2000, the Sub-Committee on Organized Crime of the House of Commons Standing Committee on Justice and Human Rights tabled a report proposing a series of amendments that could be made to the *Criminal Code* to facilitate the fight against criminal organizations. The Sub-Committee began its work in April 2000, and, in view of the nature of the subject under study, its members decided at the outset to perform their work in camera. Among other things, the Committee recommended that the *Criminal Code* be amended in such a way as to group together all provisions concerning activities relating to organized crime in a specific part entitled "Organized crime, designated substance offences, gangs and money laundering". A number of the Committee's recommendations were incorporated into Bill C-24, which received Royal Assent in December 2001.

A SOCIETAL DEBATE

These considerations of the global environment help put the drug issue in context. Always considered as a public security question, this issue more fundamentally concerns the upheavals societies are currently experiencing as a result of globalization. The place of drugs in those societies, which are shifting painfully from the modern to the post-modern world, attempting to reinvent society after individual destiny, so central to the cultural "revolutions" of the 1960s, has replaced family and collective destiny, raises questions about the boundaries of the individual and his relationship to others and about the very possibility of community given the significance of the individual. As the sociologist A. Ehrenberg has emphasized:

> [Translation] *(…) drugs appear as the condenser of uncertain responsibility. For democratic societies, it is the opportunity for a consideration of the limits of private freedom, that is to say of the tension between minimum contact with one's self, without which one cannot enter into relations with others, and minimum distance from self, without which one cannot make a society.* [20]

In another way, this is also what B. Alexander said in a brief he submitted to the Senate Committee:

> *Because western society is now based on free-market principles which mass-produce dislocation, and because dislocation is the precursor to addiction, addiction to drug use and to other substitute life styles within western society is not the pathological state of a few, but, to a greater or lesser degree, the general condition. Because free-market society increasingly provides the model for globalization, addiction is becoming more and more prevalent everywhere on earth (…).* [21]

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[20] Ehrenberg, A. (1995) *L'individu incertain*. Paris: Calman Lévy, page 163.
[21] Alexander, B.K. (2000) "The globalization of addiction." *Addiction Research*, Vol. 8, No. 6, page 504.

As may be seen, the drug issue cannot simply be raised in terms of criminalization or decriminalization because it refers to much deeper societal issues relating to the role of government of the self in a context in which political government of the community is changing, and to the relationship between the two. Reducing the drug issue to a question of more or less repressive or more or less liberal criminal legislation is to rule out broader questions and to play the game of the particular interests of institutions which have every interest in reducing the figure of the addict to that of the "other", the deviant, the pathological case, and drugs to mere illegal drugs, whereas the faces of drugs are many and diverse. As the International Narcotics Control Board states in its 2000 report, trafficking in licit psychoactive drugs and their increased use are, in many respects, much more disturbing phenomena than the illegal drug market. There is a great risk that we will mistake the tip of the iceberg for the iceberg as a whole and allow ourselves to drift away on notions as simplifying as they are dangerous for a true public policy on drugs.

PART II

CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES

CHAPTER 5

CANNABIS: FROM PLANT TO JOINT

Cannabis, marijuana, pot, grass, kif, grifa, ganja–from so many cultures, so many names for the drug made from *cannabis sativa indica*, one of the two main varieties of hemp. Beyond these various names are also different ways in which the drug is used and the context of those various usages: here marijuana is rolled with cigarette tobacco in a cigarette paper (joint), there kif is smoked in a pipe and elsewhere *ganja* is smoked in a water pipe. Sometimes it is baked into cookies or cakes. The French *pétard*, the English joint or the Indian *bangh* are all names for the product consumed and, at the same time designate different usages: marijuana is most often composed of the plant's flowering tops and dried, powdered leaves; *sinsemilla* is a preparation consisting of female tops of a private variety of seeds, whereas Indian ganja consists solely of fertilized flowering tops.[1]

These names are not mere accidents of folklore: like other substances, cannabis has codified uses that vary across cultures. The words used to name the same drug refer to a set of relations that populations of various cultures maintain with it, a kind of code of manners, but also of reasons to use the drug. In North America (United States and Canada), marijuana has long been identified with youth and the sexual liberation of the 1960s; in India and Jamaica, *ganja* has religious aspects which it does not necessarily possess in the West; and this same drug has still other cultural meanings in the Maghreb. We return to this question in Chapter 6.

This chapter first describes the cannabis plant and the various forms in which it becomes a consumer drug. We then take a brief look at the geographical origin of the cannabis plant and the routes along which it circulates in the modern world, noting at the same time its current modes of production (soil-based and hydroponic) which have developed in certain regions of Canada. We then describe the pharmacokinetics of the cannabis plant, in particular its main active ingredients and their metabolism in the body.

[1] See in particular INSERM (2001) *Cannabis. Quels effets sur le comportement et la santé ?* Paris: Les Éditions Inserm, page 143 passim; Ben Amar (in preparation); Wheelock, B.B. (2002) *Physiological and Psychological Effects of Cannabis: Review of the Findings*. Report prepared for the Senate Special Committee on Illegal Drugs, Ottawa: Senate of Canada.

ONE PLANT, VARIOUS DRUGS[2]

There are a number of varieties of cannabis. The best known are *Cannabis sativa*, *Cannabis indica* and *Cannabis ruderalis*. *Cannabis sativa* is the main variety which grows in virtually any climate. In dry, sandy and slightly alkaline soils, it yields plants that can reach up to seven meters in height. In Canada, the preferred variety for soil-based cultivation is *Cannabis indica*, which is a shorter plant, but with higher concentrations of Δ^{9-}THC (the main active ingredient of cannabis, discussed more fully below). There are male and female plants. In general, female plants are richer in Δ^{9-}THC than the males, which are often smaller and bare of leaves. Δ^{9-}THC is mainly found in the resin secreted by the flowering tops.

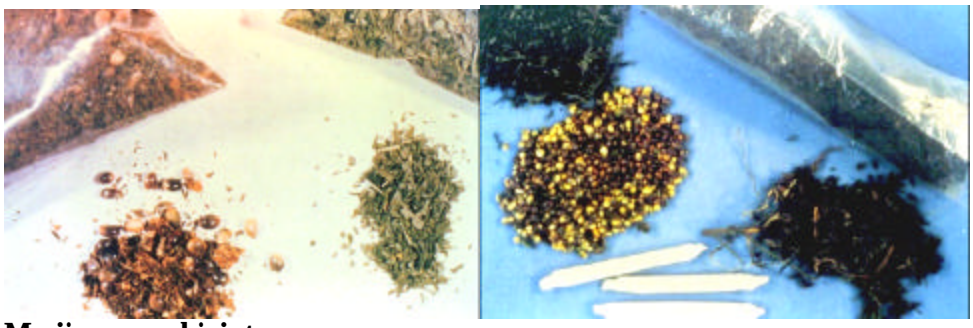
Flowering tops and leaves of cannabis

It appears that cannabis was first known in China some 6,000 years ago, then subsequently in India, then the Middle East, Africa, Mexico and South America. Cannabis can be cultivated in a number of ways, in greenhouses or hydroponically, which makes it possible to increase plant productivity and achieve high Δ^{9-}THC levels. Methods for genetically selecting the best greenhouse varieties and crops have also made it possible to increase the active ingredient content.

[2] This section draws freely on various papers, in particular those by Ben Amar (in preparation), of INSERM, *op. cit.*, and Pelc, I., (2002) (ed.) *International Scientific Conference on Cannabis*, Brussels. In particular, we wish to thank Professor Ben Amar for his permission to reproduce the plates.

Male and female cannabis plants

Marijuana, which is a Mexican term initially used in reference to cheap tobacco, but which subsequently designated certain parts of the cannabis plant, is generally green or brown in colour and produces a characteristic odour when burned. It resembles oregano or coarse tea.[3] Marijuana comes from all the parts of the plant once dried. In this form, its THC content is lower; THC content is increased by selecting the flowering tops of the female plant. Dried and coarsely powdered, marijuana is most often rolled into thin cigarettes together with cigarette tobacco (joint), and sometimes smoked in a pipe or, less frequently, in cigar form. A typical joint contains between 0.5 and 1 g of cannabis. Like hash, it can also be baked into cookies and cakes, and be drunk as an herbal tea as well. A number of specialists told us that domestic cannabis made through controlled greenhouse production costs approximately $100 an ounce, and is then sold on the street at average prices ranging between $200 and $250. While we consider this estimated production cost high, the only other available studies concern production costs in developing countries such as Morocco.



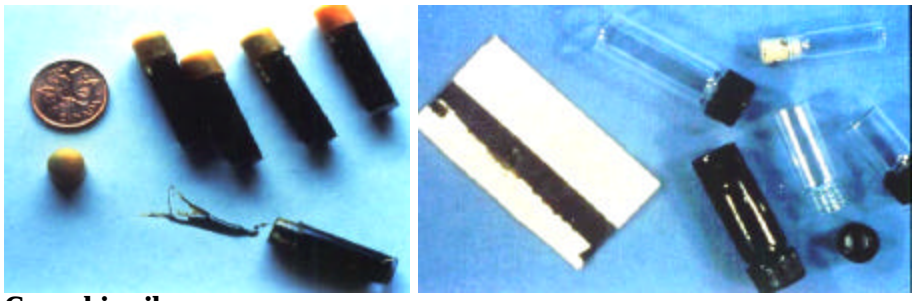
Marijuana and joints

[3] On these questions, see in particular: McKim W.A. (2000) "Cannabis" in McKim, W.A. (ed.) *Drugs and Behaviour. An Introduction to Behavioral Pharmacology.* Upper Saddle River: Prentice Hall; Health Canada (1990) *Straight Facts About Drugs and Drug Abuse.* Ottawa: Department of Supply and Services; and Comité permanent de lutte à la toxicomanie (2001) *Drogues. Savoir plus. Risquer Moins.* (Édition québécoise) Montréal: Stanké.

Hashish, also known as hash, shit, kif (in North Africa) and *charas* (in India), is the viscous resin produced by the marijuana plant and obtained by pounding then compressing the dried leaves and flowering tops to obtain what, in France, is called a "barrette" or here a cube or block. It takes approximately 45 to 75 kg of cannabis to produce 1kg of hash, which is sold in light brown to black pieces of hard or soft consistency. It is frequently smoked, alone or mixed with tobacco or marijuana, in a cigarette (joint), pipe or, more rarely, cigar. It may also be baked into cookies or cakes. The Δ^{9-}THC content of hash is generally between 3% and 6% in normal production. As is the case for cannabis, Δ^{9-}THC content can be increased through growing methods and resin concentrations to achieve levels of more than 10% on average. Slightly more expensive than marijuana, hashish sells for approximately $300 to $350 an ounce on the street.

Haschich

There are two other cannabis-based products, marijuana and hashish oils, which are extracted from resin using 90-proof alcohol, which is subsequently evaporated through exposure to the sun. These oils are viscous, greenish brown to blackish, foul-smelling liquids, with generally higher cannabinoid concentrations of up to 30% to 60% Δ^{9-}THC. Oils are generally dripped onto cigarette paper or tobacco then smoked. They are scarce and more expensive than other products.



Cannabis oils

The following passage from a report prepared by Labrousse and Romero for the *Observatoire français des drogues et des toxicomanies* (OFDT; French Monitoring Centre for Drugs and Drug Addictions) in 2001 on cannabis production in Morocco describes the various stages of production very clearly.

From Cannabis to Oil – The Production Process in Morocco

Kif is the name given to the cannabis plant as a whole. (…) Cut and dried in the sun (generally on rooftops) for at least a month and a half, it is preserved in houses for several months under plastic tarpaulins. Chopped by hand with a special knife on a board, it is then mixed with tobacco for smoking. The traditional mixture consists of one-third kif, two-thirds tobacco and is smoked in a *sebsi*, a long wooden pipe with a terracotta or stone pipe bowl.

Chira is the powder resulting from solidification of the small resin drops exuded by the flowering tops of the female plants. To separate the resin from the dried plants, processors pound or shake the plants over a stretched thin nylon veil that serves as a screen. The first powder to fall, golden beige in colour, is called *sigirma*. This is the top quality, so-called double-zero powder which is said to contain as much as 20% THC. The next powder to fall is called *hamda*, which is mixed with plant waste giving it a greenish colour. *Hamda* is lightly screened to yield various product qualities: zero, no. 1, no. 2, no. 3 and no. 4 (the lowest quality), containing respectively from 10% to 2% THC. (…) It takes approximately 100 kg of kif to obtain 1 kg of top-quality hashish.

Peasants (…) told us that the rest of the operation, when carried out by traffickers, took place in ostensibly secret buildings isolated in the mountains. (…) There the powder is placed in cellophane bags, then heated and compressed to yield resin or hashish, readied for the market in the form of small bars (generally 250 grams) called *tbisla* or "little plate". (…) The "double zero" quality, which derives its name from the two holes made in the bar with the end of a lit cigarette, is reserved for domestic consumption and preferred customers. Misinformed foreign customers often receive hash that has been cut with black polish, glue, henna, fig, earth or even medication.

(…) Cannabis oil is derived from no. 3 and no. 4 quality resins and produced by diluting hashish in a container with pharmaceutical alcohol. After six to eight hours of distillation, the liquid is filtered and stirred until all the alcohol has evaporated. Local production of this high value-added liquid (it takes 10 kg of hashish to produce one liter of oil) is less marginal than is generally thought.

Labrousse, A. and L. Romero (2001) *Rapport sur la situation du cannabis dans le RIF marocain*. Paris: OFDT.

CANNABIS ROADS

Where does the cannabis and hashish available in Canada come from? What quantities are imported and how much is produced locally? What routes are used to transport the drugs between provinces? What quantities are exported to other countries? What is the monetary value of this market? These are constantly recurring questions. They serve various purposes: to underline the scope of the drug “problem” generally, to explain the power of organized crime which makes money from drugs, as well as to substantiate the discrepancy between the size of the problem and the limited resources governments allocated to reducing supply. But this information can also assist in better understanding the extent of the problem experienced by peasants in the

various producer countries, the ecological issues raised by the cultivation of drugs, as well as the strategic position of drugs in geopolitics.

The cultivation of cannabis is the most widespread of all illegal drugs, which is not surprising since, not only does the plant grow readily in a number of climates, but it also requires little processing before becoming marijuana. According to the 2000 report of the *United Nations Drug Control Program* (UNDCP):

> *Over the last decade, 120 countries reported illicit cultivation of cannabis in their territory. Interpol identifies 67 source countries for cannabis through seizures made in 1998. (…) Estimating the extent of illicit cannabis cultivation, production and trafficking is much more difficult than for other plant-based drugs because of the significant amount of wild cannabis growth, the diverse nature of cultivation and the sheer magnitude of trafficking. In contrast to other plant-based narcotic drugs, illicit cannabis products can originate from three qualitatively distinct sources of supply: outdoor illicit cultivation; naturalized cannabis plant populations (wild growing cannabis); and plants cultivated indoors by means of sophisticated growing technology. (…) The large number of countries reporting an increase in cannabis consumption (two-thirds of all countries reporting drug abuse trends in 1996) would suggest that overall production must have increased; but this is only partly confirmed by seizure data. (…) Cultivation estimated (including wild growth), based on reports from Member States in the 1990s, ranges from 670,000 hectares to 1,850,000 hectares. Production estimates vary by a factor of 30, from 10,000 tonnes to 300,000 tonnes. Linking production and consumption estimates, UNDCP estimates world wide cannabis production to be at about 30,000 tonnes.* [4]

As may be seen, estimates vary greatly and are enormously difficult to validate. How can anyone estimate the number of cannabis plants that are transformed into marijuana? The data provided by the governments of various countries on cultivated areas are themselves only approximations. As to the number of greenhouses and other forms of production, there is quite literally no way of knowing.

The work of the team at France's *Observatoire géopolitique des drogues*, under the direction of Alain Labrousse, is exemplary in the field. The box from the same report produced for the OFDT in 2001, describes a three-month field project in which the authors cross-checked data from various sources.

Variable Estimates – The Case of Morocco

In their study, Labrousse and Romero state that, according to the Department of Agriculture, cannabis was produced on 75,000 hectares in 2000. (By comparison, in its 2000 report, the ODCCP cites the figure of 50,000 hectares in cannabis production in Morocco, an official figure provided by the Department of the Interior.)

Based on their own work in the field, they estimate that 90,000 hectares were in production in 1999 and between 110,000 and 120,000 in 2001. That production involved approximately 200,000 families, between one and one and a half million persons. Based on those areas, production would be between 1,600 and 3,000 tonnes, after deducting the quantities of kif set aside for national consumption.

Labrousse and Romero, *op. cit.*

[4] United Nations Office for Drug Control and Crime Prevention (2001) *World Drug Report 2001*. Oxford: Oxford University Press, pages 30-32. Available on line at http://www.undcp.org/adhoc/world_drug_report_2000/report_2001-01-22_1.pdf.

In particular, it has been observed that, when linked to the population of potential cannabis users (which the Centre estimates at some 120 million persons), the estimated global production of 30,000 tonnes is much nearer the 10,000 tonne floor than the 300,000 tonne ceiling.

According to the UNDCP, the main producers are Colombia and Mexico (marijuana) and Morocco (hashish). According to the International Criminal Police Organization (Interpol), Morocco, Afghanistan and Pakistan are the main sources of hashish and Colombia, Niger and South Africa of cannabis. Lastly, according to Labrousse, marijuana production is exploding, with Colombia becoming again the major producer it was in the 1970s, and production rapidly increasing in West Africa (Nigeria, Ghana, Congo, Ivory Coat, Senegal), although the great steppes of the Commonwealth of Independent States (Kazakhstan, Kirghizistan, Ukraine, Belarus and Azerbaijan) have virtually unlimited export potential, while Afghanistan and Pakistan likely produce 2,000 tonnes of hashish, the equivalent of Morocco's production.[5] In addition, Canada has been a cannabis exporting country for a number of years now.[6]

Traditionally, the cannabis available in Canada comes mainly from Mexico, Jamaica and the countries of the horn of Africa, while hashish originates mainly in Asia and the Middle East:

> *The hashish market in Central Eastern Canada is known world-wide. U.S. criminals are among the international traffickers who orchestrate multi-tonne shipments of this drug from Pakistan directly to Montreal by mothership or container. In 2001, some shipments transited the United Arab Emirates, Africa and Europe before reaching Canada. Multi-kilo quantities are also imported from Jamaica by couriers travelling on board commercial airlines.*[7]

While a large portion of cannabis sold in the Canadian market was of foreign origin until the 1980s, the situation has radically changed since that time. It is estimated that national production has now supplanted imports. In its 1999 report, the Royal Canadian Mounted Police writes:

> *It is estimated that more than 50% of the marihuana available in Canada is produced domestically. Of the foreign marihuana seized in or en route to Canada in 1999, at least 5,535 kilograms originated from Jamaica, 825 kilograms from South Africa and 860 kilograms from Mexico. Foreign shipments arrive directly into Canadian ports of entry or transit through the United States before reaching Canada. On June 11, 1999, U.S. Customs intercepted 2,464 kg of Jamaican marihuana and 141 kg of hash oil at Newark, New Jersey in a marine container bound for Montreal. Furthermore in Project JOULE*

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[5] Labrousse, A. (2000) *Drogues. Un marché de dupes.* Paris: éditions alternatives; see also "L'approvisionnement des marchés des drogues dans l'espace Schengen." *Les Cahiers de la Sécurité Intérieure,* 32, 2e trimestre 1998.

[6] See, for example, in OGD (1996) *Atlas mondial des drogues.* Paris: PUF.

[7] Royal Canadian Mounted Police (2002) *Drug Situation in Canada (2001).* Ottawa: author.

on June 20, 1999, 2,617 kg of Jamaican marihuana destined for Canada were seized in Stuart, Florida. [8]

How much cannabis and hashish are available in Canada? What is the monetary value of those drugs? It is in fact impossible to answer these questions, for obvious reasons, since the drugs are illegal. While we know the amount of tobacco produced and sold in cigarette form, and the volume of alcohol produced or imported and consumed, and sales turnover can be calculated in both cases on the basis of those volumes, it is impossible to do this for illegal drugs.

For a time, the United Nations International Drug Control Program suggested that the total value of the illegal drug "industry" was approximately US $400 billion, greater than the oil industry.[9] The total value of cannabis obviously cannot be separated from that amount, even though we know that the largest number of persons who use drugs use cannabis. No one really knows how or on what basis these figures are advanced, whether they were produced using a rigorous calculation method or merely noted down on a napkin over a meal.[10] And yet they often serve as a reference. In a series of articles published on the illicit drug issue in 2001, *The Economist* cited the $400 billion amount before suggesting a more conservative estimate of US $150 billion.[11] By comparison, the value of the pharmaceutical industry is near US $300 billion, that of the tobacco industry $204 billion and that of the alcoholic beverages industry $250 billion.

Since the authors provide itemized accounts of their calculation methods, we will now continue our analysis of the Moroccan example.

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[8] Royal Canadian Mounted Police (2000) *Drug Situation in Canada (1999)*. Ottawa: author.

[9] UNDCP (2000) *op. cit.*

[10] The Committee invited the Executive Director of UNDCP or a delegate to testify before it, but the invitation was turned down.

[11] "Stumbling in the Dark", *The Economist*, July 28 - August 3, 2001.

Yields and Returns from Cannabis – The Case of Morocco

Cannabis is a not very demanding plant that grows in poor soils, which it quite quickly renders unfit for any other form of agriculture. As a result of the illegal nature of this crop, the income it generates is disproportionately high compared to that from legal food and cash crops. It is also a non-perishable product that can be sold from the home, into an ever certain market and on credit. In particular, it enables local populations to improve their living conditions and opens the way to initiatives by the peasants themselves.

Estimates of per-hectare cannabis income vary with soil type, rainfall, degree of irrigation, whether the cannabis is processed into chira (powder), period of sale and other factors. In addition, researchers give various estimates based on the same criteria. This is due to the fact that it is difficult to obtain reliable data from mistrustful peasant farmers. Income from the production of unprocessed kif varies, depending on sources, from 12,450 to 210,000 French francs per hectare.

(…) while cannabis is highly profitable on irrigated perimeters, it is much less so on pluvial lands, particularly in poor years. (…) Many peasant farmers who likely cultivate only 1.5 ha to 3 ha (non irrigated) of cannabis, earn, in poor years, only 20,000 F to 40,000 F from that crop to support families of, in many cases, more than 10 persons.

(But) cannabis is 12 to 46 times more profitable than grain crops.

In 1997, based on production of 1,397 tonnes of hashish for the Rif as a whole, Pascual Moreno estimated the return for Moroccan producers (from the peasant farmer to the major trafficker) at $1.816 billion. Since a certain number of Moroccan traffickers operate outside the country, Moreno estimated the return to the Moroccan economy from cannabis profits at $2 billion, compared to $750 million for textile exports, $460 million from foreign investments and $1.26 billion for tourism. He also estimated the profits of European traffickers at $3 billion (apparently not including street sales).

However, since cannabis is more profitable than any other crop, peasant farmers tend to abandon food crops and to supply themselves from the market. As a result, there is a growing food shortage in the region.

Labrousse and Romero (2001) *op. cit.*: 12-15.

We know of no similar field work for Canada or Mexico. In addition, in Canada, climatic conditions have stimulated development of greenhouse and hydroponic crops, and the ratio of these cultivation methods to soil cultivation methods is not known.

We therefore use the following figures and data on cannabis production, cannabis and hashish imports and the monetary value of those drugs in the Canadian market, with considerable reservation and prudence.

According to the RCMP, "*the annual production of marijuana in Canada [is] at least in the 800 tonne range. This estimate appears overwhelming, however investigators believe it is quite conservative, and it is supported by intelligence and seizures of marijuana in plant and bulk forms.*"[12] The same figures are stated in the 1998 and 2002 reports. Note as well that, at 800 tonnes, Canadian production represents approximately 2.5% of global production, as stated by the UNDCP.

In its 1998-1999 annual report, the Observatoire géopolitique des drogues stated that, based on police sources, the value of the illegal drug market in Canada was $7 billion to $10 billion a year.[13] For 2001, the RCMP estimated that the market value

[12] Royal Canadian Mounted Police (2000), *op.cit.*

[13] World Geopolitics of Drugs (1999) *Annual Report 1998/1999*. Paris: WGD, page 178.

of all illegal drugs was $18 billion.[14] It is impossible to estimate the share of cannabis and hashish in that total. As we most often do not know the calculation basis for these estimates, they must also be prudently considered. As the Assistant Deputy Solicitor General stated in his appearance before the Committee, the calculation methods, based on the assumption that police and customs organizations seize 10% of all drugs, are unscientific and unreliable.[15] We nevertheless note an apparent inconsistency: the seeming stagnation of cannabis production at 800 tonnes and of hashish imports at 100 tonnes since 1998, as well as the declining prices of heroin and cocaine in a stable, even declining market (RCMP reports) are not consistent with the presumed doubling in total value of the drug market. As a result, in dealing with these various estimates of the quantity of drugs produced and monetary value of the drug market, the Committee often had the impression that, ultimately, no one really knew how big it was.

With regard to hashish, the RCMP believes that it

> *is easier to estimate the quantity of hashish entering the Canadian market annually than the quantity of any other illegal drug. Unlike what is observed for other drugs, such as cocaine and marijuana, that can be found across Canada and the United States, hashish use in North America is a localized phenomenon. The drug is very popular in Quebec, Ontario and the Atlantic Provinces, whereas demand is limited elsewhere in Canada and supply is sporadic at best in the northeastern United States. Consequently, Montreal organized criminal groups are specialized in the massive importing of hashish and have a monopoly on its distribution in bulk. In view of these facts and of information on multi-tonne hashish shipments seized in Canada and abroad and on those we know have entered the Canadian market, RCMP analysts estimate that at least 100 tonnes of the drug are imported into Canada each year.* [16]

Canada is also an in-transit country for drugs to the United States, and a significant portion of Canadian cannabis is intended for export, in particular to that country.

> *Smuggling of Canadian marihuana to the United States remains a source of concern for enforcement officials on both sides of the border. Though this activity is particularly noticeable on the British Columbia–U.S. border, it is not limited to that province. There is intelligence that the Hell's Angels in Quebec are supplying marihuana to their U.S. counterparts. Intelligence also indicates that there is marihuana smuggling activity across the Great Lakes. Despite the foregoing, few U.S. marihuana seizures can be traced back to Canada.* [17]

In 1999, Washington officials suggested that Canada could be placed on the list of countries suspected of a soft stance in the fight against drug production and trafficking.

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[14] Greater Toronto Area Combined Forces Special Unit (2002) *Fact Sheet - Heroin*. Available on line at: http://www.cfseu.org/heroin.html.

[15] Mr. Paul Kennedy, Testimony before the Senate Special Committee on Illegal Drugs, June 10, 2002.

[16] *Ibid*.

[17] Royal Canadian Mounted Police (2000) *op. cit*..

More recently, officials of the Drug Enforcement Administration repeated that Canada's trafficking in cannabis toward the United States was a significant problem. One RCMP officer told a national newspaper that approximately 70% of marijuana grown in Canada wound up in the United States,[18] whereas, according to the 2002 report of the International Drug Control Agency, the figure was approximately 60%.[19] We have heard, and RCMP officers confirmed it, that cannabis from British Columbia has such a high value that it was traded on par with cocaine. According to those police officers specialized in the war on drugs, British Columbia's triple A quality cannabis is worth approximately $4,000 a pound in Canada and one kilogram of cocaine is currently worth US $11,000. However, while reference is made to this supposition in the annual report for 1999, it is not confirmed:

> *Canadian marihuana is sometimes used as a currency to purchase cocaine that is warehoused in the U.S.A. The exchange ratio is about three to one. Exchanges of one to one have been rumoured but never substantiated. Furthermore, such a rate of exchange does not make sound commercial sense considering that a kilo of cocaine sells for $13,000 U.S. (in lots of 50 kilos or more) while the wholesale price of a kilo of marihuana ranges around $6,000 or $8,000 U.S.* [20]

In its 2002 report, the RCMP merely mentions the fact that Canadian cannabis is exchanged for cocaine, without saying whether it is on an equal weights basis. We also note a certain inconsistency here as the price of a kilogram of cocaine is expressed in US dollars, whereas that of a kilogram of marijuana is expressed sometimes in Canadian dollars, at other times in US dollars.

British Columbia, Ontario and Quebec are the main producers in Canada. British Columbia's large production can be attributed in particular to suitable climatic conditions, but there are probably also sociocultural explanations, as the Pacific Coast mentality explains in part why cannabis appears to have taken root there to a greater extent.

Cannabis production in British Columbia appears to have increased significantly over the past 10 years, becoming, according to some analysts, one of the province's biggest industries in terms of monetary value, which some analysts set at $6 billion, whereas, according to some police officers, a conservative estimate would be $4 billion.[21] If marijuana sells for $225 an ounce, at 16 ounces a pound, British Columbia would appear to produce the equivalent of 550 tonnes of cannabis a year, more than two-thirds of the total amount of cannabis circulating in Canada.

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[18] National Post, May 17, 2002. The Committee is interested, and somewhat amused, to note that this article and a previous report on the Global television network on May 13, 2002, outlining the concerns of American representatives, followed the Committee's publication of its Discussion Paper.

[19] International Narcotics Control Board (2001) *Report of the International Narcotics Control Board for 2000.* Available on line at: http://www.incb.org.

[20] Royal Canadian Mounted Police (2000) *op. cit.*.

[21] RCMP, private meeting.

Testifying in Richmond, B.C., on 14 May 2002, RCMP Superintendent Clapham said there were between 15,000 and 20,000 illegal cannabis production sites in British Columbia (figures from the Drug Enforcement Administration), while RCMP narcotics specialists, the next day, put the figure at 7,000. Regardless of the true number, the figures, as may be seen, must necessarily be considered very carefully.

As to growing methods, soil-based production is still the most popular, but the more sophisticated, hydroponic and aeroponic,[22] methods are expanding, particularly among criminal gangs that have the necessary infrastructure.

> *It is not uncommon to find indoor grow operations involving over 3,000 plants. Those figures vary considerably from one province to another, overall less than 10 percent of all marihuana seized in Canada was grown using hydroponics (a method of growing plants with the roots in nutrient mineral solutions rather than in soil). Indoor grow operations still rely mostly on soil-based organic cultivation but hydroponics is gaining in popularity. Despite the availability of highly sophisticated technologies designed to increase the yield even more, most growers do not bother to go to such lengths, preferring simpler and proven methods. Marihuana remains the most popular illicit drug, both in terms of consumption and trafficking. The annual marihuana production has been estimated to be around five million plants. Given the relatively low cost of setting up a grow operation and the considerable profits it generates, this activity has become increasingly attractive, even to otherwise law-abiding citizens. In the majority of regions, large operations are invariably run by outlaw motorcycle gangs, although Asian-based organizations have been making inroads in British Columbia and Alberta. More and more groups are using "crop sitters" and other go-betweens to tend their plantations. This hands-off approach makes it difficult for police to link the operation to the people who are actually behind it. Outdoor crops are often grown on Crown lands located in remote areas in order to reduce the risk of detection.* [23]

In all, with considerable reservations as to the validity of the data, the Committee submits the following:

	Marijuana	Hashish
Estimated quantity	800 tonnes	100 tonnes
- national production	approximately 50%	?
Source	National production (British Columbia, Ontario, Quebec) Imports: Mexico, Jamaica	Imports: Pakistan, Afghanistan, Morocco
Value (wholesale)	$2,000 to $4,000/pound	?
Retail value (ounce)	$225 to $250	$325 to $350

[22] Technique whereby the roots are suspended and sprayed regularly with water enriched with nutrient material, still very rare and the effectiveness of which remains to be proven. (Source: RCMP (2002)).

[23] RCMP, Drug Situation in Canada (1999) *op. cit.*.

PROPERTIES OF CANNABIS

Classified in the pharmacopoeia as a hallucinogenic, psychodysleptic or psychotomimetic, cannabis is a disrupter or modulator, that is to say that it alters perceptions and emotions. Classified in the international conventions and national legislation as a narcotic, cannabis belongs to the class of psychotropics which comprises five major groups: depressants (alcohol, Valium), stimulants, minor (coffee, nicotine) and major (cocaine, amphetamines), disrupters (cannabis, LSD), antipsychotics and medication for mood disorders (lithium).

More than 460 known chemical constituents are present in cannabis.[24] Of that number, more than 60 are identified as cannabinoids. The main active ingredient in cannabis, which was identified by the team of Dr. Mechoulam in 1964,[25] is Δ^9-tetrahydrocannabinol, common called THC. Other cannabinoids present in Indian hemp include delta-8-tetrahydrocannabinol, cannabinol and cannabidiol, but they are present in small quantities and have no significant effect on behaviour, compared to Δ^{9-}THC,[26] although they can modulate the product's overall effect.[27] Cannabinol also has anti-inflammatory effects.

For a better understanding of the effects of cannabis discussed in the following chapters, we will first consider its pharmacological properties. Consequently, readers may skip this technical section without risk of not properly understanding the rest of the report. In the following paragraphs, we first discuss Δ^9THC levels and, second, specifically examine the pharmacological properties of that substance.

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[24] See in particular Grinspoon, L. and J.B. Bakalar (1997) *Marijuana. The Forbidden Medicine.* New Haven and London: Yale University Press; Clark P.A. (2000) "The ethics of medical marijuana: government restrictions vs. medical necessity", *Journal of Public Health Policy*, 21: 40-60; as well as Wheelock (2002) for the Senate Committee.

[25] Gaoni, Y. and R. Mechoulam (1964) "Isolation, structure and partial synthesis of an active constituent of hashish", *Journal of the American Chemistry Society*, 86: 1646-1647; and Mechoulam, R. and Y. Gaoni (1965) "A total synthesis of delta-9-tetrahydrocannabinol, the active constituent of hashish", *Journal of the American Chemistry Society*, 87: 3273-3275.

[26] Smith, D.E. (1998) "Review of the American Medical Association Council on Scientific Affairs Report on Medical Marijuana", *Journal of Psychoactive Drugs.* 30: 127-136; McKim W.A. (2000) "Cannabis", in McKim, W.A. (ed.) *Drugs and Behavior. An introduction to behavioral pharmacology.* Upper Saddle River: Prentice Hall.

[27] Ashton, C.H. (2001) "Pharmacology and effects of cannabis: a brief review", *British Journal of Psychiatry.* 178: 101-106.

D^9THC Concentrations

The Δ^9THC content of marijuana generally varies in natural growing conditions from 0.5 to 4%.[28] Δ^9THC content serves first as a basis for distinguishing the drug type of plant from the fibre type: permitted concentrations vary by country - in Canada, as in France, it is 0.3% for the fibre type. For more than a decade now, techniques for selecting powerful strains and cultivation (in greenhouses and hydroponically) have made it possible to achieve Δ^9THC concentrations of 15% or more. Δ^9THC content is also used to distinguish between various cannabis products and thus to determine their price: the content of sinsemilla, for example, generally varies between 7% and 14% and is more expensive than "regular" cannabis.

The question of Δ^9THC content, its variability, how it is determined and its effects has raised numerous issues. While all specialists agree that maximum active ingredient concentrations have increased over the past 20 years, opinion is divided on average concentrations in cannabis available on the market. Estimates vary as to the preponderance and consequences of Δ^9THC concentrations.

First, it should be emphasized that studies show that concentrations are subject to extreme variability, for a number of reasons. First, failing a control system at source, the Δ^9THC content of marijuana is estimated on the basis of police seizures. However, only a portion of the drug seized is analyzed for THC content,[29] and analyses are not all equally reliable, depending on how police or customs officials conducted the seizures and how the products were preserved and transported to the lab. In addition, between a seized product in clandestine lab or at a customs post and the product sold on the street, a number of changes can be made: tobacco, herbs and other products can be added to the gram of "pot" sold at a school which alter the nature of the drug and thus the quantity of active ingredient. This is even truer for hashish, as seen above in the example on processing in Morocco.

Second, since cannabis is a widespread illegal product, it is impossible to take a representative sample of the drug available on the market at a given time for analysis. Thus it is impossible to measure the difference between the Δ^9THC content of cannabis seized at the production or delivery site and that of cannabis used by individuals. And third, the active ingredient concentration varies with the geographical area of origin, climatic conditions and production conditions. Likely circulating in the

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[28] Huestis, M.A *et al.* (1992) "Characterization of the absorption phase of marijuana smoking", *Clinical Pharmacology and Therapeutics*, 52: 31-41.

[29] Note, for example, that, in the United States, there is no systematic method for measuring THC. As emphasized in a comparative analysis of changes in price of heroin, cocaine and marijuana, "Another problem is that the DEA does not test marijuana for THC content, so there is no marijuana counterpart to the pure grams reported for cocaine and heroin. The difficulty this causes is the STRIDE data provide no basis for adjusting price changes for marijuana's quality." Abt Associates (2001) *The Price of Illicit Drugs: 1981 through the Second Quarter of 2000.* Washington, DC. Report prepared for the Office on National Drug Control Policy.

market at any given time is a significant variety of cannabis products reflecting the diverse conditions in which they were produced. It follows that two samples seized in Vancouver in the same week could have very different concentrations, as would be the case for samples seized the same week in Vancouver, Montreal and St. John's.

Experts told the Committee that cannabis in the Canadian market was 700% more powerful than the same drug in the 1970s. Some suggested that the average Δ^9THC content of cannabis on the market is approximately 30%, compared to 3% to 4% in the 1970s.

> *The cannabis used today is up to 500 percent higher in THC - that is a range between five percent to 31 percent - than the cannabis most adults remember from the 1960s and 1970s.* [30]

In its 1999 annual report, the Royal Canadian Mounted Police estimated the average content of seizures at 6%.[31] In Quebec, the Montreal Police Department asserted that the THC content of cannabis is now 25%. In a private meeting with Committee members, RCMP narcotics experts in British Columbia emphasized that it is *impossible in the current state of affairs to determine the average content of cannabis in the country* or in a given province, in particular as a result of the extreme variability of seizures and methods of analysis. The officers who conduct the seizures do not always pay attention to the manner in which they preserve the product, such that it may lose its Δ^9THC content: heat, light and humidity affect the stability of cannabis. Lastly, the experts providing cannabis for therapeutic purposes whom we met said they kept various grades of cannabis, based in particular on Δ^9THC concentrations, and that, in certain cases, the products offered to patients reached concentrations of 27%.

The most exhaustive studies on changes in Δ^9THC levels in cannabis have been conducted in Australia, the Netherlands, France and the United States. They show, first, that more powerful products have appeared in the market beside the traditional forms of cannabis: "skunk" (a variety originating in the United States and the Netherlands), "super-skunk" and "pollen" (stamens of male plants). Canada has not lagged behind, with *BC Bud* and *Quebec Gold* in particular.

More specifically, the studies on Δ^9THC concentrations show similar trends:

- In Australia, a study by Wayne and Wendy on 31,000 seizures conducted between 1980 and 1997 shows that average content varied little over the period and was between 0,6 % and 13 %. Among other things, it appears that the main development has been a more significant selection than

[30] Testimony of Mchael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, for the Canadian Association of Chiefs of Police, Senate Special Committee on Illegal Drugs, Issue No. 14, page 74.

[31] Royal Canadian Mounted Police (1999), *Annual Report*.

previously of the parts of the plant with the highest concentrations.[32] The authors of this study make the following observation which applies equally to Canada:

A number of factors probably explain the persistence of the belief that the THC content of cannabis plants in Australia has increased 30 fold in the absence of any supporting data. First, defenders of the claim often point to reports of single samples with unusually high THC content tested by the police. At best, such samples indicate the maximum THC content that has been achieved (assuming that there were no errors in the test results) but they do not tell us what the THC content is in the cannabis that is typically used by consumers. Second, biases in the sampling of tested cannabis are amplified by the attention that the print and electronic media give to unusually potent samples, creating the false impression that cannabis with exceptionally high THC is the norm. Third, uncontested repetition of these assertions in the media has established them as "fats"; those who context these claims are asked to prove that they are false rather than the (usually nameless) proponents being asked to provide evidence that they are true. Fourth, an increase in average THC content seems to explain an apparent increase in the number of cannabis users who experience problems as a consequence of their use. [33]

- In the Netherlands, the *Drug Information Monitoring System* of the Trimbos Institute has conducted various studies since 2000 on average Δ^9THC content. The local variety, *Nether-Weed*, contained an average of 8.6% THC in 2000 and 11.3% in 2001, whereas imported varieties were stable at approximately 5%. One of the reasons given for this difference was that the local variety was fresher and contained a lower ratio of cannabinol to Δ^9THC. In addition, *Nether-Weed* resembles sinsemilla, which comes from the unfertilized flowers of the female plant and is cultivated in greenhouses.
- In France, the Roques report referred to concentrations of up to 20% in the case of certain Dutch hydroponic varieties.[34] In its recent report, France's *Institut national de la santé et de la recherche médicale* notes a toxicological study conducted by Mura on the Δ^9THC concentrations of seizures since 1993. From 1993 to 1995, the average concentration was 5.5%, but approximately 8% since 1996, with spikes of up to 22%.[35] In 2000, 3% of marijuana samples analyzed contained Δ^9THC levels of more than 15%.
- Lastly, in the United States, data for 2000 show an average concentration of 6%, compared to 4.1% in 1997. In fact, recalling a study recently conducted in Mississippi, Dr. John Morgan noted:

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32 Wayne, H. and S. Wendy (2000) "The THC content of cannabis in Australia: evidence and implications", *Australian and New Zealand Journal of Public Health.* 24: 503-508.

33 *Ibid*., page 504.

34 Roques, B. (1999) *La dangerosité des drogues*. Paris: Odile Jacob.

35 INSERM (2001) *Cannabis: quels effets sur le comportement et la santé?* Paris: Les Éditions Inserm.

(…) in the midst of this furore over the remarkable increases in marijuana potency, it is interesting that the potency of the commercial crop sold in the United States has not varied enormously over the 30 years that potency has been assessed by the analysis of THC content in criminally seized marijuana. In fact, I recently looked at the report, which also comes from Mississippi, that the mean THC content of some 40,000 seizures since 1974 is about three percent. It has gone up in the last 10 years. In fact, in the last 10 years I believe the arithmetic mean is more than four percent while in the 10 years before that it was about 3.5 percent. [36]

The following table summarizes some of the data on a historical basis for certain countries.

Year analysed	Domestic Marijuana (USA) Foreign Marijuana (Netherlands)			Sinsemilla (USA) Nether-Weed (Netherlands)		
	= 3 %	= 5 %	= 9 %	= 3 %	= 5 %	= 9 %
USA, 1996[1]	63%	25%	3%	93%	77%	49%
USA, 1997[1]	63%	29%	6%	96%	85%	64%
USA, 2000[2]	Average of 6.07% (DEA)			Average of 13,65% (DEA)		
Netherlands, 2000-2001[1]	75%	48%	7%	93%	87%	35%
Netherlands, 2001-2002[1]	80%	55%	4%	100%	99%	78%
Australia, 1997[3]	Between 0.6% and 13%					
Western Australia	Average of 3,8%					
Canada 1999[4]	Average of 6%			Not available		

(1) Source: Rigter H. and M. von Laar (2002) " Epidemiological Aspects of Cannabis Use", International Scientific Conference on Cannabis, Brussels, page 32.
(2) Drug Enforcement Administration, http://www.usdoj.gov/dea/concern/marijuana.html
(3) Source: Hall, W. and W. Swift (2000) *op. cit.*, page 505
(4) Source: RCMP, Annual Report for 1999.

In short, it appears that the main change has been in maximum concentrations obtained as a result of sophisticated cross-breeding and cultivation methods, whereas average concentrations have not significantly changed over the past 30 years.[37] What conclusion can be drawn from this? In the minds of some, if cannabis could still be called a "soft drug" in the 1970s, that is no longer the case today. Some are not reluctant to say it is a drug comparable to heroin or cocaine in its addictive power. As an example, the Canadian Police Association has issued the following opinion on the risks associated with cannabis.

Generally, marijuana and its derivative products are described [as soft drugs] to distance the drug from the recognized harm associated with other illegal drugs. This has been a successful yet dangerous approach

[36] Dr. John Morgan, Professor at the City University of New York Medical School, testimony before the Senate Special Committee on Illegal Drugs, June 11, 2001, Issue No. 4, page 29.
[37] ElSohly, M.A., *et al.* (2000) "Potency trends of delta9-THC and other cannabinoids in confiscated marijuana from 1980-1997", *Journal of Forensic Sciences*, 45(1): 24-30.

> *and contributes to the misinformation, misunderstanding and increasing tolerance associated with marijuana use. Marijuana is a powerful drug with a variety of effects. (…) Marijuana use is associated with poor work and school performance and learning problems for younger users. Marijuana is internationally recognized as a gateway drug for other drug use. Risk factors for marijuana dependence are similar to those of other forms of drug abuse.* [38]

Others associated the increase in demand for treatment for cannabis dependence with the increase in active ingredient concentrations. As the National Post reported:

> *The potent BC Bud, which has a THC content as high as 25% compared to the 2% typical in the 1970s, is also leading to health concerns in the United States. Admissions for marijuana drug treatment in Washington State now exceed the rate for treatment of alcoholism. Cannabis admissions in Cook County, Ill., have risen by 400% in the last year.* [39]

Can it be said that cannabis has in fact become a "hard" drug like cocaine and heroin? Apart from the validity of the effects of cannabis itself as described by the Police Association, and as will be discussed in detail in the Chapter 7, that contention does not take into account the way in which the drug is used or the lack of knowledge of the effects of Δ^9THC concentrations. Studies on the ways in which cannabis is used, considered in Chapter 6, show that regular users appear to prefer medium to mild cannabis, and that they adjust their use to the strength of the drug. Interviews with individuals who use cannabis for medical purposes tend moreover to confirm this perception. More significantly, for lack of any specific studies on the question, the effects of higher Δ^9THC concentrations are simply not known. Lastly, as will be shown in the following section, the bio-availability of Δ^9THC, that is to say the proportion that is actually absorbed by the body following combustion, is highly variable. As emphasized in the report of the World Health Organization (WHO) on cannabis, considering all these factors, the actual quantity of THC absorbed by the cannabis user is difficult to estimate.[40] Ultimately, while it can be a legitimate preoccupation, the real issue of Δ^9THC content has more to do with our ability to control it and better know its effects, rather than making all kinds of alarmist and unfounded statements about its level.

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[38] Sergeant Dale Orban, Regina Police, at the Senate Committee hearing on May 28, 2001.
[39] National Post, May 17, 2002.
[40] World Health Organization (1997) *Cannabis: a health perspective and research agenda.* Geneva: WHO, 1997. On line at: www.who.org.

Pharmacokinetics [41]

Upon inhalation, and depending on the smoker's way of smoking and smoking experience, between 15% and 50% of the Δ^9THC present in the smoke is absorbed into the bloodstream. The percentage also depends on the Δ^9THC concentration in the smoked product. The substance is absorbed very quickly, and maximum blood concentrations are achieved in less than 15 minutes after the start of inhalation. The effects felt almost immediately after absorbing the smoke diminish gradually over the next 60 minutes and generally last a maximum of three hours after inhalation. In other words, THC levels in the blood plasma are highest immediately after absorption, whereas maximum effects are felt approximately 30 to 40 minutes later. The following table reproduced from the ISERM collective assessment, shows the time to appearance and duration of detection of cannabinoids in the blood.[42]

Concentration, time to appearance[1] and duration of detection[2] of cannabinoids in the blood after smoking a marijuana cigarette containing 15.8 mg or 33.8 mg of D^{9}THC

Component	Maximum concentration	Time to appearance of peak (hr)	Duration of detection (hr)
D^{9}THC	84.3 (50-129)[3]	0.14 (0.10-0.17)	7.3 (3-12)
	162.2 (76-267)[4]	0.14 (0.08-0.17)	12.5 (6-27)
11-OH-D^{9}THC	6.7 (3.3-10.4)	0.25 (0.15-0.38)	4.5 (0.54-12)
	7.5 (3.8-16.0)	0.20 (0.15-0.25)	11.2 (2.2-27)
D^{9}THC-COOH	24.5 (15-54)	2.43 (0.8-4.0)	84.0 (48-168)
	54.0 (22-101)	1.35 (0.54-2.21)	152.0 (72-168)

(1) average interval between start of consumption and appearance of a concentration peak
(2) average interval between start of consumption and moment when lowest concentration of component is detected (> 0.5 mg/ml)
(3) cigarette containing 13.8 mg (1.75%) of Δ^9THC
(4) cigarette containing 33.8 mg (3.55%) of Δ^9THC

Bio-availability of Δ^9THC is slower and weaker when the drug is ingested orally (cookies, cakes, herbal teas): approximately 4% to 12%; although slower to be felt and different in quality, its effects are longer lasting.

In all, we do not know how the effects of THC (concentration) interact with personal factors (way of smoking, health status, alcoholism or medication). However, it is likely that the same THC concentration does not have the same effect on all smokers, which moreover tend to be confirmed by the plasticity of cannabis in the hormonal stream (see below).

[41] This section is based to a large extent on the INSERM 2001 report as well as the European scientific report 2002 and the survey work done by Wheelock 2002 for the Committee.
[42] INSERM (2001) *Cannabis. Quels effets sur le comportement et la santé?* Paris: author, page 340.

Δ^9THC is highly lipophilic and is quickly distributed to all fatty tissues, including the brain. It is also characterized by an entero-hepatic cycle and renal reabsorption which results in persistent effects. In a driving simulator study, a significant linear correlation was found up to seven hours following absorption, particularly on the trajectory control.

Δ^9THC undergoes oxydative metabolism resulting in the production of various elements, in particular 11-hydroxy-tetrahydrocannabinol (11-OH Δ^9THC) a psychoactive metabolite which, transported by albumin, whereas Δ^9THC attaches mainly to lipoproteins, penetrates the brain more deeply than Δ^9THC; 8 β-hydroxy-Δ^9-tetrahydrocannabinol, potentially psychoactive but whose action would be negligible; and various other components not known for their psychoactive effects. In addition to the potentially psychoactive elements, cannabis contains approximately 200 derivatives of combustion and pyrolysis comparable to those found in tobacco, though some of which are highly carcinogenic and are more concentrated in cannabis smoke than tobacco smoke.

Cannabinoids are eliminated in various ways: through digestion, the kidneys and perspiration. Approximately 15% to 30% of Δ^9THC in the blood is eliminated in urine, 30% to 65% through stools. Because it binds strongly to tissues, Δ^9THC is eliminated slowly in urine: the urine of regular heavy users contains traces of Δ^9THC-COOH 27 days after they have last used cannabis.

Regular users metabolize Δ^9THC up to twice as fast as individuals who have never previously used the drug. One study showed, in particular, that the intravenous administration of one 5 mg dose of Δ^9THC resulted in higher blood levels in regular users than occasional users.[43]

Cannabinoids act on the body through the endogenous cannabinoid system, consisting of neurochemical substances (endogenous ligands) and specific receptors. The behavioural and central effects of cannabis are due to the agonistic action of its main ingredients (in particular Δ^9THC, exogenous cannabinoid), on the endogenous cannabinoid receptors (anandamide, 2-arachidonoylglycerol) present in the nervous tissues of the brain.

Although the chemical structure of Δ^9THC was identified by Mechoulam in 1964,[44] it wasn't until very recently that the characteristics and location of the endogenous cannabinoid system was determined.[45] Two types of cannabinoid receptors have been isolated: CB1 in 1990[46] and CB2 in 1993.[47] CB1 is mainly expressed in the

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[43] Cited in INSERM (2001) *op. cit.*, page 148.

[44] Guoli and Mechoulam (1964) *op. cit.*

[45] Devane, W.A. *et al.* (1992) "Isolation and structure of a brain constituent that binds to the cannabinoid receptor", *Science*, 258 (5090): 1946-1949.

[46] Matsuda, L.A. *et al.* (1990) "Structure of a cannabinoid receptor and functional expression of the cloned DNA", *Nature*, 346(6284) 5561-564.

central and peripheral nervous system. CB2 is expressed essentially in the cells of the immune system. It follows from this distribution that CB1 is essentially involved in psychotropic effects and CB2 in immunomodulatory effects.

The main endocannabinoids are arachidonoylethanolamide (also called anandamide - a word derived from Sanskrit, literally meaning congratulated) and 2-arachidonoylglycerol (2-AG). These are the only two endogenous molecules known to be capable of binding to cannabinoids receptors CB1 and CB2 and replicating the pharmacological and behavioural effects of Δ^9THC. Anandamide levels in the brain are comparable to those of other neurotransmitters such as dopamine and serotonine. The highest levels corresponding to high CB1 density areas, that is to say the hippocampus, striatum, the cerebellum and the cortex. Like anandamide, 2-AG reproduces all the behavioural effects of Δ^9THC or anandamide, but its action is less powerful.

The CB1 receptors are among the most abundant neuronal receptors in the central nervous system, and their distribution correlates remarkably with the behavioural effects of cannabinoids on memory, sensory perception and control of movements, as shown in the table below.

Location of CB1 receptors in the CNS and correlated pharmacological effects [48]

Structures	Marking	Physiological consequences	References
Forebrain			Herkenham et al., 1990
Amygdala	+		Herkenham, 1992
Olfactory systems	+		Tsou et al., 1998, 1999
Cerebral cortex	++	Cognitive effects	Katona et al., 1999
Basal nuclei	++	Locomotive effects	Rinaldi-Carmona et al., 1996
Hippocampus	++	Cognitive effects (short-term memory inhibition) and antiepileptic action	Matsuda et al., 1990, 1993 Hohmann, 1999
Thalamus/hypothalamus	+	Endocrine and antinociceptive effects	Marsiaco and Lutz, 1999 Westlake et al., 1994
Midbrain	-		
Grey nucleus	-		
Colliculi	-		
Optic nuclei	-		
Black substances/ventral tegmental area			
Hindbrain			
Grey periaqueductal area	+	Antinociceptive effects	
Locus ceruelleus	-		
Raphe	-		

[47] Munro, S. *et al.* (1993) "Molecular characterization of a peripheral receptor for cannabinoids", *Nature*, 365: 61-65. Note that a recent scientific conference of the National Institute on Drug Abuse in the United States reported on the work of researchers on the hypothesis that there are additional receptors and other ligands. To our knowledge, the latter have not yet been formally identified in the research setting.

[48] Table reproduced from INSERM (2001), *op. cit.*, page 298.

Structures	Marking	Physiological consequences	References
Bridged nucleus	-		
Brainstem	-	No lethal dose, no acute mortality	
Cerebellum	++	Motor effects (balance)	

++: abundant marking; +: intermediate marking; -: little or no marking.

This concentration of CB1 receptors largely explains the effects of Δ^9THC. Intense expression of CB1 receptors in the basal nucleus and molecular layer of the cerebellum is thus consistent with the inhibiting effects of cannabinoids on psychomotor performance and motor coordination. Their expression in the cortex and hippocampus is consistent with the modulation of elementary forms of learning, explaining in particular the reversible deleterious effects on short-term memory and cognitive function. Their lack of marking in the brainstem explains the absence of acute toxicity or lethal doses of cannabis derivatives. The CB1 receptors in the thalamocortical system participate in the sensory disturbances and analgesic properties of cannabis. Similarly, the presence of receptors in the periaqueductal area and the dorsal horn of the spinal cord contribute to its antinociceptive power.

We also note that the CB1 receptors do not merely inhibit brain function. As a result of circuit effects, cannabinoids can stimulate certain neuron populations, in particular dopaminergic cells in the mesolimbic pathway. Together with the observation that prolonged treatment with cannabis (at doses corresponding to the equivalent of 575 cannabis cigarettes a day!) appears to induce lasting adaptive changes to the central nervous system and to the positive relationship between cannabinoids and stress hormones (corticotrophine), this explains the difficulties (irritability, sleep disorders and so on) observed in regular users when they have stopped using cannabis. We return to this issue in the Chapter 7 in the discussion on cannabis tolerance and dependence.

Lastly, recent works suggest there are significant interindividual variations in the effects of cannabinoids depending on sex steroid hormones in men and women: it appears that the effects of exogenous and endogenous cannabinoids can be modulated by the hormonal state of each individual and that, in exchange, the CB1 receptors and endocannabinoids are able to regulate hormonal activity.

As was observed in the WHO report in 1997, various research questions remain unanswered, in particular how and to what extent cannabis use alters the endogenous cannabinoid and what the relationship is between blood plasma cannabinoid levels and induced behavioural effects.

CONCLUSIONS

In conclusion, the Committee makes the following findings:

Conclusions of Chapter 5	
On production	➢ **The size of the cannabis market is estimated at 800 tonnes a year.** ➢ **The size of the national production has significantly increased, and it is estimated that 50% of cannabis available is now produced in the country.** ➢ **The main producer provinces are British Columbia, Ontario and Quebec.** ➢ **Estimates of the monetary value of the cannabis market are unreliable. For example, if 400 tons are grown yearly in Canada, at a street value of $225 per ounce, the total value of the Canadian production would be less than $6 billion per year, less than the often quoted value of the BC market alone.** ➢ **An unknown proportion of national production is exported to the United States.** ➢ **A portion of production is controlled by organized crime elements.**
On THC	➢ **THC is the main active ingredient of cannabis; in its natural state, cannabis contains between 0.5% and 3% THC.** ➢ **Sophisticated growing methods and genetic progress have made it possible to increase THC content in recent years, but it is impossible to estimate the average content of cannabis available in the market; it is reasonable to consider that content varies between 6% and 31%.** ➢ **THC is fat soluble and readily spreads in the innervated tissues of the brain; it reaches a peak in the blood plasma in less than nine minutes and falls to approximately 5% after one hour.** ➢ **The body is slow to eliminate THC and inactive THC metabolites can be detected in urine up to 27 days after use in the case of regular users.** ➢ **Psychoactive effects generally last two to three hours and as many as five to seven hours after use.**

CHAPTER 6

USERS AND USES:

FORM, PRACTICE, CONTEXT

Who uses cannabis? How do the patterns of use in Canada compare to those in other countries? In what context is cannabis used? Why? What populations are most vulnerable? What are the social consequences of cannabis, specifically on delinquency and criminal behaviour? Most important, what trajectories do cannabis users follow, specifically with respect to consumption of other drugs?

Partial answers to these questions, at the very least, are prerequisite to establishing policy on a substance. If the aim is to deter, one needs to know what is to be deterred and within what target group. If the aim is to help people for whom consumption poses a problem, one must have at least an idea of the composition and size of the group in question. And if one is looking for indications that a public policy reduces all use or at-risk use, then knowing the evolution of patterns of use within a population is a requisite.

In Canada, knowledge of patterns and contexts of cannabis use verges on the abysmal. In the early 1980s, the USA, the United Kingdom, and Australia introduced monitoring systems for the general population and the student population and use them as the basis of annual (USA) or biannual (United Kingdom and Australia) reports on trends. In the last five years, a number of European countries have introduced data collection systems as part of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Canada, by contrast, has carried out only two epidemiological general population surveys specific to drugs (1989 and 1994), and only some provinces conduct surveys of the student population, using different methods and instruments that preclude data comparison. Furthermore, everything suggests that few sociological or anthropological studies are conducted on the circumstances or context of illegal drug use (specifically for cannabis). At any rate, very little has been brought to our attention. The result is that our pool of knowledge on users and characteristics of use is lacking.

We have no explanation for this situation, at least no satisfactory explanation. In the 1970s, following up on the work done by the Le Dain Commission, Canada could have set up a trend monitoring system. In the 1980s, when Canada's Anti-Drug Strategy–to which the federal government allocated $210M over five years–was adopted, a data collection system could have been created. The fact that it wasn't could

be due to an absence of leadership or vision; a fear of knowing; the division of powers among levels of government; or the absence of a socio-legal research tradition within the departments responsible for justice and health. In fact, all of the above are probable factors. Whatever the case, it is our contention that the situation, unacceptable by definition, requires timely remedial action. We must resign ourselves to working with the scarce available data, and more significantly the virtually non-existent comparable data. We will also look at studies and data from other countries.

The chapter is divided into four sections. The first covers consumption patterns in the population as a whole and specifically in the 12-18 year age group and compares the patterns in various countries. The second section looks at what we know about reasons for and details on use, including origins and cultural differences. The third section deals specifically with cannabis user trajectories, including escalation. The fourth and last section covers the relationship between cannabis use and delinquency and crime.

PATTERNS OF USE

Epidemiological surveys are the main method of measuring consumption patterns. These surveys cover the general population (usually 15 years of age and over) and specific populations, usually students. Most epidemiological surveys of the general population are done by telephone and based on a validated questionnaire. Personal interviews are involved in some cases. Some surveys of students are based on a questionnaire distributed in class.

Due to the low consumption of illegal drugs by the population as a whole, samples must necessarily be large (in Canada over 12,000 respondents). Whatever the sample size, these surveys inevitably underestimate consumption. Respondents tend to under-report, either because individuals simply refuse to respond because of the legal implications, or because some at-risk persons are not included in a telephone survey. Then there is the matter of memory: the more time elapsed between consumption and the survey, the less reliable one's memory of occasions, circumstances, and quantities.

Furthermore, some reports, including the report by the French National Institute for Health and Medical Research (INSERM) and the *Canadian Profile* of the Canadian Centre on Substance Abuse (CCSA), use data on police and customs seizure as indirect indicators of use. We have opted to discuss data on seizures and other police and customs activities in Chapter 14. In our opinion, these data, rather than accurately reflecting use, are indicators of police drug-related activities and to some extent, market conditions.

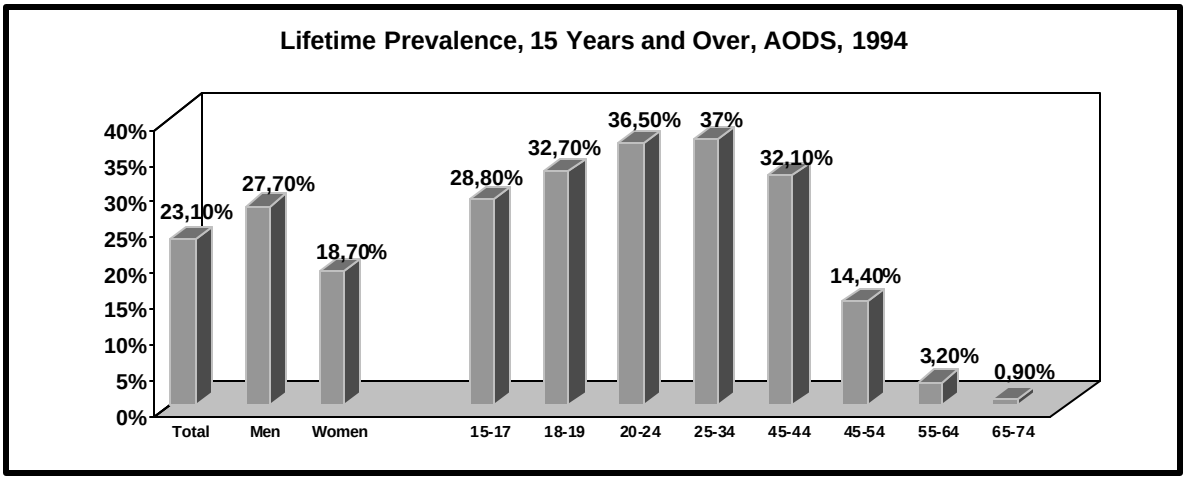
Not all surveys measure phenomena in the same way, although, in the past two years, significant strides have been made toward improving data comparability. Generally speaking, lifetime prevalence (minimum one time consumption) is measured.

This episodic or experimental consumption is distinguished from consumption within the previous year. Frequent consumption (e.g., within the past month) is less frequently measured. Heavy users are even more rarely studied. Furthermore, regular consumption tends to be measured in terms of dependency criteria - described in detail in the following chapter - rather than quantity-related indicators. As described in greater detail later in this chapter, this makes it difficult to distinguish among categories of users, specifically at-risk users and heavy users. Such information is essential to identifying target groups for preventive measures.

Consumption by the population as a whole

In Canada, five national surveys are the sources of data on consumption of psychoactive substances, alcohol, tobacco, and illegal drugs. The Health Promotion Survey (HPS) was conducted in 1985 and 1990; the Alcohol and Other Drugs Survey (AODS) in 1989 and 1994. The 1993 General Social Survey (GSS), a survey conducted on a regular basis, includes drug-related data. These are the data referred to in the following paragraphs.

In the 1994 survey, 23% of respondents reported consuming cannabis at least once in their lifetime. As shown in the bar graph below, men are more likely than women to have consumed cannabis, as are persons under 35 years of age.



Consumption varies by province. According to the AODS, consumption is highest in British Columbia (35.4%), followed by Alberta (29.4%), Manitoba (25.2%), Nova Scotia (25.1%) and Quebec (24.7%); and lowest in Newfoundland (16.3%), Ontario (16.6%) and Prince Edward Island (18.6%).

Lifetime prevalence was unchanged from the 1989 study. At the time of the Le Dain Commission, in 1970, the figure stood at 3.4%; by 1978 it was up to 17%, showing a steady increase in cannabis consumption.

Prevalence over the previous twelve months is a more sensitive indicator of current consumption as reporting is less dependant on long-term memory. The following table shows the evolution of this indicator beginning with the 1985 study.

Cannabis consumption in the last 12 months, 15 years and over[1]

Year	Survey	Sex		
		Men	Women	Total
1985	Health Promotion Survey	6.9%	4.3%	5.6%
1989	National Alcohol and Other Drugs Survey	8.9%	4.1%	6.5%
1990	Health Promotion Survey	7.0%	3.0%	5.0%
1993	General Social Survey	5.9%	2.5%	4.2%
1994	National Alcohol and Other Drugs Survey	10.1%	5.1%	7.4%

By comparison, the percentage of users in the last year was 1% in 1970 and 9.7% in 1979.

The rate of use reported in these surveys is twice as high for men as for women. It is important to note the variations among studies. Because the AODS deals specifically with psychoactive substances, rather than being part of a broader survey of health or living conditions, it would appear to be more reliable.

We have no detailed data on incidence (i.e., new consumers) or rate of discontinuation. As will be seen further on, rising prevalence among young people would indicate increased incidence. With respect to discontinuation, it is generally believed that the vast majority of users do not continue using, although we are lacking specific information in Canada on this issue.

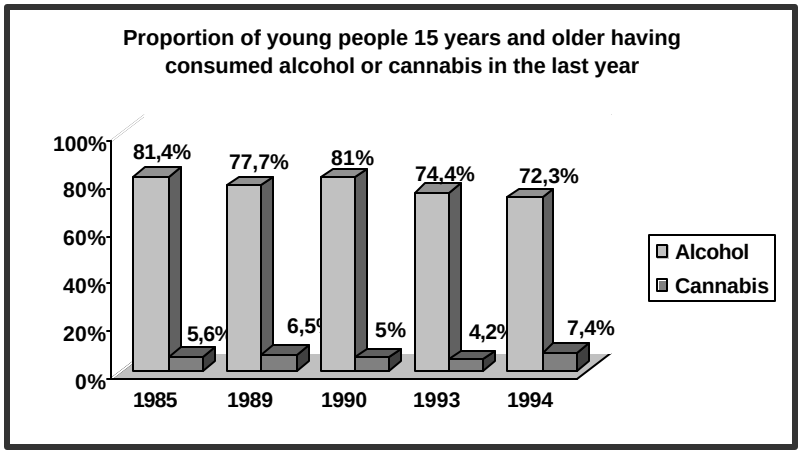
We are aware that there are limitations to comparing the various psychoactive substances. As properly pointed out by Dr. Zoccolillo in his testimony, each has its own characteristics and effects.

> *There is little point in comparing the levels of harm from cocaine, marijuana and alcohol. Each drug has specific kinds of harm. If you were to compare the effects of tobacco and cocaine in young people, you would conclude that cocaine is terrible but tobacco is not worth worrying about, because the harm from*

[1] Table reproduced from CCSA-CAMH (1999), *Canadian Profile. Alcohol, tobacco and other drugs. Ottawa: author,* page 142.

tobacco takes 30 years to appear. The point is that there are different patterns of harm and making comparisons among them is not a useful exercise. [2]

Nonetheless, to place the phenomenon in context, we believe it is valid to compare Canada's consumption of cannabis in the general population to consumption of other substances. The 1994 Alcohol and Other Drugs Survey shows that, of total illegal drug consumption, cocaine accounts for less than 1%, and heroin, LSD, and amphetamines together for approximately 1%. In the case of legal drugs, alcohol consumption is about 75%, tobacco approximately 30%. The accompanying graph compares consumption of cannabis and alcohol among those over 15 years of age.



General population studies have been conducted in Ontario since 1977, giving the province the most extensive database in Canada. Of even greater interest, is the fact that Ontario (again since 1977) has conducted studies in schools. This practice provides for a better tracking of trends.

According to the 2000 report of the Centre for Addiction and Mental Health (CAMH)[3], more than one third (35%) of Ontarians over 18 years of age have consumed cannabis at least once in their lifetime and 10.8% within the last 12 months. The figure for users within the past year has changed little since 1984 (11.2%), although it is up slightly from the 1977 figure (8%). The 18-29 age group shows the steadiest increase, from 18.3% in 1996 to 28.2% in 2000; the 1984 figure for the cohort is 28.5%. In the long term, we also see an increase in consumption within the last 12 months in the 30-49 age group (from 6.5% in 1977 to 18.7% in 2000). The following table sets out selected data from the report.

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[2] Testimony by Dr. Mark Zoccolillo, Professor of Psychiatry and Pediatrics, McGill University and Montreal Children's Hospital, Special Senate Committee on Illegal Drugs, second session of the thirty-sixth Parliament, October 16, 2000, Issue 1, page 80.

[3] Adlaf, E.M. and A. Ialomiteanu (2000) *CAMH Monitor Report: Addiction and Mental Health Indicators among Ontario Adults, 1977-2000.* Toronto: Centre for Addiction and Mental Health, pages 61-67.

Proportion of Ontarians 18 years old and over using cannabis users in the previous 12 months

(N =)	1977 (1059)	1982 (1026)	1984 (1043)	1987 (1075)	1989 (1098)	1991 (1047)	1992 (1058)	1994 (2022)	1996 (2721)	1997 (2776)	1998 (2509)	1999 (2346)	2000 (2406)
Total	8.1	8.2	11.2	9.5	10.5	8.7	6.2	9.0	8.7	9.1	8.6	10.4	10.8
M	11.2	12.3	15.6	12.3	13.0	11.5	9.1	11.4	12.6	11.4	12.1	13.2	14.3
W	4.5	4.1	7.1	6.8	8.2	6.0	3.6	7.0	5.3	7.0	5.4	7.8	7.7
18-29	22.6	22.7	28.5	20	24.6	19.9	13.3	19.6	18.3	21.4	25.2	27.1	28.2
30-39	3.9	4.2	9.5	11.6	11.8	9.1	6.6	10.2	11.3	9.8	8.2	10.3	12.3
40-49	2.3		2.2	5.4	3.9	3.0	2.4	4.3	6.1	4.3	4.	6.8	6.4
50-64	1.2	1.3	1.8		1.4		1.3			1.7	1.4	4.1	2.9
65+													

Of those who consumed cannabis at least once in their lifetime, 68% did not consume within the last 12 months, 15% consumed less than once a month, and 17% more than once a month. Of users within the last year, 47% consumed less than once a month and 53% at least once a month.

In Quebec, general population studies were done in 1987, 1992, and 1998. *L'enquête sociale et de santé* (ESS)[4] reports that 31.3% of people 15 and over used cannabis or another illegal drug at least once in their lifetime, and 13.5% had consumed cannabis at least once in the past few months. As elsewhere, consumption is a function of age: in the 15-24 age group, consumption of illegal drugs is 39.7%; it is 18.4% in the 25-44 age group, 8% in the 45-64 age group, and 5.5% in the 65 plus age group. Although 83.7% of the 45-64 age group and 93.8% of the 65 plus age group report never having used a prohibited drug, over 40% of the 25-44 age group and half (50.3%) of the 15-24 age group report current or past consumption.

Consumption among young people

A number of witnesses have reported "worrying" increases in cannabis consumption among young people (under 18).

> *Given the existing research on the escalating rates of cannabis use in the general population of young people, our street youth and our youth at risk, coupled with knowledge about the harms associated with drug use, we know that our problem is growing.* [5]

[4] Chevalier, S., et O. Lemoine (2000) « Consommation de drogues et autres substances psychoactives. » in *Enquête sociale et de santé 1998*, Québec : Institut de la Statistique du Québec, chapter 5, page 137.

[5] Testimony of M.J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, Canadian Association of Chiefs of Police, Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, March 1, 2002, Issue 14, page 77.

Special consideration needs to be given to minors when developing drug policy. A policy created only with adults in mind may have strong, unintended negative consequences for adolescents. We have a parental obligation to adolescents. They are not adults. [6]

The Ontario students survey is equally disconcerting. A dramatic upswing is noted in the use of all drugs since 1993.(…) The use of cannabis has more than doubled to 29 per cent.(…) Unfortunately, the only statistic that has decreased is the one that records the students who do not use drugs. That figure has decreased from 36 per cent to 27 per cent. From almost one-third of the students not using drugs, we now have almost a one-quarter of the students not using drugs. We are clearly in a time where young people are turning to drugs as an answer to life's problems. [7]

It is a fact that consumption of psychoactive substances by young students has increased significantly in the past several years. Nationally, the survey conducted among Grade 6, 8, and 10 students (approximately 2,000 young people in each grade) in 1990, 1994, and 1998[8], reports the following with regard to marijuana use:

Proportion of Grade 8 and 10 students who have consumed cannabis at least once

	1990	1994	1998
Grade 8			
girls	10%	11%	18%
boys	11%	13%	21%
Grade 10			
girls	24%	27%	41%
boys	26%	30%	44%

Surveys on consumption of psychoactive substances, including cannabis, among young people have been conducted in some provinces. These give a clearer and more detailed picture of the evolution of cannabis consumption among young people in those provinces, although the results cannot be compared from province to province.

Atlantic

In the Atlantic provinces (Newfoundland and Labrador, Prince Edward Island, Nova Scotia, and New Brunswick) identical comprehensive surveys on cannabis consumption by high school students were first conducted in 1996.[9] The process was

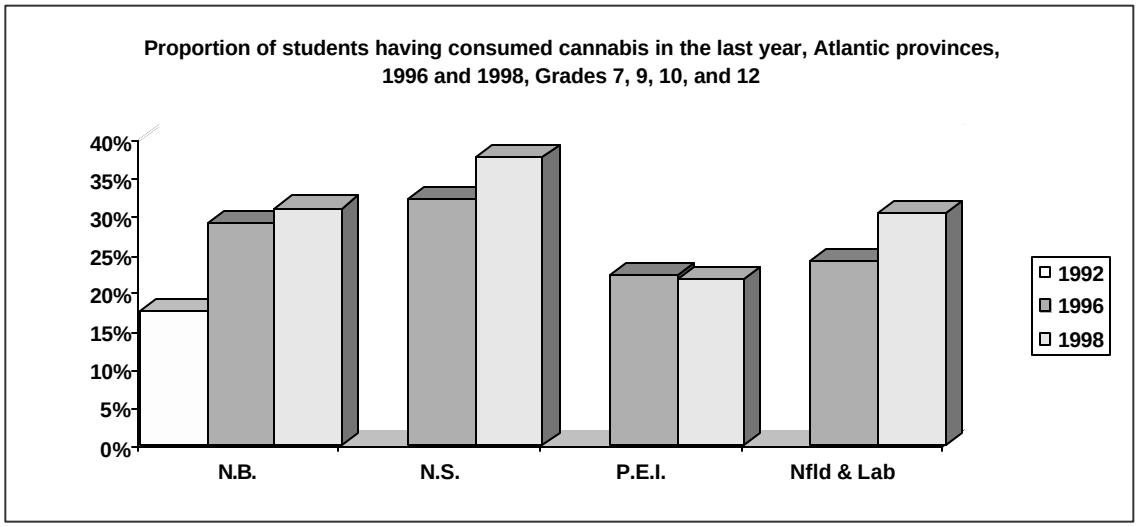
[6] Testimony of Dr. Mark Zoccolillo, *op. cit.*, page 77.

[7] Testimony of R.G. Lesser, Chief Superintendent, Royal Canadian Mounted Police, Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 29, 2001, Issue 8, page 9.

[8] King, A.J.C. et al., (1999) *Trends in the Health of Canadian Youth. Health Behaviours in School-Age Children.* Ottawa: Health Canada.

[9] New Brunswick conducted student population studies in 1986, 1989, and 1992.

repeated in 1998. The 1996 survey covered 14,908 students and the 1998 survey, 13,539 in grades 7, 9, 10, and 12.[10] The following graph illustrates the data from the two surveys and the 1992 reference year for New Brunswick.



Cannabis consumption among students in the Atlantic provinces rose from 28% in 1996 to almost 33% in 1998. The provincial trends follow.

❖ In Nova Scotia, between 1991 and 1998:

- The percentage of students using illegal drugs nearly doubled;
- The percentage of students reporting consumption of cannabis within the last year was close to 38% in 1998, compared to 32% in 1996;
- Distribution by school grade: 11.4% in Grade 7, 41% in Grade 9, 47.6% in Grade 10 and 51.7% in grade 12;
- The percentage of students using cannabis more than once a month tripled, from 4.4% to 13.5%; more men (17.5%) than women (9.3%) consumed cannabis once a month.

❖ In New Brunswick:

- The proportion of students reporting cannabis consumption climbed from 17.4% in 1992 to 29% in 1996 and 31% in 1998;
- Among cannabis users, 5.5% experimented during the year and 11% were frequent users (more than once a month);

[10] See http://www.gov.ns.ca/health/student-drug-use/contents.htm for Nova Scotia and http://www.gnb.ca/0378/en/sdus1998/index.htm for New Brunswick. A summary is also available on the CCSA's website at: http://www.ccsa.ca/Reports/STUDENT.HTM

- As in the other provinces, more men (33.4%) than women (28.3%) consumed cannabis.

By comparison, in 1996 56% of students in the Atlantic provinces reported consuming alcohol at least once during the last year; the corresponding figure for 1998 is 59%.

Manitoba

In Manitoba, a 2001 non-random survey of schools in the province was conducted among 4,680 students in 32 schools.[11] Although the sample is not completely representative of all students in Manitoba, it is sufficiently large to give a satisfactory representation of the situation in the province.

Virtually all students reporting consumption of illegal drugs in the course of the preceding year used marijuana (96%). 47.7% of students consumed it at least once in their lifetime, 39.7% in the course of the preceding year (compared to 37.4% in 1995 and 38.8% in 1997). The mean age of initial use is 14.1 years. More boys (40.4%) than girls (35.4%) consumed cannabis in the course of the preceding year. Of the users, 8.5% consumed it approximately once a month and 15.8% more than once a month (20.5% of boys and 11.2% of girls).

By comparison, 87.4% of students consumed alcohol at least once in their lifetime, and 80.4% at least once in the course of the preceding year. The mean age of first consumption is 13.3 years. Of those who consumed alcohol in the course of the preceding year, 26% reported consumption once or more weekly, 46.5% at least once a month. Weekly consumption rises with school grade, from 17% in the 1st year of high school to 33% in the 4th. Finally, 27.7% of students consumed cannabis, alcohol, and tobacco in the course of the preceding year.

Ontario

In Ontario, in the 2001 Ontario Student Drug Use Survey (OSDUS)[12] an average of 33.6% of young people in Grade 7 to Grade 13 report using cannabis at least once, and 29.8% in the past several months (the corresponding figures for tobacco are 33.8% and 23.6%; for alcohol 70.6% and 65.6%). Rate of use is significantly higher for boys than girls. Examination of changes in trends shows that, following a dip in the early 1990s, the results in the two most recent surveys are similar to those in the late '70s and early '80s.

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[11] Patton, D., et al., (2001) *Substance use among Manitoba high school students.* Winnipeg: Addictions Foundation of Manitoba. Available at www.afm.mb.ca

[12] Adlaf, E.M. and A. Paglia (2001) *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS.* Toronto: Centre for Addiction and Mental Health.

Proportion of Ontarians in grades 7 to 13 using cannabis in the previous 12 months

(N =)	1977 (4687)	1979 (4794)	1981 (3270)	1983 (4737)	1985 (4154)	1987 (4267)	1989 (3915)	1991 (3945)	1993 (3571)	1995 (3870)	1997 (3990)	1999 (2868)	2001 (2326)
Total	25.1	31.7	29.9	23.7	21.2	15.9	14.1	11.7	12.7	22.7	24.9	29.2	28.6
M.	29.4	36.4	33.2	28.0	24.4	18.7	14.7	13.2	14.8	25.7	25.7	32.5	32.1
W.	21.1	26.	26.3	19.4	17.9	13.2	13.5	9.9	10.7	19.8	24.1	25.8	25.1
7th	5.6	10.4	5.7	5.2	4.7	3.8	0.9	0.7	1.7	2.8	3.4	3.6	5.1
8th	-												
9th	23.2	29.2	27.1	25.1	18.3	12.1	12.9	8.1	8.7	19.6	23.9	25.5	28.8
10th	-												
11th	39.4	50.2	44.2	42.1	35.1	24.3	22.5	20.2	22.3	40.7	42.0	48.1	45.7
12th	-												
13th	42.4	43.6	37.4	36.5	30.8	30.5	28	20.5	21.6	27.5	31.9	43.3	43.9

Comparison of cannabis use trends to trends for other substances shows that:

- In the past 12 months, tobacco consumption fell from 30.4% to 22.3% of students;
- In the past 12 months, alcohol consumption fell from 76.3% to 62.6% of students;
- Heroin [heroine being a female hero] consumption slipped from 2.0% to 1.2%;
- Cocaine consumption remained steady at 3.8%;
- Amphetamine consumption edged up from 2.7% to 3.1%; and
- Ecstasy consumption shot up from 0.6% in 1993 (first inclusion) to 6.0% in 2001.

The Ontario survey examines frequency of consumption. Of those who used cannabis in 2001, 25% did so once or twice, 30% from 3 to 9 times, and 45% more than 10 times. Overall, 16.9% of students consumed cannabis at least 6 times in the course of the past 12 months. The following table illustrates the evolution of consumption frequency in the preceding 12 months (1981 base year).

Frequency of consumption in the preceding 12 months among users in Ontario[13]

	1981 (1002)	1983 (1304)	1985 (907)	1987 (701)	1989 (570)	1991 (515)	1993 (455)	1995 (873)	1997 (1019)	1999 (778)	2001 (636)
Freq.											
1-2	28.2	32.4	33.7	39.8	42.6	37.1	41.1	31.7	29.5	28.8	25.6
3-5	12.4	15.1	18.3	16.2	17.2	17.7	17.5	17.1	16.3	14.7	17.1
6-9	14.0	12.5	11.3	9.0	10.5	12.2	10.1	10.4	12.4	13.9	11.4
10-19	13.0	11.4	11.3	14.1	11.8	9.8	9.0	12.5	12.3	11.9	14.9
20-39	10.7	9.0	8.3	6.2	8.3	8.9	8.8	9.0	9.8	9.5	10.2
40 +	21.7	19.5	17.1	14.8	17.1	14.3	13.6	19.4	19.7	21.2	20.9

[13] Table reproduced from Adlaf and Paglia, *op. cit*., page 57.

On a smaller time scale, the study looks at consumption over the past four weeks. Overall, 8.4% of students consumed cannabis weekly, and 3.1%, daily. The proportion of students who did not consume cannabis in the past month fell from 90.2% in 1987 to 66.6% in 2001.

The following table illustrates the evolution of monthly consumption among users over the preceding 12 months for the 1987-2001 time period. There is a marked reduction in the percentage of students who had used no cannabis in the past month (from 41% in 1987 to 30% in 2001) and, conversely, an increase in the number of students who used it daily (from 3.5% in 1987 to 9.1% in 2001).

Frequency of monthly usage among users in the preceding 12 months, OSDUS[14]

	1987 (701)	1989 (570)	1991 (515)	1993 (455)	1995 (873)	1997 (1019)	1999 (778)	2001 (636)
Never								
Total	41.1	46.0	44.1	37.2	30.9	33.0	30.5	30.6
Men	38.1	44.8	38.6	29.7	28.4	28.9	28.5	23.2
Women	45.3	47.2	51.8	47.5	33.8	36.9	33.0	39.8
1-2 times a month								
Total	36.6	38.3	34.5	36.9	35.7	34.2	34.8	33.2
Men	36.7	33.8	33.4	35.8	33.8	30.4	31.1	32.9
Women	36.4	42.9	36.0	38.1	37.9	37.9	39.4	33.6
1-2 times a week								
Total	9.7	9.6	7.9	9.9	14.4	13.7	12.5	11.3
Men	9.8	10.6	8.7	12.7	15.5	14.6	12.9	12.
Women	9.5	8.5	6.7	6.1	13.2	12.8	12.0	10.1
3-4 times a week								
Total	4.9	2.6	5.8	5.9	9.2	7.6	8.5	8.3
Men	4.6	4.8	8.5	7.4	9.4	10.2	10.2	9.9
Women	5.5	0.4	2.0	3.8	9.0	5.1	6.3	6.4
5-6 times a week								
Total	4.1	1.0	2.4	5.1	3.6	3.9	4.4	7.4
Men	5.3	1.9	3.2	7.5	4.4	4.5	5.9	7.5
Women	2.5		1.2	2.0	2.5	3.4	2.6	7.3
Daily								
Total	3.5	2.6	2.6	5.0	6.3	7.6	9.3	9.1
Men	5.6	4.1	4.1	6.9	8.6	11.4	11.3	14.3
Women	0.8	1.1	1.1	2.4	3.6	3.9	6.6	2.8

[14] *Ibid.*, page 58.

OSDUS also provides information on quantity consumed. Among 2001 users over the past 12 months, 15% smoked less than one joint, 21% approximately one, 22% two or three, and 15% more than four. The study also looks at the question of age at the time of first consumption. Again in 2001, 10.2% of students used cannabis for the first time, including 31.7% of cannabis users over the past 12 months. The age of initial use does not vary with sex or region, but is significantly linked to educational level: between Grade 8 and Grade 9 (14-15 years of age), the proportion of those who have smoked cannabis shoots up from 6% to 14.9%. Early initiation (Grade 7, approximately 12 years of age) to cannabis has fallen over the years: in 2001, 2% of Grade 7 students said they had used cannabis at least once in the preceding year (at about 11 years of age), a figure below those for 1997 (5%) and 1991 (8%).

Quebec

In Quebec, some observers report a "disturbing" increase in regular consumption of cannabis by young people. According to Michel Germain, Director of the CPLT, increased use is closely related to social values, specifically messages relating to a relaxed attitude to drug use, as opposed to socio-demographic factors such as family income or composition.

The data available are not directly comparable to those collected in Ontario. They come from three general population surveys conducted by *Santé Québec* in 1987, 1992, and 1998 and cover the 15-24 year age group. Respondents numbered 3,136, 3,912, and 3,587 respectively, and were divided into three age groups (15-17, 18-19, and 20-24).[15]

At first glance, the study reveals a statistically significant drop between 1987 and 1998 in the number of young people who report no drug consumption (71.3% in 1987, 57.4% in 1992, and 50.3% in 1998). The figures for "current" consumers (last 12 months) are 39.7% for 1998 and 27% for 1992. By age group, the increase in illegal drug consumption (significant in each case to $p < .001$) is as follows:

- 15 – 17 years: 26.2% to 37.6%
- 18 – 19 years: 28.1% to 41.6%
- 20 – 24 years: 26.2% to 40.3%

Among drug users, the percentage of those who use marijuana exclusively climbed from 15% in 1992 to almost 26% in 1998, whereas the proportion of those who use other drugs remained steady at approximately 13%.

[15] Vitaro, F, Gosselin C. and A. Girard (2002) *Évolution de la consommation d'alcool et de drogues chez les jeunes au Québec de 1987 à 1998: constatations, comparaisons et pistes d'explication.* Montréal: Comité permanent de lutte à la toxicomanie.

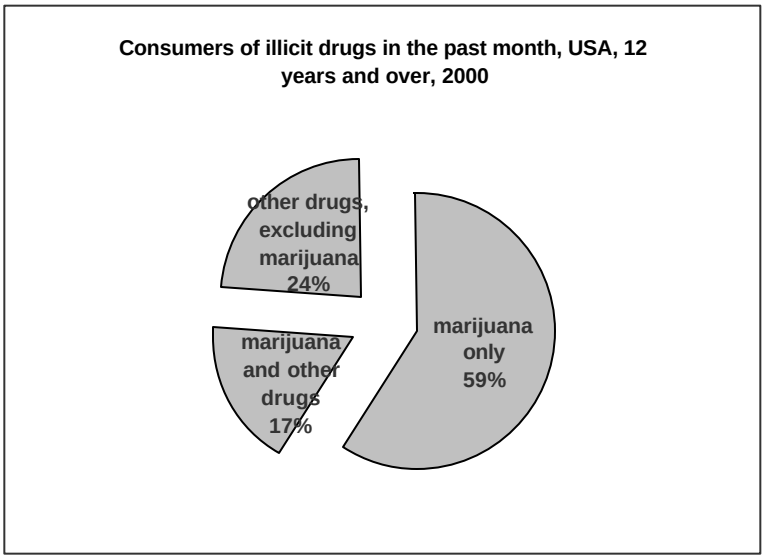
Use patterns in other countries

Obviously, use patterns are not immediately comparable from one country to another, not only because of cultural differences but because the systems for collecting data on use patterns do not all measure the same things in the same way, or even for the same time period. In Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is gradually working toward uniformization of data collection in the various countries of the Union with a view to improving comparability. Nonetheless, significant differences among countries remain.

In spite of these reservations, it is interesting to compare use patterns among the various countries. We will begin by looking at the situation in the United States, the United Kingdom, France, and the Netherlands, and then attempt to compare some of the indicators selected.

United States

In the United States, two major surveys have been conducted for a number of years: a general population survey conducted by the Department of Health and Social Services, and the University of Michigan *Monitoring the Future* study of cohorts of graduates conducted for the *National Institute on Drug Abuse* (NIDA).



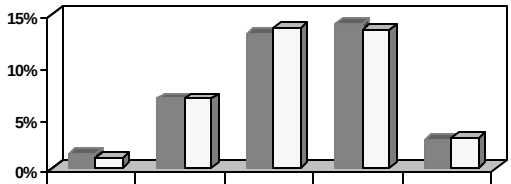
The 2000 general population survey[16] shows that 6.3% of Americans 12 years and over used illegal drugs during the past month, and 4.8% (4.7% in 1999) consumed cannabis. Overall, 14 million Americans are considered *current users* of illegal drugs, i.e., consumers in the past month. Among this group of users, 76% are consumers of marijuana and 59% of marijuana only.

The estimated number of new users in 1999 was 2 million, compared to 2.6 million in 1996 and 1.4 million in 1990. Two thirds of the new consumers were between 12 and 17 years of age, the others in the 18-25 age group. Average age at the first experiment with cannabis was 17 in 1999, compared to about 19-20 at the end of the 1960s.

[16] Substance Abuse and Mental Health Services Administration (2001) *Summary of findings from the 2000 national household survey on drug abuse.* Washington, DC: Department of Health and Social Services

Frequency of consumption among current users increased between 1999 and 2000: in 1999, 31.6% consumed cannabis 100 days or more during the preceding year, compared to 34.7% in 2000. Finally, the distribution by age group follows the expected trends, as shown in the following chart.

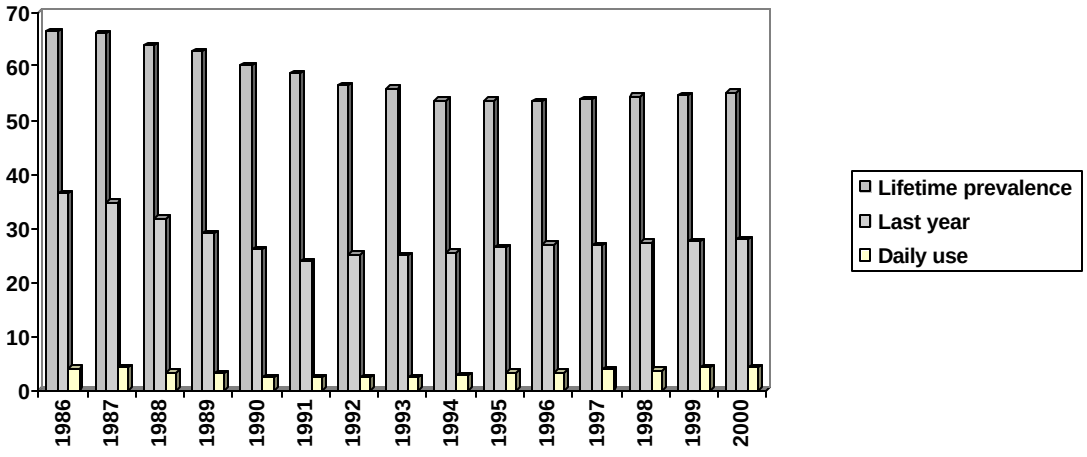
Cannabis consumption in the last month,1999 and 2000, USA, by age group



	12-13	14-15	16-17	18-25	26+
1999	1.50%	6.90%	13.20%	14.20%	2.80%
2000	1.10%	6.90%	13.70%	13.60%	3.00%

The *Monitoring the Future* 2000[17] survey gives use patterns beginning in 1986 for cohorts of young graduates between 19 and 32 years of age. The following figure summarizes the data.

Lifetime prevalence, use in the last year and daily use, 19-32 years of age, USA, 1986-2000



[17] Johnston, L.D., et al., (2001) *Monitoring the future. National Survey Results of Drug Use, 1975-2000. Volume II College Students and Young Adults Ages 19-40.* Bethseda, Michigan: NIDA.

In 2000, lifetime prevalence in the 31-32 age group was 73% for all illegal drugs, 68% for marijuana.

United Kingdom

In the United Kingdom, the *British Crime Survey*[18] has measured illegal drug use patterns every two years since the early 1980s. Since establishment of the EMCDDA, *Drugscope*,[19] the United Kingdom correspondent, annually reports use patterns and related indicators.

The percentage of respondents between the ages of 16 and 59 who consumed an illegal drug during the last year in the United Kingdom rose from 9.9% in 1994 to 10.7% in 2000. The figures for cannabis are 8.4% and 9.4% respectively. Lifetime prevalence of cannabis use in the 16-29 age group climbed from 34% in 1994 to 44% in 2000. As a function of age, the use patterns over the last year are as follows:

- 16-19 years of age: from 29% in 1994 to 25% in 2000;
- 20-24 years of age: from 23% in 1994 to 27% in 2000;
- 25-29 years of age: from 12% in 1994 to 17% in 2000.

In all instances, consumption by men is greater than consumption by women.

The report notes that the most significant change is in consumption of cocaine by young men in the 16-29 age group (up from 1.2% to 4.9%).

France

The work of the *Observatoire français des drogues et de toxicomanies* (OFDT) [French monitoring centre for drugs and drug addiction] has greatly improved monitoring and understanding of trends in France. The OFDT publishes a bi-annual report on use patterns and related indicators (e.g., seizures, enquiries, applications for treatment) and a series of studies and technical reports on specific issues. In its 2002 report, the OFDT[20] gives the following figures on cannabis consumption:

- Lifetime prevalence: 21.6% of adult population (18-75)
- Occasional use (at least once in the past year): 6.5%
- Repeated use (at least ten times within the past year): 3.6%
- Regular use (ten times per month and over): 1.4 %

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[18] The 1998 and 2000 reports are available on-line at the Home Office website: http://www.homeoffice.gov.uk/rds/pdfs/hors224.pdf

[19] The 2000 report is available on-line at the following website: http://www.drugscope.org.uk/wip/11/3/pdf/UK%20DRUG%20SITUATION%202001.pdf

[20] Observatoire français des drogues et de toxicomanies (2002) *Drugs and Drug Addiction: Indicators and Trends 2000.* Paris: author, pages 98-99.

More than twice as many men as women experiment with marijuana; in the 18-34 age group, 40.5% of men have tried it. The proportion of experimenters drops with age. Repeated consumption is reported by 14.6% in the 18-25 age group, compared to 1.6% in the 26 and over age group. The OFDT reports that the percentage of the adult population (18-34 age group) who have experimented with cannabis continues to rise due to increased "trivialization" of cannabis. Among adolescents, consumption has risen significantly. In 1993, 34% of boys and 17% of girls reported having consumed cannabis by the age of 18, compared to 59% and 43% respectively in 1999. The OFDT report goes on to say that experimentation with cannabis has become standard behaviour for young people in late adolescence.

Interestingly enough, the OFDT report allows for construction of a user typology and, without too great a stretch, identification of the warning signs of possible at-risk behaviour.

The following table shows frequency of consumption among young people in late adolescence.[21] In addition to the differences according to sex found in other epidemiological surveys, this table shows that fewer than one quarter of 17 year-old boys report occasional use, compared to one third of 19 year-olds. At the same time, the figure for boys, between the ages of 17 and 19, who abstain drops by 10 points.

Frequency of cannabis consumption by young people in late adolescence in 2000, by age, sex and type of consumption

Type of consumption	Definition	Girls, 17 yrs	Boys, 17 yrs	Boys, 18 yrs	Boys, 19 yrs
Abstinence	Never	59.2	49.9	45.1	39.8
Experimental	Past consumption, but not in the last year	5.0	5.4	6.5	8.2
Occasional	Between 1 and 9 times a year	23.3	20.9	19.9	19.4
Repeated	More than 9 times a year, less than 10 times a month	7.4	9.3	9.9	10.1
Regular	Between 10 and 19 times a month	2.6	6.4	6.2	6.8
Intensive	20 times or more a month	2.	8.0	12.4	15.8

The other interesting breakdown in the OFDT study–one that points to potential problems (and could be useful for preventive purposes) even though the report makes it clear that no equivalence was made between these profiles and risk–concerns circumstances of use. A separate category is created for those who smoke alone or in

[21] *Ibid.*, page 100.

the morning or at noon. A near-perfect linear relationship can be seen between type and circumstances of use, as shown in the table below.[22]

Frequency of cannabis use, in the morning or alone, by young people in late adolescence, in 2000, by type of consumption

Type of use	Morning or noon			Alone		
	Never	Occasionally	Often	Never	Occasionally	Often
Occasional	57.2	40.4	2.4	81.9	16.2	1.9
Repeated	17.9	69.8	12.3	46.4	46.6	7.0
Regular	4.7	58.9	36.4	19.9	60.2	19.8
Heavy	1.1	22.7	76.1	4.5	38.2	57.3

The situation was explained by Jean-Michel Coste, Director of the Monitoring Centre in his testimony to the Committee:

> *I think it is extremely important to answer the concerns of authorities when, in matters of prevention, those authorities are looking for something whose objective is not only to prevent first use, but also to prevent going from regular use to use that turns into a problem. From the investigation point of view, it is important to define this idea of problematic use and grade the users. It is possible to do this by trying to find occasional users, those who use repeatedly or regularly and those who constitute a problem.*
>
> *Right now, we are trying to define three user criteria. We are trying to see if the young person uses cannabis on an intensive or daily basis, if he often uses alone or uses often in the morning. If we get a combining of those three criteria, I think we can define something covering the notion of problematic use of cannabis.*[23]

The Netherlands

The Netherlands is a country of particular interest because of the unique approach it adopted in 1976.[24] An epidemiological survey of use patterns of the general population was conducted in 1997; the results of a second (2001) survey are expected soon. For individuals between the ages of 15 and 64, the data show a lifetime prevalence of 19.1%, consumption in the preceding year of 5.5%, and consumption within the past month of 2.5%. First-time users in the preceding year account for 1% of the population, and average user age is 28. In the 15-34 age group, lifetime prevalence is 31.8% and use within the last year, 14.2%.

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[22] *Ibid.*, page 101.

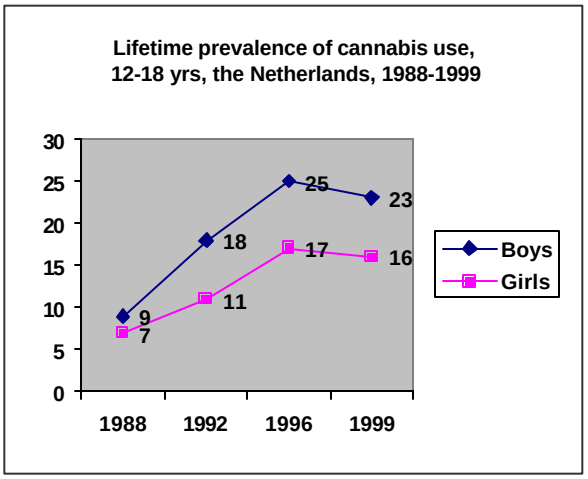
[23] Mr. Jean-Michel Coste, Director, *Observatoire français des drogues et des toxicomanies*, testimony given before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 1, 2001, Issue 7, pages 31-32.

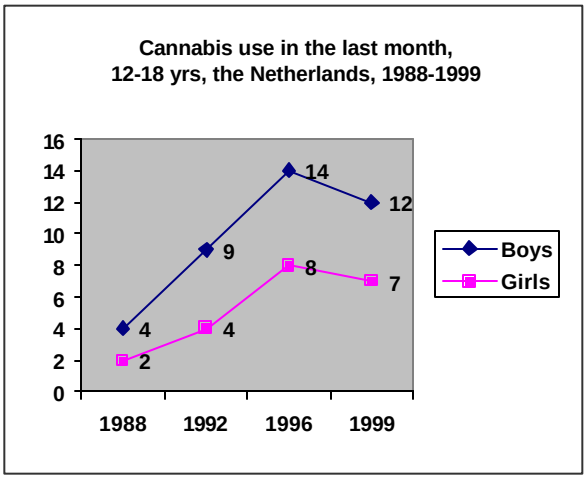
[24] Chapter 20 discusses public policy approaches in various countries in greater detail.

Among recent users (within the past month), frequency is distributed as follows:

- Consumption on 1 to 4 days during the course of the month – 45%
- Between 5 and 8 days – 14%
- Between 9 and 20 days – 15%
- Over 20 days – 26%

In addition, since 1984, the Netherlands has conducted surveys of students between the ages of 10 and 18. The data produced show a significant increase in lifetime use and current use (past month) as in the following charts (data for 12-18 age group only). [25]





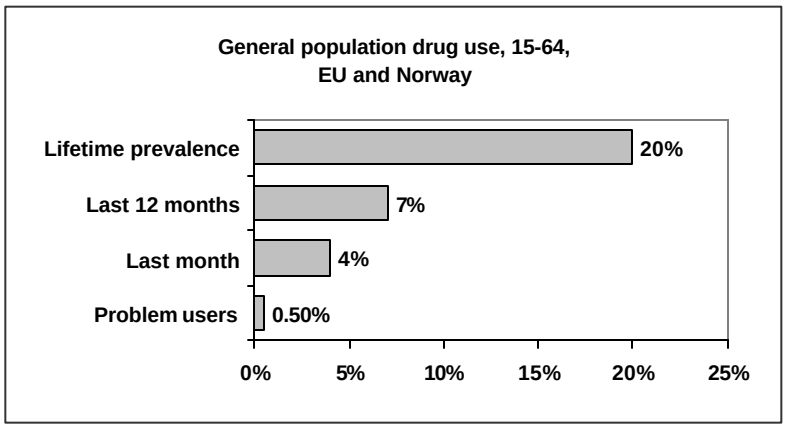
As in the other studies, more boys than girls are consumers and prevalence increases with age: in the 16-17 age group, lifetime prevalence for boys is 43%, for girls 31%, with current use figures 22% and 11% respectively.

Use patterns in Europe, ages 15-64

EMCDDA publications covering Europe and Norway reveal an interesting gradation in the nature of illegal drug use. Although the table shown here covers all illegal drugs, we know that cannabis is the drug of choice for at least 90% of users in all countries. The table is relevant here because we will be attempting to estimate proportions of users in Canada by cannabis use.

[25] Trimbos-Instituut (2000) *The Netherlands Drug Situation 2000*. Report to the EMCDDA. Available on line at: http://www.emcdda.org/multimedia/publications/national_reports/NRnetherlands_2000.PDF

In other words, of the approximately 50 million people who have experimented with an illegal drug at least once in their lifetime, approximately 17.5 million have used drugs in the preceding 12 months, 10 million, in the past month, and 0.5% are considered at-risk users.



International comparisons

In spite of significant differences in survey methods (type of questionnaire and form of entry), indicators, years and age range covered, the following tables provide valuable indications of prevalence in a group of countries.

The first table sets out information on year of survey, age of respondents, and proportions reporting prevalence of cannabis consumption in their lifetime and in the last year. For purposes of comparison, we have added the most recent Ontario data on the general population.

Lifetime prevalence and consumption in the last year, general population [26]

Country	Year	Form of entry	Sample	Age	Lifetime prevalence	Last year
Australia	1998	Mixed	10,000	14+	39%	18%
USA	1999	Mixed	66,706	12+	35%	9%
USA	2000	Mixed	71,764	12+	34%	8%
U.K.	2000	Mixed	13,021	16-60	27%	9%
Denmark	2000	In person	14,228	16-65	24%	4%
France	1999	Telephone	11,526	15-65	23%	8%
Belgium	1998-1999	Telephone	3,311	18-50	21%	?
Germany	2000	Mail	6,332	18-60	21%	6%
Ireland	1998	Mail	10,415	15-65	20%	9%
Spain	1999	In person	12,488	15-65	20%	7%
Netherlands	1997	In person	22,000	15-65	19%	6%
Switzerland	1997	Telephone	13,004	15-60	19%	5%
Greece	1998	In person	3,752	15-65	13%	4%
Sweden	2000	In person	2,000	15-65	13%	1%
Germany (East)	2000	Mail	1,430	18-60	11%	5%
Finland	1998	Mail	2,568	15-70	10%	3%
Ontario	2000	Telephone	2,406	18 +	35%	10.8%

[26] Table adapted from Rigter, H. and M. von Laar (2002) "The Epidemiology of cannabis use." in Pelc, I. (ed.), *International Scientific Conference on Cannabis*. Brussels.

Lifetime consumption prevalence is 10% in Finland compared to 39% in Australia; consumption in the preceding year in Sweden is only 1%, in Australia, it is 18%. The Ontario figures of 35% and 11% respectively are among the highest cannabis consumption figures reported.

The second table is specifically about young people.

Prevalence of consumption by young people, 15-16 years old, 1995 and 1999 [27]

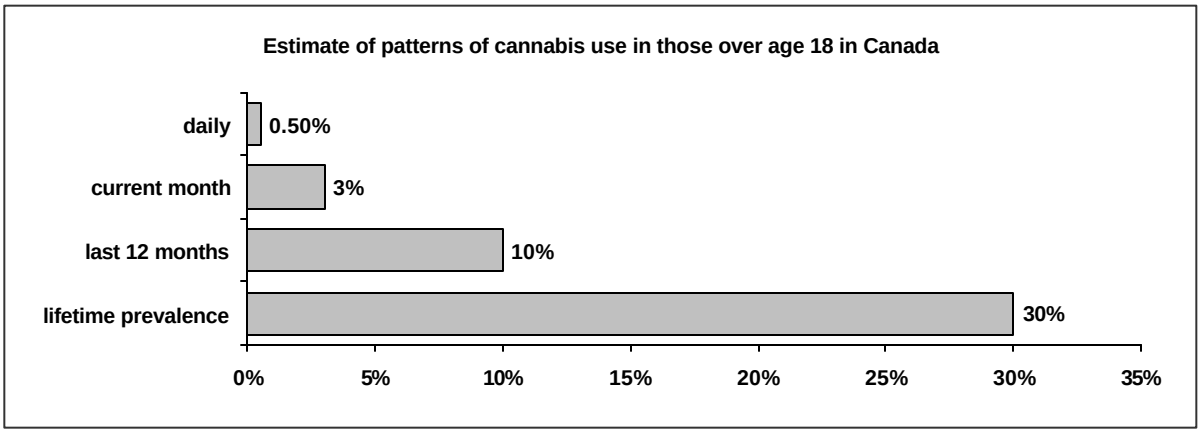
Country	Lifetime prevalence		Last month		> 6 times in the last month	
	1995	1999	1995	1999	1995	1999
USA	34%	41%	16%	19%	7%	9%
Russia	41%	35%	24%	16%	9%	6%
France	-	35%	-	22%	-	9%
Ireland	37%	32%	19%	15%	7%	5%
Netherlands	29%	28%	15%	14%	6%	5%
Italy	19%	25%	13%	14%	5%	4%
Denmark	17%	24%	6%	8%	1%	1%
Norway	6%	12%	3%	4%	1%	1%
Finland	5%	10%	1%	2%	0%	1%
Greece	2%	9%	1%	4%	0%	2%
Portugal	7%	8%	4%	5%	1%	2%
Sweden	6%	8%	1%	2%	0%	0%

We lack readily-comparable data for Canada. Returning to the Ontario data, we see that, in 1995, 40.7% of Grade 10 students had consumed cannabis at least once in the preceding year; the figure for 2001 is 45%. Similarly, in 1995, 19% of all high school students consumed cannabis more than six times monthly; the figure for 2001 is 25%. This means that, consumption levels in Canada appear to be among the highest in the world for this age group.

To summarize

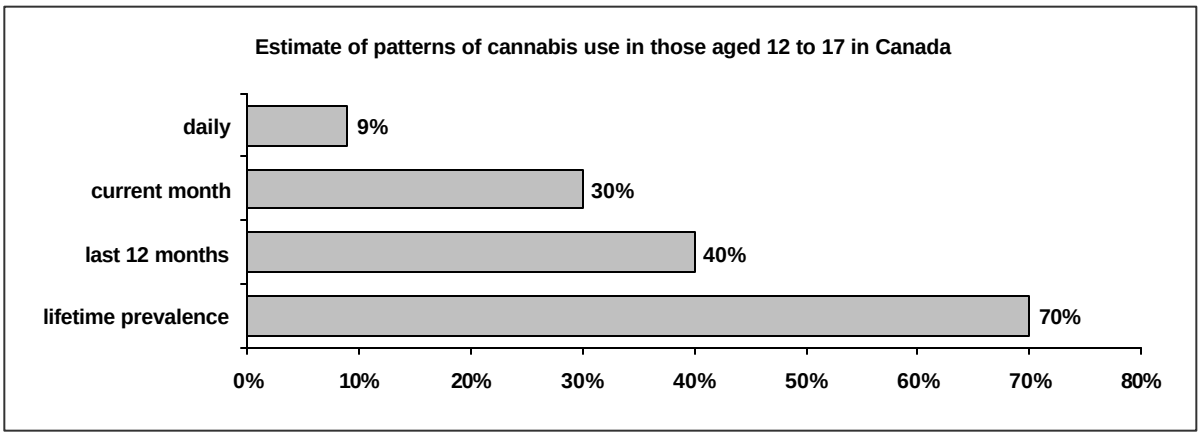
In the absence of recent reliable data on a national scale, we can only hypothesize. For the population over age 16, there is reason to believe that cannabis use is as follows:

[27] Table adapted from Rigter and von Laar, *op. cit*., page 20.



Based on the last census, there are approximately 20 million Canadians between the ages of 18 and 64. If we accept the values used in this graph, there are then approximately 2 million Canadians over age 18 who have used cannabis during the preceding 12 months, approximately 600,000 who have used it during the past month, and approximately 100,000 who use it daily.

In young people aged 12 to 17, the situation could be as follows:



According to the latest census, there are approximately 2.5 millions young persons aged 12 – 17 in Canada. If 40% have used cannabis in the preceding year and 30% in the past month, this means 1 million and 750,000 young users in each category respectively. Approximately 225,000 would make daily use of cannabis.

Overall, these epidemiological trends indicate a number of things. At the simplest level, they clearly show division by generation and gender: people under the age of 35 consume more than those over 35; and men are more frequent consumers than

women. Furthermore, users are more likely to be single. The data appear constant both over time and among countries.

At the same time, there have been changes to the user profile. Rates for the 30-49 age group have tended to increase, supporting to some extent the hypothesis that these are the first cohorts of '70s users. Although the tendency in the '60s was to identify users as working-class or unemployed, there has been an increase in employed individuals with post-secondary or university education.

Some authors link usage to living in an urban area–for example, in the Netherlands, use is far more widespread in metropolitan than in rural areas. This factor does not apply in Canada. In Ontario for example, students outside Toronto consume more cannabis than do those in Metro Toronto. Cannabis use is also related to non-practice of religion, families in which at least one parent has a post-secondary education, and single parent families.[28]

According to the Ontario studies, age of initial use seems to be lower than it was in the 1970s (close to 16 years of age); it now stands at between 13 and 15 years of age (a mean of approximately 14). On the other hand, as we have said, early initial experience is down (currently 2% compared to 8% in the early 1980s). If age of first experience appears related to regular consumption in late adolescence and early adulthood (18-25 years) as suggested by the American studies, it is clear that consumption is inversely proportional to age and the rate of cessation is high. For those who continue to consume in the long term, the age of cessation is delayed until the late 30s.

On a more complex level, these trends would lend support the OFDT hypothesis concerning "trivialization" of cannabis consumption. The following section shows that a number of researchers–including persons who have testified before the Committee–impute this "trivialization" to a reduction in the perception of cannabis-related risks (health and legal consequences) and greater availability. Aside from "trivialization", there is also an acculturation aspect, the idea that cannabis will eventually be considered a psychoactive substance akin to alcohol or tobacco, whose risks we learn to recognize and manage.

Furthermore, cannabis consumption rates vary widely from one country to another with no apparent relation to public policy. This is one of the strong hypotheses that we will revisit in greater detail in our Chapter 21 examination of public policy.

[28] See for example Rigter, H. and M von Laar (2002) "Epidemiological aspects of cannabis use." in Pelc, I. (ed.) *International Scientific Conference on Cannabis.* Brussels.

PATTERNS AND CIRCUMSTANCES OF USE

Why do people use cannabis? In fact, why have people felt the desire or the need to use all manner of psychoactive substances since time immemorial? We suspect that these questions are highly charged with symbolic and political meaning: when it is a question of cannabis, sometimes the focus is on its "soft drug" nature, its festive and sociable side, and sometimes the focus is more on its role as part of a marginal, if not pre-delinquent, trajectory and the risks associated with moving on to other drugs. When it comes right down to it, and rather surprisingly, we know very little about users' motivations and experiences.

We can distinguish two large groups of studies: socio-anthropological studies that try to identify users' practices and certain environmental factors that put these practices in context, and psychological studies that try to relate personality and family-related factors to cannabis use. Although both types of studies are just as relevant to understanding the nature of the phenomenon, their approaches and their results are often difficult to reconcile. But, first, a few historical notes on the uses of cannabis.

Cannabis in history [29]

Although the historical routes of cannabis still remain obscure, archaeologists discovered a Chinese village where they uncovered the oldest use of the cannabis plant, dating back approximately 10,000 years. It was primarily used for clothing, ropes and fishing nets, paper and other decorative purposes. It was also considered one of China's five cereals. Around 2000 B.C. the Chinese became aware of the psychotropic and medicinal properties of cannabis oil (resin) and used it in particular for the treatment of menstrual fatigue, gout, rheumatism, malaria, constipation and absentmindedness, and as an anaesthetic. Religious uses were also identified, and the Chinese noted that its use allowed communication with spirits and lightened the body. In the first century B.C., Taoists used cannabis seeds in their incense burners to induce hallucinations that they considered a way to achieve immortality.

Several historians attribute the origins of cannabis to the Scythians around Siberia and North Central Asia towards the 7th century B.C. According to Herodotus, a Greek historian who lived in the 5th century B.C. marijuana was an integral part of the cult of the dead that the Scythians followed to honour the memory and spirit of their departed leaders. Indications of cannabis use, often for religious purposes, have also been found with the Sumerians and, according to some, in certain passages of the Bible.

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[29] This section is based extensively on Spicer, L. (2002) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*, Ottawa: Library of Parliament, report commissioned by the Committee from the Library of Parliament.

The first ethnographic description of ancient people inhaling marijuana as a psychotropic stimulant was confirmed by a Russian anthropologist, Rudenko, in 1929. Not only did he find the embalmed body of a man and a bronze cauldron filled with burnt marijuana seeds, but he also found shirts woven from hemp fibre and metal censors designed for inhaling marijuana smoke. Apparently this activity was not religious in nature but was a daily activity in which both men and women participated, as confirmed by the discovery of the frozen body of a 2,000-year-old woman in the same cemetery where Rudenko made his first discovery. Archaeologists found some of her possessions, including a small container of cannabis that would have been smoked for pleasure and used in pagan rituals, buried in a hollow tree trunk.

In India, cannabis has been closely associated with magical, medical, religious and social customs for thousands of years. According to legend found in the Vedas, Siva is described as "The Lord of Bhang", a drink made of cannabis leaves, milk, sugar and spices. This drink is still part of the traditions of certain castes. Cannabis is also renowned for its use in Tantric sexual practices. Approximately one hour before the yoga ritual, the devotee drinks a bowl of bhang after reciting a mantra to the goddess Kali. Similarly, "charas" holds a special place in the prayer ceremony called Puja. Lastly, cannabis was used for medical purposes.

Although not indigenous to Africa, the cannabis plant is part of religious, medical and cultural traditions across almost the entire continent. In Egypt, it has been grown for over a 1,000 years, while the first evidence of its presence in central and southern Africa dates back to 14th century Ethiopia where ceramic smoking-pipes containing traces of cannabis were discovered. In North Africa, cannabis influenced music, literature and even certain aspects of architecture since in some homes, a room was set aside for kif where family members gathered to sing, dance and tell stories. The plant was also used as a remedy for snake bite (Hottentots), to facilitate childbirth (Sotho) and as a remedy for anthrax, malaria, blackwater fever and blood poisoning (former Rhodesia).

In South America, it would have been primarily slaves imported from Africa who brought cannabis. East Indian labourers brought cannabis to the Antilles, and Jamaica in particular, where it is not only used recreationally but is integrated in many aspects of Jamaican, and particularly Rastafarian, culture.

As for North America, it is not known exactly when the psychotropic properties of cannabis were discovered. Some think that it played a role in several native cultures; others doubt that it ever played a significant role. The oldest evidence of the existence of cannabis in North America dates back to Louis Hébert, Champlain's apothecary, who introduced cannabis to white settlers in 1606, essentially as a fibre to be used to make clothing, cordage, sails and rigging for ships. However its psychotropic properties were not discovered until the 19th century. Between 1840 and 1900, it was used in medicinal practice across almost all of North America. It was prescribed for various conditions such as rabies, rheumatism, epilepsy and tetanus, and as a muscle relaxant.

Moreover, its use became so widespread that cannabis preparations were sold freely in drug stores.

The first study of cannabis was conducted in 1860 by the *American Governmental Commission*. When presenting the findings of the Commission to the *Ohio State Medical Society*, Dr. Meens said:

> *Cannabis effects are less intense than opium, and the secretions are not so much suppressed by it. Digestion is not disturbed; the appetite rather increases; the whole effect of hemp being less violent, and producing a more natural sleep, without interfering with the actions of the internal organs, it is certainly often preferable to opium, although it is not equal to that drug in strength and reliability.* [30]

At the same time, other doctors criticized its use because of the variability and uncertainty of its effects. As for its recreational uses, they seem to have been noted for the first time at the beginning of the 20th century and quickly became the subject of social concern, especially because of the association of cannabis with Mexican and then black American workers, strengthening fears about its criminogenic and aphrodisiac effects. In 1915, California became the first state to prohibit possession of cannabis. Canada followed suit in 1923, while the United States outlawed possession in 1937. However, in 1944, the La Guardia report, from the State of New York, emphasized the harmless effects of cannabis. It was followed by reports from the Le Dain Commission in Canada and the Schafer Commission in the United States at the beginning of the 1970s. On the international scene, cannabis was prohibited by the Single Convention of 1961 (which will be discussed more fully in Chapter 19).

In Canada, mass use of cannabis came with the 1960s. Prior to that, the phenomenon was almost invisible and there were only 25 convictions for cannabis possession between 1930 and 1946. In 1962, the RCMP reported 20 cannabis-related cases. Then came the explosion: 2,300 cases in 1968 and 12,000 cannabis convictions in 1972. According to the Le Dain Commission, the sudden growth in cannabis use could be attributed to the hippies, the Vietnam War, underground newspapers and the influence of the mass medias. On top of these major counterculture movements, Canada became more open to the world: more and more young Canadians were travelling and Canada itself received more and more visitors and immigrants. Since then, except for a few years, cannabis use for non-medicinal purposes has increased as we saw in the previous section.

Trajectories of use

Most studies identify quantity and frequency of use. Thus as we saw in the previous section, the OFDT report, for example, identifies experimentation, occasional, repeated, regular and heavy use, with frequency of use (number of times a month) and circumstances (alone or in a group, morning or evening) as the preferred indicators of

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[30] Quoted in Spicer, *op. cit*., page 29.

at-risk use. However, this knowledge of certain characteristics of use by young people in particular tells us very little about what will follow. If we could stop time at a given moment in a user's history, the knowledge would not help us determine what would happen next. For example, with this knowledge we could not answer the question of whether or not cannabis use begun during adolescence is part of a trajectory leading to increased use. Now, a certain number of those who testified before the Committee told us that they had observed dependence in cannabis users. Also, certain government documents, in the US in particular, do not hesitate to point in this direction by measuring requests for treatment and by reporting that requests for treatment of cannabis dependence are on the rise. For example, documents given to us by American drug authorities indicate that 40% of people who meet the DSM IV diagnostic criteria for dependence (which will be dealt with in the following chapter) have a primary diagnosis of cannabis dependence.[31] Unless we believe that a few occasional uses lead to dependence, we must accept that a relatively significant number of young people who try cannabis during adolescence will embark on a trajectory of use that will lead to dependence.

But what is the situation exactly? What are these trajectories of use? What are the stages? Is there a progression?

First of all, like Professor Mercier, we must point out that the idea of a trajectory is itself slightly inaccurate.

> *The concept of trajectory is based first of all on the basic principle whereby individuals will go through a number of stages or successive phases. It is true that the concept of trajectory is somewhat incorrect. A trajectory is somewhat of a metaphor for the trajectory of the planets and the stars, that is something very focused and in continuous motion. The word "journey" ("trajet") would be more accurate. A journey includes detours, round trips, et cetera. So we must bear in mind that this concept of trajectory is not necessarily linear, but that there will be different situations and different paths. The word "journey" is a more accurate way of describing the relationship an individual will have with psychotropic substances during his or her life. There is another important concept as well. In addition to trajectories, phases and stages, there are also transitions and passages, when individuals move from one stage to another.*[32]

Some, like the INSERM report, speak of contact, experimentation and commitment phases. Contact is seeing cannabis or knowing people who use it. Experimentation, of course, is trying it, and may be limited to a single time. Lastly, commitment refers to the various ways of managing use, from relative commitment where there are significant changes in use to true commitment where there are fewer changes. The report specifies that these three stages are not in all trajectories and do not always follow one another in a coherent fashion. Furthermore, there will often be

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[31] Office of National Drug Control Policy (2002) *National Drug Control Strategy*. Washington, DC: The White House.

[32] Professor Céline Mercier, testimony before the Special Senate Committee on Illegal Drugs, Canadian Senate, first session of the thirty-seventh Parliament, December 10, 2001, Issue No. 12, Page 6.

periods of cessation, followed by resumption or a definitive cessation. Nevertheless, according to INSERM, *"commitment probably constitutes the most important stage if we want to understand what cannabis use corresponds to. However, the data on this commitment phase seems the most inconsistent as most works deal with initiation."*[33] [translation]

In fact, the data on committed use is still very sketchy, such that beyond a few generalities, we really know very little about the circumstances and trajectories of cannabis use. It is as if we were first worried about classifying users according to their risk of becoming dependent, or were trying to make them fit into a ready-made model. While testifying before the committee, Professor Mercier recalled the five stages in the classic pattern of addiction: initiation, gradual start of abuse, dependency, treatment and reintegration. However, as she pointed out, this is only one of the possible trajectories, the one that has been studied most frequently with regard to drugs (alcohol, heroin and cocaine in particular), and yet it hardly applies to cannabis. In any event, it is clear that with cannabis users, there is great variability in use.

The epidemiological data presented in the previous section indicate fairly clearly that cannabis use decreases significantly with age. More specifically, the rate of cessation is significant, as the following table shows.

Rate of Cessation (percentage of lifetime users who did not use cannabis in the previous year), USA, 1996 [34]

Age Group	Women	Men
12-17	26%	20%
18-25	54%	39%
26-34	82%	74%
35 +	91%	82%

Consequently, the rate of continuation is relatively low. It was 24% in the US in 2000, 17% in Denmark, 29% in France and Germany (West), 24% in Switzerland and 8% in Sweden. The only exception is Australia with a rate of continuation of 46%.

That being said, these data says nothing about the period during which cannabis use is continued, the frequency of use or the quantities used. Epidemiological studies tend to establish that most users stop consumption during their thirties, but only ethnographic studies can provide more information. Unfortunately they are few.

The INSERM report describes studies conducted in Australia, France and the United States. Most show progress towards regulated cannabis use, that is, use both

[33] INSERM (2001), *op. cit.*, page 28.
[34] Rigter, H. and M. von Laar, *op. cit*., page 27.

stabilized–fewer variations in use–and use more integrated into social living conditions, that is, more integrated into personal and professional life. A significant proportion of long-term regular users are men, and are more likely to be single and have creative occupations. Most say they use cannabis to relax and relieve stress, to help them sleep, or to alter their state of consciousness.[35]

In Canada, Hathaway studied regular users[36], using open-ended interviews from October 1994 to June 1995. The study involved a sample of 30 regular users (15 men and 15 women), aged 22 to 47 (average age 32). Participants had used cannabis for 3 to 31 years with the average being 17 years; 40% had used it daily for 20 years or more. This data is in complete agreement with what INSERM suggested. Long-term users integrate their regular cannabis use into their daily lives and social activities while remaining aware of the symbolic value of this "tolerable deviance". While most started after coming into contact with a small group of users who served as more or less long-term support, the users who were most at peace with their drug use were those who regulated their use independently.

> *In this study, I found that moving from a pattern of use that is dependent on one's level of participation with other users to one that is independently regulated marks a crucial transition in the marijuana user's relationship to the drug. (…) their continuing use of the drug does not necessarily suggest an inability to commit to conventional adult roles. Instead, adapting one's marijuana use to suit an otherwise conventional way of life appears to make the practice significant on a more personal level than that previously fostered through affiliation with marijuana-using groups.* [37]

For a certain number of users, this acculturation of the drug occurs after a more or less prolonged period of abstinence during which they distance themselves from the group of users. This makes it possible for them to determine for themselves the role cannabis will play in their lives. Moreover, every participant in the study had managed to integrate their use into their personal or professional life. Users associate their drug use primarily with free time and relaxation after a day at work; some even compare its role with that played by alcohol. Although 97% used cannabis at least weekly and 37% used it daily, only 7% (2 people) defined their use as problematic. Most went through periods of abstinence or of decreased use without experiencing difficulties.

Another study, reported by Rigter and von Laar,[38] was conducted in the State of New York on a cohort of users who were followed for a period of twenty years. This study identified four types of users:

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[35] INSERM (2001), *op. cit.*, pages 55-58.

[36] Hathaway A. D. (1997a) "Marijuana and lifestyle: exploring tolerable deviance." *Deviant Behaviour: An Interdisciplinary Journal*, 18, pages 213-232; and (1997b) "Marijuana and tolerance: revisiting Becker's sources of control." *ibid*, pages 103-124.

[37] Hathaway, A.D. (1997a), *op. cit.*, page 219.

[38] Rigter, H. and M. von Laar, *op. cit*., pages 28-29.

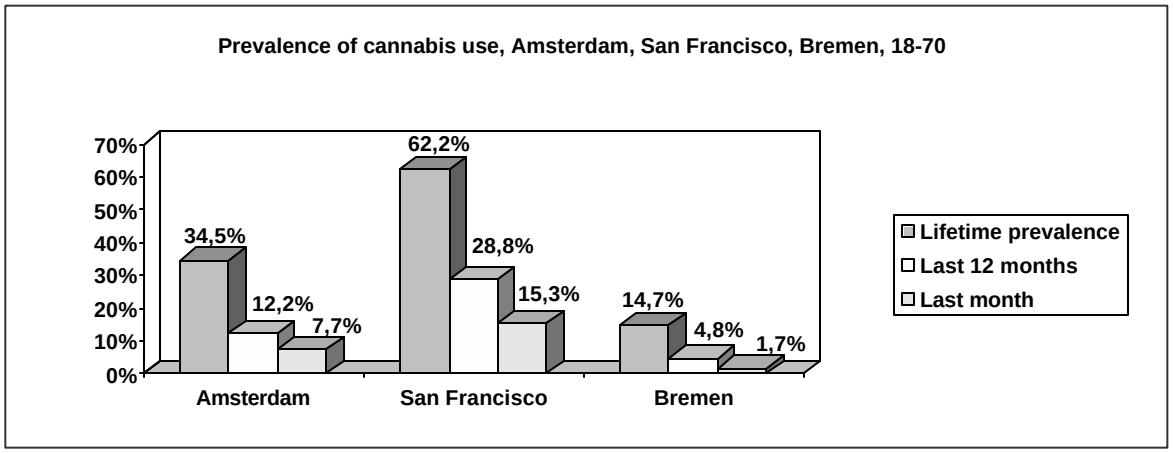
- Early-onset heavy-use: start around age 15 and become regular users around age 17.5; daily use for a duration of 131 months on average; 49% still use around age 34-35;
- Early-onset light-use: start around age 15 but fewer (44%) go on to daily use (for an average duration of 28 months); only 10% still use at age 34-35;
- Mid-onset heavy-use: start around age 16; two-thirds become daily users (average duration 42 months) and still use at age 34-35;
- Late-onset light-use: start at age 19.5 and a minority become daily users (21%). Almost all discontinue use around age 34-35.

In all, this study shows that there were clearly more light users than heavy users. The latter had less education, went to church less often, were more likely to have a history of delinquency, and changed jobs more often. Early-onset users showed a greater tendency towards episodes of delinquency and mental disorders, started to drink and smoke tobacco sooner, had a greater tendency to experiment with other drugs, and tended to identify positive reasons for using marijuana.

But it is risky to propose typologies, because boundaries are fluid and users switch from one type of use to another fairly easily. This was shown in particular by the comparative study conducted by Cohen and Kaal in Amsterdam, San Francisco and Bremen.[39]

The study involved a sample of experienced users consisting of 216 people in Amsterdam, 265 in San Francisco and 55 in Bremen. The sophisticated method of selecting candidates from epidemiological studies conducted in the general population of these cities is important because it reveals the prevalence of use. The following chart shows this data.

[39] Cohen, P.D.A. and H.L. Kaal, *The irrelevance of drug policy. Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam: University of Amsterdam, CEDRO.



The average age of participants varied between 33 and 37; most had a spouse and a stable job. The average age for initiation into cannabis use in the three cities was 16, that is, at a younger age than people who had only occasional exposure to cannabis (21.2 in Amsterdam and 19.5 in Bremen). Most were introduced by friends and their first experience was as part of a group. At age 19, they were regular users (at least once a month) and their heaviest use was around age 21.5. Trajectories of use were determined using six patterns:

1) More to less: after an initial period of heavy use, the individual gradually decreased his use
2) Gradually more: the individual gradually increased his use
3) Stable: amount and frequency did not change
4) Up-top-down: use increased, reached a peak, and then decreased
5) Intermittent: frequent discontinuation after initiation
6) Varying: use rises and falls

As the following table shows, no less than 75% of respondents in the three cities correspond to patterns 4 (48.7%) and 6 (25%).

Patterns of Use in Regular Users [40]

	Amsterdam		San Francisco		Bremen	
	Number	%	Number	%	Number	%
Pattern 1	17	8	18	7		
Pattern 2	13	6	17	6	6	11
Pattern 3	24	11	5	2	5	9
Pattern 4	104	48	133	50	24	44
Pattern 5	7	3	25	9	2	4
Pattern 6	51	24	66	25	18	33

During their period of heaviest use, approximately 45% of those studied used cannabis regularly. However, during the preceding year, approximately 35% used it less than once a week and more than 35% did not use it all. During the past three months, more than 50% did not use cannabis at all, and less than 10% used it on a daily basis. As for amounts, the authors of the study concluded that they are low. During their period of heavy use, less than 18% of those studied smoked more than one ounce per month, whereas during the preceding year, approximately 60% had smoked less than 4 grams (1/7 of an ounce) per month. Users were divided fairly equally between those who preferred medium or mild cannabis and those who preferred a stronger variety (with a more marked preference for the mild varieties in Amsterdam). Users have a certain number of rules regarding use: no smoking at work or school (more than 35%), during the day, or in the morning.

Most long-term users had had periods of abstinence that varied from one month to a year or longer, most often because they no longer felt the need or the desire to smoke. Moreover, between one-third and one-half had decided to decrease their use at various times.

Thus we can see that trajectories of use do not follow a linear progression, and are marked by key periods when the user integrates cannabis use into his social and personal life, distances himself from groups of users, stabilizes the role marijuana plays in his personal life, with periods of heavy use, especially at the beginning of the trajectory, followed by periods of either decreased use or of ups and downs in terms of frequency and amount.

Factors related to use

Following logically from what we saw in the previous section, studies on factors that could explain the use of drugs, and cannabis in particular, deal primarily with initiation or experimentation.

The INSERM report examines a set of studies on factors that could explain cannabis use: the influence of the family environment (use by parents, socialization,

[40] *Ibid.*, page 48.

parental teaching methods, quality of the parent-child relationship, parental models), peers (symbolic values of use, norms) and educational and social environments.[41] There is no clear conclusion, but the report notes that the studies manage either poorly or not at all to take into account the user's role in social situations and consequently the incremental impact on use arising from the variability of social stresses as well as the methods of integration. We would also add that these studies do not reflect trajectories of use.

First of all, along with *DrugScope*, we note that the epidemiological approach to analysis of drug use, cannabis in particular, is based on a medical model of analysis of the prevalence of disease, whereas the reasons (which are not necessarily the causes) for drug use can very easily lie outside the medical field and, in a broader sense, outside the psychosocial model. Attributing dependence – understood here in terms of a disease – to factors pertaining to the relationship between the locus of control and the environment has consequences for the understanding of the phenomenon as well as for public policy. The report by this British body contains a table of the explanations of drug use we feel it useful to reprint here.

Attribution Explanations of Drug Use [42]

Attribution	Common Sense Meaning	Resulting Public Policy
Internal x stable	Drug use is a disease (dependence model)	Treatment model
Internal x unstable	Drug use is the periodic seeking of pleasure	Reduced demand model (replace drugs with something else)
External x stable	Shortcomings in the environment explain drug use	Change the environment
External x unstable	Availability of drugs explains their use	Reduced supply model

In fact, we must not forget that, with regard to psychoactive substances, the medical model of disease is still a dominant model for comprehension and forms the other part of the public response along with the penal model.[43] As we were told several times, drugs, and cannabis in particular, are not dangerous because they are illegal, they are illegal because they are dangerous. We will have occasion to comment on this statement in greater detail in the following chapters.

[41] INSERM (2001) *op. cit.*, pages 28-50.

[42] DrugScope (2001) *United Kingdom. Drug Situation 2000.* Report to the EMCDDA, page: 19.

[43] On this subject, see for example the work of Bergeron, H. (1996) *Soigner la toxicomanie. Les dispositifs de soin entre idéologie et action.* Paris: L'Harmattan; and Barré, M.D., M.L. Pottier et S. Delaître (2001) *Toxicomaie, police, justice: trajectoires pénales.* Paris: OFDT.

For now it is enough to remember that attempts to explain drug use most often involve looking for defects in personality or the environment rather than trying to understand the choices made by users.

Among the factors related to the locus of control, studies identify primarily:

- Peer influences: the first uses depend on the influence of other young people in the group;
- Family influences: a family environment where parental supervision is lacking, where drug use is tolerated, where siblings or parents have criminal backgrounds, and where parents themselves are users;

Among the factors related to the environment, studies mention:

- The availability and accessibility of drugs: the more drugs are available, the greater their use will be;
- Social tolerance: the more drug use is accepted, the higher levels of use will be;
- Perception of risk: the less the risk of social disapproval or the perceived risk to health, or the risk of legal action, the greater the use there will be.

According to the report *Monitoring the Future*, there is no doubt that young people's perceptions of drugs and their attitudes towards them determine the levels of use, which in return must determine public policy:

> *Early in the decade of the 1990s we noted an increase in the use of a number of illicit drugs among secondary students and some important changes among the students in terms of certain key attitudes and beliefs related to drug use. (…) Specifically, the proportions seeing great risk in using drugs began to decline, as did the proportions saying they disapproved of use. As we predicted, those reversals indeed presaged "an end to the improvements in the drug situation that the nation may be taking for granted." The use of illicit drugs rose sharply in all three grade levels after 1992, as negative attitudes and beliefs about drugs continued to erode. This pattern continued for some years.* [44]

And further on:

> *We can summarize the findings on trends as follows: over more than a decade – from late 1970s to the early 1990s – there were very appreciable declines in use of several illicit drugs among twelfth-grade students, and even larger declines in their use among college students and young adults. These substantial improvements – which seem largely explainable in terms of changes in attitudes about drug use, beliefs about the risks of drug use, and peer norms against drug use – have some extremely important policy implications. One is that these various substance-using behaviours among American young people are malleable – they* can *be changed. It has been done before. The second is that demand-side factors appear to have been pivotal in bringing about those changes. The reported levels of availability of marijuana, as reported by high school seniors, has held fairly steady throughout the life of the study. (Moreover, both*

[44] Johnston, L.D., et al., (2001) *op. cit.*, page: 6.

> *abstainers and quitters rank availability and price very low on their list of reasons for not using.). And in fact the perceived availability of cocaine actually was rising during the beginning of the sharp decline in cocaine and crack use, which occurred when the risks associated with that drug suddenly rose sharply. (…) Over the years, this study has demonstrated that changes in perceived risk and disapproval have been important causes of change in the use of several drugs. These beliefs and attitudes surely are influenced by the amount and nature of public attention paid to the drug issue in the historical period during which young people are growing up. A substantial decline in attention to this issue in the early 1990s very likely helps to explain why the increases in perceived risk and disapproval among students ceased and began to backslide.* [45]

In other words, social disapproval – through government information campaigns, for example – can generate attitudes that reject drug use and will be reinforced by actions likely to increase the risks associated with use (the risk of arrest, for example).

A study conducted in Newfoundland and Labrador involving a sample of 3,293 people is an example of this approach applied in Canada.[46] The questionnaire included questions about activities (family activities, housework, extracurricular activities, school work, sports, work, religious life), the availability of cannabis, use by parents, peers and the individual, parental and peer norms regarding cannabis, personal preferences and norms regarding cannabis. Analysis of variance dealt with the interaction of these various variables to explain personal use of cannabis. Overall, the model explains only 57% of use in the provincial sample, 65% for boys and 54% for girls. The results show that peer use is the main factor related to personal use (29% of variance), followed by personal preferences (themselves influenced by peer norms), personal norms and having to do chores around the home. Availability is not directly related to use and works through peer norms and use. Parental use is strongly linked to perceived availability. The authors conclude that this model has clear implications for interventions to prevent cannabis use:

> *In the province wide sample, Peer Use, Peer Norms, Availability, Own Preferences and Own Norms together account for 56% of the 57% of Own Use predicted by the model. Peer Norms and Availability work though Peer Use, so important targets for intervention should be Own Norms, Own Preferences and Peer Use. Of these variables, Own Preferences and Peer Use contribute the most to prediction of Own Use, together accounting for 48.8% of the variance. It is of interest that a large part of availability is predicted by Parental Use, suggesting Peer Use arises from possible supplies of the marijuana/hashish from parental sources. This ought to be a target for intervention strategies as well. The model suggests sources of influence on target variables that ought to be considered in any intervention strategies.* [47]

Taking into consideration the limits of the model as well as the differentiation between the sexes and provincial health districts with respect to the relative weight of

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[45] *Ibid.*, page 30.

[46] Wasmeier, M., et al., (2000) *Path analysis survey of substance use among Newfoundland and Labrador Adolescents. Marijuana/haschish and Solvent use.* Memorial University of Newfoundland.

[47] *Ibid.*, page 15.

the independent variables, we have to wonder if this type of analysis is a true reflection of use, including initial use. Furthermore, in the light of international trends in use on the one hand, and studies on users on the other, we wonder about the postulates of this type of mechanical model based on the rationality of the actors.

Finally, Aquatias et al., conducted a study on cannabis use among youth in the suburbs of Paris.[48] The authors make a particularly interesting distinction between forms of use based on user characteristics and the ideological representations of cannabis use. They demonstrate in particular (1) that there exist "hard" uses of soft drugs and (2) that the traditional distinction between the festive, socially integrated and group-regulated forms of use among middle class youth, and the excessive and socially unregulated uses of disadvantaged youth does not hold. Depending on factors related to their environment, both groups can have regulated and unregulated forms of use.

Factors traditionally associated with unregulated use such as social disenfranchisement, poor living conditions in the suburbs and the lack of professional integration, are only part of the picture. Other factors related to tensions arising in the environment (for example family-related problems or being in conflict with the law) and the capacity to remain autonomous from their social milieu also play an important role in the trajectories of these cannabis users.

> [Translation] *In trying to understand what factors determined these different forms of cannabis use among these youths, we have obviously noted the importance of factors related to social dislocation: difficulties in social integration and a lack of financial resources capable of fostering their autonomy from the living environment.*
>
> *However, facing similar difficulties to get a job and socio-economic resources, some smoke cannabis without any excess, some not at all and others smoke considerably. Even within the group of youth who have a job, some smoke high potency cannabis intensively while others have more regulated forms of use and consume less.*
>
> *Social dislocation is obviously a factor explaining the different forms of use just as integration in the job market serves to regulate these practices. But these complementary factors only constitute the more general context to these behaviours of intensive and prolonged use of cannabis.*
>
> *(…)*
>
> *Among those who experience social dislocation the most, those who smoke cannabis in an intensive and prolonged manner also experience the strongest social tensions such as problems with their local reputation, being in conflict with the law or family related problems… (…).*
>
> *Conversely, those who have a more regulated use are both better integrated in their environment and at the same time more autonomous with respect to local social life.* [49]

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[48] Aquatias, S., (1999) « Usages du cannabis et situations sociales. Réflexion sur les conditions sociales des différentes consommations possibles de cannabis. » in Faugeron, C. (éd.) *Les drogues en France.* Paris: Georg. Pour l'étude originale: Aquatias. S. et coll. (1997) *L'usage dur des drogues douces, recherche sur la consommation de cannabis dans la banlieue parisienne.* Paris: OFDT.

[49] Aquatias, S. (1999) *op. cit.,* pages 48-49.

The authors propose a classification of forms of use which we reproduce since it has, in part, inspired our own classification.[50].

	Regulated solitary uses	Regulated group uses	Unregulated solitary uses	Unregulated group uses
Intensive use	After work	Boredom	Personal problems	Holidays, parties
Medium or low level of use	Before and after work	Generally in the evening Boredom		

Finally, the authors distinguish between four levels of use:

- Occasional: from experimentation to use in parties;
- Moderate daily use: 3 to 5 joints per day or about one gram;
- Strong daily use: 5 or 6 joints per day or between 0.9 and 1.2 grams;
- Intensive daily use: over 1.2 gram per day.

To summarize

From an analysis of the life stories of users and their "trajectories", we have learned primarily that, for a proportion of experimenters, which varies between 15% and 20% of the population, who will become regular users, the circumstances and patterns of their "career" as a user vary considerably but that for a significant proportion of these long-term users, use is integrated into their social and personal life.

Further, contrary to some studies, uses of cannabis are not determined only by a series of psychological or environmental factors. In all cases, it seems that specific events, elements of one's particular life story, can trigger unregulated forms of uses, characterized in particular by intensive and solitary use. While such unregulated uses appear to be temporary, we did not come across any study that examined the trajectories of these users.

We also note that negative social attitudes and the characteristic of the cannabis market appear to have little impact on patterns of use.

Finally, we note that regular use does not necessarily mean problem use. At the same time, we have learned that early onset and rapid progression towards regular use are factors in problem use. In other words, and this will be important for choosing public policy and interventions, initiation at a young age (under age 16) and rapid progression towards regular use (under age 20) are markers that should be used to identify and prevent heavy use. Chapter 7 will discuss this issue in greater detail.

[50] *Ibid.*, page 45.

STEPPING STONE TO OTHER DRUGS?

The stepping stone theory holds considerable sway in debates on marijuana. In fact, the concern is that cannabis use leads to the use of other drugs, in particular, the so-called hard drugs, such as heroin and cocaine.

> *It logically follows that more people using drugs will increase the number of people being harmed by them. Cannabis is believed to be the foundation upon which most young people begin experimenting with illicit drugs. (…) The "gateway" concept has been around for a long time, and again, although there is no definitive evidence, the National Institute on Drug Abuse has reported that neuro-toxicological research suggests that marijuana "may alter the brain in ways that increase the susceptibility to other drugs." Many believe that cannabis use provides the impetus for those people looking to increase the psychotropic effect a drug has on them.* [51]

We should first define our terms. The "stepping stone" theory holds that cannabis use inevitably leads to use of other drugs. In this theory, cannabis use would lead to neurophysiological changes, affecting in particular the dopaminergic system (also called the reward system), thus creating the need to move on to the use of other drugs. This theory has been completely dismissed by research. We share this conclusion with several international bodies doing drug research, including the British organization *DrugScope*:

> *The Stepping-Stone theory has proved unsustainable and lacking any real evidence base. The "evidence" that most heroin users started with cannabis is hardly surprising and demonstrably fails to account for the overwhelmingly vast majority of cannabis users who do not progress to drugs like crack and heroin. The Stepping-Stone theory (often confused among the general public for the Gateway theory) has been dismissed by scientific inquiry. The notion that cannabis use "causes" further harmful drug use has been, and should be, comprehensively rejected.* [52]

The "gateway" theory suggests that users' trajectories offer them choices as they start their trajectory of use and that one of these choices is to use other drugs. According to this theory, certain factors, such as early initiation and more regular and heavier use, reinforce this possibility. However, these factors themselves, and early initiation to cannabis in particular, are related to earlier factors, arising from the family environment and social living conditions, that predispose the more vulnerable young people to this early initiation and more rapid progress towards regular and heavy use.

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[51] M. J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, Canadian Association of Chiefs of Police, testimony before the Special Senate Committee on Illegal Drugs, Canadian Senate, first session of the thirty-seventh Parliament, Issue 14, page 75.

[52] DrugScope (2001) *Evidence to Home Affairs Committee Inquiry into Drug Policy.* Available on-line at: http://www.drugscope.org.uk/druginfo/evidence-select/evidence.htm

> *The link between cannabis and other drug use, according to this explanation, is thus a reflection that there are a number of risk factors and life pathways that predispose young people to use cannabis and that they overlap with the life pathways that predispose young people to use other illicit drugs.* [53]

In addition to these factors that predispose some young people to heavier use of psychoactive substances – including alcohol and tobacco first of all – the sociological conditions under which users can obtain cannabis are such that they are in contact with an environment that is at least marginal if not criminal. Dealers are often the same people who also sell heroin, crack, amphetamines, cocaine and ecstasy such that the probability that a young cannabis user, already more vulnerable due to the factors of his personal trajectory, would come into contact with these other substances more easily. We would also add that wholesalers and dealers "cut" or even mix their products; we were told at times that ecstasy, for example, could contain many things other than MDNA.

Furthermore, if it is true that use of substances such as heroin and cocaine develops almost necessarily out of prior use of marijuana, then it also develops out of the use of other substances, nicotine and alcohol in particular, which are more gateways to a trajectory of use than cannabis.

If we come back to trends in drug use in the population, while more than 30% have used cannabis, less than 4% have used cocaine and less than 1% heroin.

However, it is true that regular and heavy users are more likely than occasional users to use other substances. The study by Cohen and Kaal[54] discussed in the previous section shows for example that more than 90% of long-term cannabis users have also used tobacco and alcohol during their lifetime. Above all, it also shows that 48% in Amsterdam and 73% in San Francisco have used cocaine at least once in their life, and 37% in Amsterdam, 77% in San Francisco and 47% in Bremen have used hallucinogens at least once. Nevertheless, no regular cannabis users were regular users of other substances. The authors also show that the most common sequence is alcohol (around age 14), tobacco (around age 15), cannabis (around age 17), followed by other drugs in the early 20s.

We feel that the available data show that **it is not cannabis itself that leads to other drug use** but the combination of the following factors:

- Factors related to personal and family history that predispose to early entry on a trajectory of use of psychoactive substances starting with alcohol;
- Early introduction to cannabis, earlier than the average for experimenters, and more rapid progress towards a trajectory of regular use;
- Frequenting of a marginal or deviant environment;
- Availability of various substances from the same dealers.

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[53] *Ibid.*

[54] Cohen and Kaal, *op. cit*., page 92-93.

CANNABIS, VIOLENCE AND CRIME

It is clear that there is some association between psychoactive substances and crime. It is just as clear that this link is much more complex than is sometimes thought, as Professor Brochu pointed out during his testimony before the Committee.

> *Just in my office at the Université de Montréal, I have 2,973 studies that attempt to show a link between psycho-active substances and crime. Most of these studies come from the United States or from English-speaking countries, which tends to colour their perspective somewhat, since we know that our neighbours to the south have very clearly opted for a punitive approach to illegal drugs. What comes out of all these studies is that the link between drugs and crime is very complex.* [55]

Since his testimony, Professor Brochu has released the study he mentioned to the Committee.[56]

We can examine the drug-crime relationship from at least three angles: the effects of the substance itself, the effects of the cost of the substance, and the drug's position in the criminal world.

A significant proportion of offenders have psychoactive substance abuse problems, predominantly with alcohol. In fact, the study concludes that alcohol is the substance most frequently associated with violent crime; in the case of crimes against property, illegal drugs predominate. Cannabis ranked third (3% to 6% according to the study), far behind alcohol (24%) and cocaine (8% to 11%).

With respect to the second approach, the authors establish that between 17% and 24% of inmates committed a crime to obtain the money needed to buy their substance of choice, most often cocaine.

Lastly, regarding the third approach, because illegal drugs are marginalized, users are exposed to a deviant environment. In the previous section we noted that, with regard to cannabis, the fact that dealers can offer heroin or crack as well as cannabis could promote a gateway trajectory towards these other drugs. Similarly, the fact that these substances are illegal could contribute to leading people to a trajectory of delinquency. Furthermore, the drug trafficking environment is a relatively violent environment where a whole series of crimes are committed. Lastly, the simple fact of selling cannabis is itself a criminal offence, and we know that a certain number of people are imprisoned for doing so.

All in all, cannabis itself does not lead to a trajectory of delinquency and it is more likely to be the other way around: someone who embarks on a trajectory of delinquency

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[55] Professor Serge Brochu, Université de Montréal, testimony before the Special Senate Committee on Illegal Drugs, Canadian Senate, First Session of the Thirty-Seventh Parliament, December 10, 2001, Issue 12, page 18.

[56] Pernanen, K. et al., (2002) *Proportions of crimes associated with alcohol and other drugs in Canada.* Ottawa: Canadian Centre on Substance Abuse.

when young is exposed to illegal drugs more quickly and can experiment at a younger age and begin a career as a user when younger.

Furthermore, simply because of its relaxing and euphoristic psychoactive effects and its effect of relaxing muscle tone, cannabis is hardly likely to lead to acts of violence.

Data from studies on long-term users confirm this global picture of the relationship between cannabis and crime. Thus, Cohen and Kaal noted that less than 5% of their respondents had committed offences to obtain cannabis (pilfering, shoplifting, theft). The offence committed most frequently in order to obtain cannabis was selling it.

In short, the Committee has learned that cannabis is not a cause of violence or crime except in rare cases, and of course excluding driving while under the influence, which will be dealt with in Chapter 8.

CONCLUSIONS

We have learned the following from all the information on trends, patterns, circumstances, trajectories and social consequences of cannabis use:

Conclusions of Chapter 6	
On trends in use	➢ **The infrastructure of national knowledge about the trends and circumstances of cannabis use is fundamentally weak and desperately needs strengthening.** ➢ **The epidemiological data available indicates that close to 30% of the population (12 to 64 years old) has used cannabis at least once.** ➢ **Approximately 10% used cannabis during the previous year.** ➢ **Up to 30% of those who used cannabis in the last year are current users (have used cannabis this month).** ➢ **Approximately 15% of current users would be daily users** ➢ **Use is highest between the ages of 16 and 24.** ➢ **The prevalence of use during the current year is highest, approximately 40%, in young people of high school age.** ➢ **The prevalence of monthly use in young people is approximately 30%.** ➢ **The prevalence of daily use in young people is approximately 9%.**
On trajectories	➢ **The average age of introduction to cannabis is 15.** ➢ **Most experimenters stop using cannabis.** ➢ **Regular users were generally introduced to cannabis at a younger age.** ➢ **Long-term users most often have a trajectory in which use**

	rises and falls. ➢ **Long-term regular users experience a period of heavy use in their early 20s.** ➢ **Most long-term users integrate their use into their family, social and occupational activities.**
On the gateway effect	➢ **Cannabis itself is not a cause of other drug use.** ➢ **Cannabis use can be a gateway because it is illegal, which puts users in contact with other substances.**
On violence and crime	➢ **Cannabis itself is not a cause of delinquency and crime.** ➢ **Young people with a trajectory of regular and heavy use are often already on a deviant if not delinquent trajectory.** ➢ **Cannabis is not a cause of violence.**

CHAPTER 7

CANNABIS: EFFECTS AND CONSEQUENCES

Cannabis, as we saw in Chapter 5, acts on the central and peripheral nervous systems in various ways. While research has established a fairly clear role for some of the components of cannabis, Δ^9THC in particular, the main active component, we are less sure of the role of other chemicals. Similarly research, which is often conducted on laboratory animals or in an even more specialized manner on molecules extracted for experimental purposes, does not reflect the conditions under which the average user uses marijuana. We have seen that, in some cases, dosages used for experimental purposes on laboratory animals, in particular to determine the chronic effects of regular use, are dosages that are unimaginable for humans, the equivalent of 570 marijuana cigarettes a day. Since THC content varies greatly with the cannabis available on the market, since users make different use of the drug depending on the place and circumstance, and since individual characteristics interact with the actual effects of cannabis, knowledge of the effects is necessarily influenced.

From an even more technical standpoint, we should point out that a statistical association – that is, the fact that two facts are concomitant – in no way indicates causality. To infer causality, a certain number of methodological prerequisites must be satisfied. In addition to the statistical association, we must be able to dismiss chance and alternative hypotheses, and show that the causative factor does precede the inferred consequence. According to the WHO:

> *Causal inferences can be drawn from research findings by judging the extent to which the evidence meets widely accepted criteria. These include: strength of association, consistency of association, specificity, dose-response, biological plausibility, and coherence with other knowledge. These criteria are not sufficient to show that an association is causal but the more are met, the more likely it is that the association* ***is*** *causal.* [1]

[1] World Health Organization (1997), op. cit., page: 3; on this question also see: Hall, W. (1987) "A simplified logic of causal inference" *Australian and New Zealand Journal of Psychiatry*, 21: 507-513.

Moreover, a strong tradition in the philosophy of science holds that you can never prove a hypothesis. The most you can do is falsify – that is, dismiss – alternative hypotheses.[2]

To try to meet the requirements of causality, researchers have developed sophisticated research methods, providing in particular for the random selection of subjects for a study, the random assignment to experimental conditions and non-experimental conditions (control group), the use of double blind and placebo techniques, the careful control of intervening variables that could represent as many alternative hypotheses as researchers are trying to eliminate. This is how, for example, they usually try to test medications that are put on the market.

For most questions involving human behaviour, *a fortiori* in society, it is difficult and rarely possible to establish such a causality relationship for the simple reason that each of these methodological requirements can rarely be met. In our case, the effects of cannabis use, the methodological constraints are particularly obvious. We cannot gather a random sample of cannabis users since we don't know the population. Therefore we must rely on alternative methods for selecting subjects (volunteers, for example). It is difficult to have people smoke cannabis who would otherwise never use it[38] without running the risk of contravening certain rules of ethics, or even legal provisions. And if we resort to people who have already smoked it, there is necessarily contamination of the control group. The cannabis that is used in the lab may be completely different from that of users who buy it off the street. And controlled laboratory conditions definitely do not reproduce the methods of cannabis use, which we know are usually a form of social ritual. As for studies–and they are numerous–conducted on animals (monkeys, mice, rats…), they may be interesting, but the possibility of transposing their results onto humans is limited. Lastly, we note that, as most cannabis smokers also smoke tobacco and drink alcohol, it is difficult to separate the effects of one from the effects of the others.

Obviously that does not prevent researchers from conducting studies, and these studies are also necessary. However, it does require researchers to be as prudent as possible when interpreting their results, in particular with respect to the ability to generalize about all marijuana users and to draw causal inferences. This is a caution that we do not always find, far from it, as this chapter will repeatedly show.

Lastly, we should note the distinction between effects and consequences. Smoking cannabis has immediate effects, some physiological and some psychosocial, that we must describe. But smoking cannabis, especially repeatedly, can also have consequences, some immediate – for example, the ability to perform certain tasks or

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[2] On this subject, see the works of Karl Popper in particular (1978 for the French edition) *The Logic of Scientific Discovery* Paris: Payot, and (1985) *La connaissance objective.* Bruxelles: Complexe.

[3] It is even a little ironic that the National Institute on Drug Abuse (NIDA) in the US finances studies that have people smoke when the Institute believes that cannabis is a gateway drug: for example, see the study by Haney, M. et al. (1999) "Abstinence symptoms following smoked marijuana in humans" *Psychopharmacology*, 141; 395-404.

the ability to drive a vehicle – and others more distant – for example if smoking cannabis results in a greater risk of lung cancer and if it has a lasting effect on memory.

We are aware of just how arbitrary these distinctions can be insofar as a human being is a whole, an organism integrated into his emotional and social environment and into his ecosystem. The physiological, psychological and social effects interact with one another, infiltrate one another, influence one another and act together rather than separately. In some ways, these distinctions remain the reflection of our incompetence, or at least of our inability, to think about the various systems of a human being as a whole, from every angle. This same incompetence can, also in part, explain the difficulty we have in creating a drug policy. It is to be hoped that those who come after us will be able to develop an integrated, holistic approach. For now, we are forced to use the means at our disposal, our fragmented understanding.

One last preliminary note. We were constantly guided by the need to be rigorous. Be that as it may, our resources did not enable us to be completely thorough and to examine the studies one by one for all these questions. In total, we know that approximately ten thousand studies have been published on cannabis over the last forty years! However, as Nelson points out, "*Although the total volume of this literature is somewhat daunting at first glance, a sampling of the material soon reveals that much is repetitive and a relatively small number of papers are continually referred to by most authors.*"[4] Despite this repetition, we could not go without examining a certain number of these studies. That is why we commissioned the preparation of a summary report[5] and also examined the summaries of scientific literature that were prepared in recent years.[6]

This chapter is divided into five sections. The first is a collection of statements on the presumed effects of marijuana that the Committee heard or that it was made aware of through its research. The following three sections examine the acute effects of cannabis, followed in turn by the physiological and neurological consequences, the psychological consequences and the social consequences. Then, because of its significance and the central place it holds in social and political concerns, we turn our attention specifically to the question of dependence possibly arising from prolonged use of cannabis.

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[4] Nelson, P.L. (1993) "A critical review of the research literature concerning some biological and psychological effects of cannabis" in Advisory Committee on Illicit Drugs (eds.) *Cannabis and the law in Queensland: A discussion paper*. Brisbane: Criminal Justice Commission of Queensland.

[5] Wheelock, B. (2002) *op. cit*.

[6] In particular the previously mentioned INSERM report (2001), *op. cit*. and the report from the International Scientific Conference on Cannabis (2002); as well as the report from the National Institute of Medicine in the US and the book edited by Professor Kalant, one of our witnesses.

EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD

During the hearings, many witnesses told us what they knew about the effects of cannabis. Some of this knowledge came from their own research work. Other knowledge came from their professional experiences. And lastly, other knowledge was either their interpretation of scientific literature or anecdotes. In this section, we will not make distinctions between the testimony and we will not evaluate its validity. We only want to highlight the richness, as well as the complexity, of what we were told.

> *Message number one is that drugs, including cannabis, are harmful. (…) There is considerable misinformation about the physiological consequences of cannabis use. There is no doubt that heavy use has negative health consequences. The most important are in the following areas: respiratory damage, physical coordination, pregnancy and postnatal development, memory and cognition, and psychiatric effects. (...)* [7]

> *Generally, marijuana (cannabis) and its derivative products are described in this context to distance the drug from the recognized harm associated with other illegal drugs. This has been a successful yet dangerous approach and contributes to the misinformation, misunderstanding and increasing tolerance associated with marijuana use. Marijuana is a powerful drug with a variety of effects. Marijuana users are subject to a variety of adverse health consequences that include respiratory damage, impaired physical coordination, problem pregnancy and postnatal deficits, impaired memory and cognition, and psychiatric effects. Marijuana use is associated with poor work and school performance and learning problems for younger users. Marijuana is internationally recognized as a gateway drug for other drug use. Risk factors for marijuana dependence are similar to those of other forms of drug abuse. (…) It was the consensus of the international community to put marijuana and other substances under international control. That decision was based on evidence of its harmfulness to human health and its dependence potential.* [8]

> *I wish to briefly review two of what I believe are fairly well-established, harmful effects of marijuana, and a number of other areas where there is considerable contention. (…) By far the most consistent and clear-cut effect of marijuana is disruption of short-term memory. Short-term memory is usually described as "working" memory. It refers to the system in the brain that is responsible for short-term maintenance of information needed for the performance of complex tasks that demand planning, comprehension and reasoning. The relatively severe impairment of working memory may help to explain why, during the*

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[7] Testimony of Michael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, for the Canadian Association of Chiefs of Police, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, Issue No. 14, page: 74.

[8] Testimony of Dale Orban, Detective Sergeant, Regina Police Service, for the Canadian Police Association, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, Monday, May 28, 2001, Issue 3, page: 47. It should be immediately noted that the last statement is completely false as we will see in Chapters 19 and 12 on international agreements and Canadian legislation that have placed cannabis on the list of controlled drugs since 1924, with no knowledge of its physical or psychological effects at that time, and for completely different reasons, when there were any.

marijuana high, subjects have difficulty maintaining a coherent train of thought or conversation. (…) Obviously this is relevant if you are going to school stoned. (…) It is becoming increasingly clear that cannabis is a drug on which regular users become dependent, and that this adversely affects large numbers of people. [9]

Marijuana has been shown to be associated with reckless drivers and motor vehicle accidents. Evidence suggests that marijuana may contribute to an appreciable number of traffic deaths and injuries in Canada. It has been shown to negatively affect the academic and social development of some adolescents. Marijuana can cause emotional and medical problems. Chronic use may be associated with lung diseases such as bronchitis, emphysema and cancer. A psychosis may develop in some individuals while other psychiatric symptoms such as anxiety, low mood, depression and panic do occur. Marijuana is known to be addictive. Although the rate of addiction varies, it is between 5 per cent and 10 per cent. I should like to stress that addiction is a disease and marijuana has the potential to be addictive to a genetically predisposed group of individuals. [10]

The evidence was that 95 per cent of the marijuana users in Canada are low, occasional, moderate users. Their consumption of marijuana does not impact on their health as long as they are healthy adults. The other 5 per cent are chronic users, people who smoke one or more marijuana cigarettes per day. If they continue to do that, they will ultimately get chronic bronchitis from the smoking process. The same would be true if they were to roll up the grass off their lawns and smoke that. They would inhale heated material over their large airways and cause damage to them. There were three primary vulnerable groups: pregnant women, which we submit is something between the woman and her doctor; the mentally ill, particularly paranoid schizophrenics (…) then, most importantly, immature youth. Young people who become involved with marijuana - particularly on a regular basis - seem to suffer from a disruption of their studies and the maturation process. As is the case with most intoxicants, it is recommended that they not become involved with them until they have matured. [11]

I have one resource from the Center for Substance Abuse Prevention in the U.S., where recent marijuana research and a number of studies indicate some of the risks. We already know and accept that cannabis has negative effects on many systems - respiratory, motor skills, memory and immune - and that it creates drug dependency and tension. In addition, we now know from numerous research studies that there is a definite and acute withdrawal syndrome associated with chronic cannabis use. (…) There is research that suggests there are effects on the developing fetus. (…) I will speak to visual scanning, specifically, attention dysfunction in the form of impaired visual scanning and related functioning. Visual scanning develops particularly in early adolescence, so earlier onset is associated with some concerns there. [12]

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[9] Dr. Mark Zoccolillo, Professor of Psychiatry and Assistant Professor of Pediatrics, McGill University and the Montreal Children's Hospital, Special Senate Committee on Illicit Drugs, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue No. 1, page 77.

[10] Dr. Bill Campbell, President, Canadian Society of Addiction Medicine, Special Senate Committee on Illicit Drugs, First Session, Thirty-Seventh Parliament, March 11, 2002, Issue No. 14, page: 56.

[11] Mr. John Conroy, Barrister, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, March 11, 2002, Issue No. 14, page 11.

[12] Dr Colin Mangham, Director, Prevention Source BC., Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, September 17, 2001, Issue No. 6, page: 71.

There are a number of negative health effects that have been created in the lab or have been observed with long-term users (…). There are, of course, health risks and negative health consequences with using the substance, but the majority of those risks only occur under specific circumstances. The majority of the risks are associated with long-term persistent and frequent use, and therefore must be understood as such. There is at this point agreement that the so-called dependence or withdrawal symptom may arise with heavy chronic users, but it is very much limited to that small population. (…) a seminal report by Hall and colleagues from Australia (…) concluded that the major risks of cannabis use can be significantly reduced by avoiding driving under the influence, by avoiding chronic and daily use, and by avoiding deep inhalation. These were the key factors that allowed us to avoid many of the major harms and risks associated with it. [13]

In any event, we are talking about plant derivatives that contain a number of psychoactive alkaloids. The psychoactive effects are predominantly of mild euphoria and time distortion, though disorientation and panic attacks may occur. The appreciation of music, art and food are said to be enhanced, as is appetite, and this later function seems important for one of the claimed medical benefits in offsetting the effects of the chronic wasting syndrome in AIDS and the prolonged nausea that accompanies chemotherapy. (…) Because the drug is usually smoked, it has acute and chronic effects that are shared with tobacco. These include airway irritation, cough, and probably with chronic use, bronchitis, chronic obstructive pulmonary disease, and lung and pharyngeal cancers. Its impact on the immune system is generally to impair the function of the immune system, but the impact on human health of this impairment is probably minor. (…) The effects of cannabis consumption on reproductive health are negative in animal studies. (…) This obviously has some relevance to human health. However, human studies have yet to show any measurable adverse impact beyond some evidence of adverse behavioural and developmental impacts on the children of mothers who smoked cannabis heavily during pregnancy. (…) The impact of cannabis on cognition is well documented. Short-term memory is adversely affected and chronic use may lead to chronic measurable defects in cognitive functioning. However, this may be more the result of persistent chronic intoxication than impairment in the substance and the working of the brain. Psychomotor skills are adversely affected by cannabis use. Driving or operating heavy machinery when intoxicated is contraindicated. Again, in contradistinction to alcohol, cannabis intoxication tends to slow drivers down rather than increase their speeds. Similarly, cannabis smokers tend not to be involved in acts of physical violence and aggression, and violence and aggression when intoxicated is reportedly very rare. Cannabis use may provoke schizophrenic symptoms in those with active schizophrenia or schizophrenic tendencies. Panic attacks and dysphoria are also mentioned in the literature. There is an amotivational syndrome described in the literature and cannabis is said to induce it, but most researchers have discredited that over the last decade. (…) Concerns have legitimately been raised about the effects of cannabis consumption on adolescent development. As use tends to peak in late adolescence, this is an important consideration. The adverse effects that have been noted include an association with risk of discontinuation of high school, job instability and progression to the use of harder drugs. The degree to which these associations are causal is very controversial. Alternative hypotheses are that cannabis use, like adolescent alcohol use, early onset of sexual activity, and tobacco smoking, are in fact markers for other risks of adverse social conditions (…) All researchers agree, however, that intoxication interferes with academic prowess. Recent studies seem to demonstrate measurable though reversible drops in IQ associated with

[13] Dr. Benedikt Fischer, Professor, Department of Public Health Sciences, University of Toronto, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, September 7, 2001, Issue No. 6, page 9.

heavy, persistent cannabis use and that engagement in illicit activities carries substantial risks, especially perhaps for youth whose connections to the school community are tenuous at best. [14]

I would like to first focus on the acute effects and then on the chronic effects. "Acute effects" are those effects that you experience during the course of action of a single dose. In the nervous system that includes a period of several hours in which (…) you become "chemically stupid." Side effects include decreased arousal and drowsiness, which acts together with the drowsiness produced by alcohol and other central nervous system depressants. Other side effects are impaired short-term memory, slowed reactions, less accuracy in test performance and less selectivity of attention. (…) Low doses generally produce the effects that cause people to like smoking pot. They include mild euphoria, relaxation, increased sociability and a non-specific decrease in anxiety. However, high doses produce a bad mood, anxiety and depression. There can be increased anxiety to the point of panic or even an acute toxic psychosis which, fortunately, is of very short duration and goes away when the drug effect wears off. High doses cause impaired motor coordination, unsteadiness of control and decreased muscle tone, which is therapeutically useful. (…) With low doses, perception is enhanced. That is part of the pleasure. In high doses, the same action produces sensory distortion, hallucinations and the acute toxic psychosis to which I have already referred. (…) It does not seriously affect the cardiovascular system. (…) As to chronic effects, in the central nervous system there is impaired memory, vagueness of thought, decreased verbal fluency, and learning deficits in chronic, heavy users. I emphasize "heavy" because the social user does not, by and large, show any significant health effects. Neither does the social user of alcohol. (…) These effects on cognitive functions fortunately tend to go away if the heavy user stops, for whatever reason. As long as use continues, there is a chronic intoxication, apathy, confusion, muddled thinking, depression, and sometimes paranoia. (…) Cannabis dependence, as defined in the conventional diagnostic criteria for dependence as set out in the latest edition of the American Psychiatric Association, or the equivalent publication of the World Health Organization, has been well documented in regular, heavy users. Numerous studies now show that a significant percentage of regular users are dependent. In some studies in Australia of long-term heavy users, mainly daily users for periods of 15, 17, 20 years, 60 per cent or more of them met the diagnostic criteria (…). Tolerance has been shown. By and large, it is not a terribly serious effect, and the physical withdrawal syndrome is not severe. Nevertheless, it is there, which indicates that physical dependence, in addition to psychological dependence, occurs as well. [15]

The long-term chronic effects of cannabis essentially cause the following symptoms: memory loss, faulty attention and concentration, a slow-motivation syndrome of passivity and low initiative, increased risk of respiratory disease, more specifically asthma, bronchitis and emphysema and a higher risk of cancer. (…) There may be hormone problems causing low fertility in men and women. In men, this can cause the development of breasts which is very unesthetic (…). Finally, in the long-term, it can also cause lower resistance to infectious disease. [16]

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[14] Dr. Perry Kendall, Health Officer for the Province of British Columbia, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, September 17, 2001, Issue No. 6, pages 33-33.

[15] Dr. Harold Kalant, Professor Emeritus at the University of Toronto, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, June 11, 2001, Issue No. 4, pages 74-76.

[16] Dr. Mohamed ben Amar, Professor of Pharmacology and Toxicology, University of Montreal, Special Senate Committee on Illicit Drugs, First Session of the Thirty-Seventh Parliament, June 11, 2001, Issue No. 4, pages 9-10.

As we can see, opinions sometimes agree and often differ. They agree at least on the nature of the consequences that may be of concern. One by one, we have seen effects that were physiological (risks of cancer, effects on reproduction and the immune system, deterioration of brain cells), effects that were psychological (amotivational syndrome, risks of psychosis, impaired cognitive function and memory in particular), and effects that were social (affecting the family and work, as well as the ability to drive vehicles and operate machinery). Opinions differ primarily on the scope of the conclusions that can be drawn from this knowledge. To what extent, in fact, can we generalize about the effects we observe in often small and rarely random samples of subjects? Also, to what extent can we generalize about the data on chronic users who represent – as we saw in the previous chapter – only a small percentage of cannabis users? And especially, to what extent does this data allow us to establish causal relationships?

The Committee also finds that most witnesses stressed the negative aspects and rarely the positive. However, if people use drugs in general, and cannabis in particular, surely it isn't just to destroy themselves or because these drugs have only negative effects. Given the limitations of making any comparison between substances, we can still draw a parallel with alcohol: most of us know the pleasure of sharing a glass of wine with friends over a good meal, just as we also know the dangers of alcohol abuse and alcoholism. The Committee also notes that it is difficult, even for the most experienced researchers, to sift through the knowledge without assigning it a valence relative to the direction public policy should take. The same knowledge may be interpreted negatively here and more moderately there, based on the interpreter's preconceptions of the "best" choice for public policy. We are not immune to this bias. Moreover, we do not deny that we had preconceptions, derived from our personal histories, our reading, and the hearings we held in 1996 to review Canada's drug legislation. Among these preconceptions, which oriented our reading of the testimony, at least at first, we note:

- The conviction that the current system does not achieve its objectives, if only because of the increase in cannabis use, by young people in particular;
- A preference for an approach that is more consensual and more in keeping with Canadian attitudes;
- A preference for a harm-reduction approach as indicated by the wording of our first mandate;
- A tendency to distinguish between soft drugs – including cannabis – and hard drugs (heroin, cocaine);
- A certain lack of knowledge about the specific effects of cannabis, from the standpoint of the toxicological and pharmacological studies conducted in recent years.

This being said, we did not work in isolation. Not only were we accompanied by our research team – sociologists, lawyers, criminologists – throughout our work, not only were we also under the close surveillance of the witnesses in a way and of the public in a larger sense, but primarily, other committees, in other countries, have conducted similar reviews in recent years. Their work was a source of inspiration and knowledge and as well a benchmark against which to compare our own conclusions.

ACUTE EFFECTS OF CANNABIS

In toxicology, acute effects are those that are produced immediately after use and while the psychoactive effects are being experienced. These effects also correspond to what has been called cannabis intoxication ever since Moreau de Tours in 1845.[17] The "real" effects – on biological systems – and the effects experienced by users can vary based on a set of factors, such as the user's experience with cannabis and other drugs (including tobacco), the user's expectations and the context of use. In fact, [translation] *"the psychoactive effects of cannabis, more than any other substance, vary from one subject to another and, for the same subject, from one experience to another."*[18] Additionally, with no reliable method to measure THC content in plasma, it is difficult to link the duration and strength of effects to the various cannabis preparations, in particular because of variations in the composition of the substance and in the bioavailability of THC. It is even more difficult to attribute relatively rare effects (for example, the appearance of psychotic symptoms) insofar as it is hard to decide if the co-occurrence is coincidental, if these effects stem from other substances often associated with cannabis use or from very high doses of cannabis, or from interactions between these various factors.[19]

The acute effects of cannabis are relatively well documented. Research sometimes distinguishes between central and peripheral effects[20], sometimes between somatic effects and psychological or psychomotor effects[21], and sometimes is simply content to list the effects of one type or another.[22]

Cannabis intoxication is generally considered to consist of two main phases:

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[17] Moreau de Tours, J., *Du haschich ou de l'aliénation mentale, étude psychologique*. Paris: Masson.
[18] INSERM, *op. cit*., page 118.
[19] See WHO, 1997, *op. cit*., 3.
[20] For example, this is the case with the classification proposed by Ben Amar (at press).
[21] This is the case with the collective expertise of INSERM (2001).
[22] This is the case with most works: WHO, 1997; Swiss Federal Commission for Drug Issues (1999) *Rapport sur le cannabis*. Berne: Swiss Federal Office of Public Health; and the report by Wheelock (2002).

- The first phase, the "high", includes the following effects:
  - A change in general mood, accompanied by gaiety or even hilarity, talkativeness, and a carefree feeling
  - A change in physical experience, including a feeling of well-being and satisfaction, a feeling of calm and relaxation, sociability
  - Alteration of intellectual functions, including increased self-confidence, magical thinking (feeling of being able to perform tasks more easily), distorted perception of time, space and self-image
  - Sensory changes, marked by increased sensory perceptions (colours, sounds sometimes seem more intense), stronger tactile impressions.

- The second phase, "coming down", is characterized by a feeling of sluggishness or drowsiness that appears gradually a little while after use.

More specifically, depending on their type of action, a distinction is made between truly somatic effects and more psychological ones.

- Somatic Effects:
  - Cardiovascular effects: approximately 10 minutes after use, heart rate, cardiac output and cerebral blood flow increase. Tachycardia (accelerated heart rate) can achieve increases of 20% to 50% compared to normal rhythm and could help trigger anxiety and panic attacks in some subjects. It can be responsible for palpitations, reduced exercise tolerance in subjects with heart conditions, and can even facilitate the development of heart problems in subjects who are at risk or are predisposed. A recent study suggests that the risk of myocardial infarction increases by 4.8 times in the first hour after using marijuana and is 1.7 times higher in the second hour, thus suggesting that cannabis may represent a risk in the 60 minutes following its use. Hypotension while the subject is lying down is also mentioned. These effects vary based on the dose and concentration of THC.
  - Bronchopulmonary effects: the effects are similar to those of tobacco. Bronchodilator activity in the 60 minutes following use is mentioned. However this does not prevent the inflammatory consequences of smoking cannabis nor the secondary bronchial hyperreactivity that is translated in particular by a cough that results from the action of the THC and the irritating potential of the products of combustion;
  - Ocular effects: redness of the eyes due to vasodilation and conjunctival irritation is mentioned;

- Other somatic effects: dry mouth due to decreased saliva secretion, increased appetite due to hypoglycemia (drop in blood sugar level), and more rarely nausea and vomiting, diarrhea and urine retention.

❖ Psychological and Psychomotor Effects:

- Diminished short term memory (so-called "working" memory): remembering words, pictures, stories and sounds;
- Disturbances in psychomotor performance, including diminished ability to pay attention and concentrate, diminished reflexes, slowed reaction time, problems with coordination of movements, and impaired and diminished ability to perform complex tasks. Thus, a study by Fant et al. describes diminished visual tracking in the central and peripheral fields of vision after 15 minutes, capable of lasting for more than 5 hours.[23] Moreover, we note that according to professor Roques, studies on the effects of cannabis on learning abilities, in particular short term memory and working memory, are open to criticism from the standpoint of methodology and their contradictory results, "*the heaviest users were the least affected*".[24] [translation]

Somatic, cognitive and psychomotor effects are related to the amount of cannabis inhaled and the concentration of THC. Thus, according to INSERM:

> *A quantity that corresponds to 25 puffs impairs psychomotor skills and cognitive performance, and more markedly than consumption of 10 puffs or 4 puffs. Maximum plasma levels then rise from 57 ng/ml (for 4 puffs from a cigarette containing 1.75% D^9THC) to 268 ng/ml (for 25 puffs from a cigarette containing 3.55% D^9THC). Heishman et al. (1997) established an approximate equivalence between 16 puffs at 3.55 % D^9THC and approximately 70g of alcohol. At these levels, memory, cognitive and psychomotor performance and mood are impaired.* [25] [translation]

The cognitive and psychomotor effects may continue for more than five hours, and some cognitive impairment may extend for 24 hours.

At high doses, or with inexperienced users, cannabis may cause a certain number of negative reactions that can even include a genuine paranoid, hallucinatory, manic or hypomanic psychotic experience. However these experiences are brief. Some disorders documented with high doses include:

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[23] Fant, R.V. et al. (1998) "Acute and residual effects of marijuana in humans." *Pharmacology, Biochemistry and Behavior*, 60: 777-784.

[24] Roques, B. (1999) *La dangerosité des drogues.* Paris: Odile Jacob, page: 184.

[25] INSERM, *op. cit*., page: 203.

- Anxiety, even panic attacks
- Confusion or disorientation
- Vertigo, nausea or vomiting
- Convulsions
- Depersonalization
- Hallucinations
- Paranoia
- Acute psychosis

These phenomena are relatively rare (less than 1 in a thousand psychiatric admissions). Primarily, it is difficult to establish that cannabis was the cause. In fact, in most cases, the most likely hypothesis is that these subjects were already predisposed, or had even already had psychotic or schizophrenic experiences. Use of other substances, alcohol, other illicit drugs, or medications, could also play an important role.

> *The link between cannabis use and psychosis is a very controversial issue. At the moment, we lack a corpus of comparable, methodologically sound studies repeatedly yielding similar conclusions. The results of existing studies are often complex or ambiguous and the personal opinions of the researchers often interfere with the interpretations. Further deepening our scientific knowledge is still necessary. However, there is extensive, albeit incomplete, consensus on the ability of heavy cannabis consumption or intoxication to induce an acute transitory psychotic state in healthy subjects. The frequency of this condition is unknown and the mechanisms are hypothetical.* [26]

In accordance with the collective expertise of INSERM, we can establish the following:

> *The psychotic disorders caused by cannabis use are brief psychotic episodes that last less than two months, even four months[sic], sometimes a week. The premorbid personality does not present a pathological aspect. Regular users are at greater risk than occasional users. Onset is abrupt, in two or three days, with or without a recent increase in the use of toxic agents, sometimes with a psychological or somatic precipitating factor. Some symptoms appear more specific: behavioural problems, aggression, visual hallucinations, polymorphic nature of the delirium along various themes, psychomotor disinhibition. (…) Compared to a schizophrenic disorder, subjects are younger, 20 to 30 years of age rather than 25 to 30, with a greater proportion of poorly socialized males.* [27] [translation]

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[26] Hanak, C. et al. (2002) "Cannabis, mental health and dependence." in Pelc, I. (ed.), *International Scientific Conference on Cannabis*, Brussels.

[27] INSERM, *op. cit*., page 124.

However, here too, the data are relatively contradictory and, according to professor Roques, there is support for the belief that usage is more widespread among people with previous mental disorders.[28]

CONSEQUENCES OF CHRONIC USE

Most of the works consulted in pharmacology, toxicology and psychiatry speak of chronic effects. For our part, we prefer to speak of *consequences* resulting from chronic use. There are two reasons for this. First of all, because these consequences result not so much from the substance itself as from the way it is used. Therefore we are not dealing with the effects of the substance, but rather with the consequences that may arise from repeated, or even heavy, use. The second reason is that, as we saw in Chapter 6, chronic cannabis users account for a small fraction (often less than 10%) of lifetime users of cannabis. As a result, the consequences in question in this section concern this small portion of the population of users and not the substance itself.

We feel this distinction is fundamental because it is common, at all levels of public discussion – whether involving politicians, the public at large, or experts – to blame the substance – here cannabis, there alcohol or medications, even other illicit drugs–when in fact we must *learn to distinguish between patterns and methods of use*. By that we mean at-risk behaviour, which varies with the substance of course, and which does not depend solely on the intrinsic properties of the substance, but stems, in an overall approach, from the relationship between the substance and its place in society (integrated or not) from the individual's characteristics, and from the society in which the substance is used.[29] Of course by that it should be clear that ***we consider as separate, for cannabis as for alcohol, use, at-risk use and heavy use*** (or abuse)[30], and that we reject the equivalency often made between use and abuse where any form of use is perceived as abuse. At the same time, we are aware of the vagueness that continues to surround these various types of behaviour – or practices – and that there is no clearly defined boundary, even less a universal boundary, between use, harmful use and dependence. For the purposes of this chapter, the consequences in question in the following three sections refer, without being more specific, to chronic use (which then includes at-risk and heavy use).

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[28] Roques, B., *op. cit*., page 186.

[29] This question has been discussed more fully in Chapter 6. For now it is enough to refer the reader to the work of Reynaud et al. (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psycho-actives.* Paris: La Documentation française.

[30] We will more clearly establish the parameters we used to make this distinction in the next chapter on use and users. Further on in this chapter we will see that dependence is a consequence of heavy use.

Physiological consequences of chronic use

The main physiological consequences of the chronic use of cannabis dealt with in scientific literature concern the respiratory system and the carcinogenicity of cannabis, the immune system, the endocrine system and reproductive functions and, to a lesser degree, the cardiovascular system.

Consequences for the respiratory system

Except for the nicotine in tobacco and the cannabinoids in cannabis, the smoke of these two products shares common irritating, even carcinogenic, properties. Although not recent, a comparative analysis of these products has shown that the concentration of certain strongly carcinogenic ingredients such as benzopyrene and benzanthracene is higher in cannabis smoke than tobacco smoke.[31] A more recent study cited by INSERM confirms this higher concentration of benzopyrene: 2.9 micrograms/100 joints compared to 1.7 for 100 cigarettes.[32] Of course, it will be argued that tobacco users generally smoke many more cigarettes a day than even chronic users of marijuana, that it is the total volume of toxic substances inhaled over time that counts, and that it can be difficult to distinguish the effects of cannabis from those of tobacco since joints often contain both products and users of cannabis are also often tobacco smokers.[33]

However we note other worrisome characteristics with respect to the potential effects on the respiratory tract of smoking cannabis. First of all, the concentration of benzopyrene in marijuana tar is 70% higher than that in the same weight of tobacco tar. Furthermore, an equal product weight of cannabis provides up to 4 times more tar than a strong tobacco. According to a study cited by INSERM, tar from a joint varies between 40 and 56 mg/cigarette whereas the allowable dose for a European tobacco cigarette is 12 mg.[34] In addition, a marijuana cigarette is generally smoked much more completely than a tobacco cigarette, inhalation – an important part of the ritual – is deeper and the smoke is held in the lungs longer and the combustion temperature of cannabis is higher than that of tobacco. Consequently, the percentage of tar deposited in the lungs is higher after smoking cannabis (> 80%) than after inhaling tobacco (64%) and the deposits are even greater for cannabis with a lower concentration of THC, probably because smokers draw on the joint more.[35]

According to INSERM's report, chronic use of cannabis *"results in unquestionable bronchial disorders (…) chronic bronchitis with a chronic cough, expectorations and a sibilant rale"*[36] [translation], a conclusion shared by the Institute of Medicine in the United States in its

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[31] Institute of Medicine (1982) *Marihuana and Health.* Washington, DC: National Academy of Sciences.
[32] INSERM (2001), op. cit., page 222.
[33] For example, those are the criticisms made by Zimmer L., and J.P. Morgan (2000 for the French version; 1997 for the American original) *Marijuana. Mythes et réalités.* Paris: Georg editor.
[34] *Ibid.*, page 221.
[35] *Ibid.*, page 221
[36] *Ibid.*, page 218.

recent report on marijuana[37] as well as by the WHO.[38] Moreover, macrophages (cells that attack foreign bodies) in the pulmonary alveoli seem to lose their ability to neutralize bacteria when exposed to cannabis smoke, hence the greater susceptibility of the bronchi and lungs to bacterial infections. According to some authors, in theory, a cannabis cigarette could cause as much damage as 4 to 10 tobacco cigarettes.[39] This data on the reduced ability of alveolar macrophages to destroy bacteria also suggests that cannabis could have an immunosuppressive action that decreases the ability of the organism, here the lungs, to fight carcinogenic cells.

The work of Tashkin in particular, but also of other researchers, is not as confirmatory on the effects of cannabis on the respiratory tract. Thus a recent study by Tashkin on heavy cannabis smokers showed that there was no decrease in the forced expiratory volume in one second to vital capacity ratio, even for those who smoked 3 joints a day, compared to tobacco smokers who registered a significant decrease.[40] Tashkin's team also questioned the development of emphysema in cannabis users and bronchiole obstruction.[41] Similarly, a study by the *Kaiser Permanent Medical Care Program* revealed that daily cannabis users who did not use tobacco were hardly more likely than non-smokers (36% vs. 33%) to consult for colds, the flu and bronchitis.[42] We also note that to date, studies are contradictory about the additivity of the effects of tobacco and cannabis.

Carcinogenic potential

With respect to the carcinogenic potential of cannabis, there is a distinction between the carcinogenic effects of cannabis smoke – a potential source of lung cancer in particular – and the mutagenic effects of THC on cells. According to the majority of authors, THC itself does not seem to be carcinogenic.[43] However, cannabis smoke, like tobacco smoke, does seem to be able to increase the incidence of cancerous tumors.

The work of Fliegel[44] indicates that the histological changes that are considered the precursors of carcinomata are present in chronic smokers of cannabis. This data is

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[37] Joy, J.E. et al., (1999) *Marijuana and Medicine: Assessing the Science Base.* Washington, DC: Institute of Medicine.

[38] WHO (1997) *op. cit.*

[39] Ben Amar (at press), *op. cit*., page 18.

[40] Tashkin, D.P. et al., (1997) "Heavy habitual marijuana smoking does not cause an accelerated decline in FEV1 with age: a longitudinal study." *American Journal of Respiratory Critical Care*, 155: 141-148.

[41] See Zimmer and Morgan, op. cit., page 148.

[42] Polen, M.R. (1993) "Health care use by frequent marijuana smokers who do not smoke tobacco." *Western Journal of Medicine*, 158: 596-601.

[43] In particular, see the conclusions of INSERM (2001), op. cit.; as well as the report by Wheelock (2002) *op. cit.* for the Senate Committee.

[44] Fliegel S.E.G. et al., (1988) "Pulmonary pathology in marijuana smokers", in Chesher G. et al. (eds.), *Marijuana: An International Research Report*, National Campaign Against Drug Abuse, Monograph 7, 43-48, Canberra, Australian Government Publishing Service; and Fliegel, SEG et al., (1997) "Tracheo-bronchial histopathology in habitual smokers of cocaine, marijuana or tobacco" *Chest*, 112: 319-326.

also supported by clinical cases of cancers of the upper aerodigestive tract in young adult cannabis smokers. These cancers are types rarely observed in young subjects. Namely:

- Thirteen cases of brain and neck cancer in young adults under the age of forty, eleven of whom were daily cannabis smokers;[45]
- Ten cases of cancers of the upper respiratory tract in young adults under the age of forty, seven of whom were probable regular users of cannabis;[46] and
- Two cases of carcinoma of the tongue in men between 37 and 52 years of age for whom the only common risk factor was the regular and daily use of cannabis.[47]

We note first of all the small number of cases, especially when compared to the large number of cannabis users. These clinical cases also present a certain number of important limitations: none compares the prevalence of cancer with a control group or evaluates the use of cannabis in a standardized way. Interpretation is also limited by the fact that the patients also smoked tobacco and drank alcohol.

The data available seems to indicate that the consequences of chronic and intense cannabis use (several joints per day for several years) are similar to those of cigarettes in terms of carcinogenic risks for the respiratory tract as well as the mouth, the tongue and the esophagus.[48] THC is generally considered to alter the functions of certain cells, namely lymphocytes, macrophages and polymorphonuclear cells, especially in *in vitro* models. However conducting controlled studies is largely recognized as a research priority in this field.[49]

Consequences for the immune system

Apart from the possible consequences for the respiratory tract defense system essentially caused by smoke, there is no conclusive data regarding the effects of cannabis on the immune system. Some studies on rodents show that high levels of cannabinoids, including THC, alter cellular immunity. In some cases, the experimental activity of cannabinoids is immunosuppressive and in others it is stimulating. These

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45 Donald P.J. (1991) "Marijuana and upper aerodigestive tract malignancy in young patients", in Nahas, G. and C. Latour (eds.), *Physiopathology of Illicit Drugs: Cannabis, Cocaine, Opiates*, 39-54, Oxford; and (1991) "Advanced malignancy in the young marijuana smoker", in Friedman, H. et al., (eds.), *Drugs of Abuse, Immunity and Immunodeficiency*, 33-36, London.

46 Taylor, F.M. (1988) "Marijuana as a potential respiratory tract carcinogen: A retrospective analysis of a community hospital population", *Southern Medical Journal* 81: 1213-1216.

47 Caplan, G.A. and B.A. Brigham (1990) "Marijuana smoking and carcinoma of the tongue: Is there an association?" *Cancer* 66: 1005-1006.

48 MacPhee, D., (1999) "Effects of marijuana on cell nuclei", in Kalant, H. et al. (eds.), *The Health Effects of Cannabis*, Toronto: Addiction Research Foundation.

49 In particular WHO (1997), op. cit.; Hall, W. and N. Solowij (1998) "Adverse effects of cannabis" *The Lancet*, 352, no. 9140, page 6; INSERM (2001), *op. cit*.

variations depend on experimental factors such as the concentration of the substance, the time and duration of administration, and the type of cell function studied. Very little work has been done on humans. According to the WHO report, if it is clear that cannabinoids have immunomodulating effects, it is also clear that the immune system is resistant to this substance. Several of the effects are relatively minimal and completely reversible, and are only experienced at higher doses than those required for the drug's psychoactive effect in humans. Lastly, still according to the WHO report, even with respect to the immunomodulating effects of cannabis smoke, the studies are not conclusive and it is hard to compare the doses used in experiments with animals to the doses used by humans. The report concludes that rigorous studies on this question are necessary.[50]

Consequences for the endocrine system and reproduction

Endocrine abnormalities are well documented in animals. In the male rat, decreased testosterone secretion with testicular atrophy, impaired production, mobility and viability of sperm, and changes in sexual behaviour have been noted with high doses. The ovulatory cycle of the female is altered. In humans, the results are contradictory, in particular because findings are not constant from one study to another, but also because similar changes occur following the absorption of prescription drugs. Furthermore, the changes observed are often borderline normal and their clinical consequences remain controversial.[51]

With respect to reproduction, the fact that the active ingredients in cannabis cross the placental barrier is well established. Nevertheless, the question of the potential effects of cannabis on the feotus is far from resolved, especially since the studies are methodologically poor. Thus, when studying pregnant women who are cannabis users, the women often come from low socio-economic backgrounds – and we know that socio-economic level is a determining factor in the size and weight of babies – and it is difficult to isolate the effect of other factors, including the use of tobacco and alcohol – which we know are risk factors for premature birth, lower weight and smaller size. In fact, studies on occasional cannabis smokers do not show any significant difference with respect to non-smokers. All in all, most studies did not observe any significant differences.[52] Nevertheless, reports from the WHO and the collective expertise of INSERM conclude that, despite methodological difficulties, there is reasonable evidence that cannabis use during pregnancy harms fetal development, in particular restricted growth and behavioural abnormalities, but that these abnormalities are rather minor.[53]

As for the neonatal consequences of cannabis use by mothers during pregnancy, longitudinal studies on cohorts of children conducted in Ottawa since 1978 by

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[50] WHO (1997), *op. cit*., page 26.
[51] INSERM (2001), *op. cit*., page 219-220.
[52] Wheelock, B. (2002), *op. cit.*, page 29.
[53] WHO (1997), *op. cit*., page: 24; INSERM, *op. cit.*, page 237.

psychologist Peter Fried's team[54] are not conclusive. All the measurements taken reveal more similarities than differences between the children of smokers and non-smokers. And when differences are observed, they are minor and it is impossible to dissociate the effects of the various substances, tobacco and alcohol in particular. Lastly, these studies involve a small sample of children and generalizations cannot be drawn from them. Another longitudinal study, reported by INSERM, involving 636 subjects, concluded [translation] "*there is a significant relationship between behavioural problems at age 10 and prenatal exposure to cannabis.*" However the report from INSERM also notes that [translation] "*if the results from these two studies seem to converge well (…) we must remember nevertheless that the postnatal environment can play an important role in the continuation of behavioural abnormalities.*"[55]

Consequences for the cardiovascular system

Chronic use of cannabis may lead to cardiovascular complications for predisposed individuals. In fact, the use of significant quantities can slow the heart rate. Also, cannabis can have similar effects to those of tobacco on heart function by increasing the muscle workload. Furthermore, some studies point out the role that the carbon monoxide found in cannabis smoke plays in the risk of cardiovascular complications.

Cognitive and psychological consequences

The main cognitive and psychological consequences of chronic cannabis use concern brain functions involved in memory and verbal and math skills; motivation; and psychiatric disorders.

Brain functions

We have seen that cannabis has acute effects on short-term memory, attention and concentration. Does chronic use eventually result in effects on cognitive function that may be irreversible? These questions first raise the question of the neurotoxicity of cannabis, defined as "*a reversible or irreversible impairment of the structure and/or functions of the central (and/or peripheral) nervous system by physical, chemical or biological agents*"[56] [translation]

According to professor Roques:

> [translation] *Cannabis dependence does not result in neurotoxicity (…). Thus old results suggesting anatomical changes in the brain of chronic cannabis users, as measured by tomography, have not been confirmed by precise modern techniques of neuro-imaging. Similarly, morphological changes in the hippocampus of the rat following administration of very high doses of THC (Landfield et al., 1988) have not been repeated (Slikker et al., 1992). (…) Several studies have been devoted to the effects of*

[54] Fried, P.A. (1995) "Prenatal exposure to marijuana and tobacco during infancy, early and middle childhood: Effects and attempts at a synthesis." *Archives of Toxicology*, 17; and Fried P.A. and B. Watkinson (1999) "36- and 48-month neurobehavioral follow-up of children prenatally exposed to marijuana, cigarettes and alcohol." *Journal of Deviant Behavior and Pediatrics.* 11: 49-58.

[55] INSERM (2001) *op. cit*., page 235.

[56] Roques, B., (1999) *op. cit*., page 73.

cannabis on evoked responses and on electroencephalograms of humans. Intermittent use produces reversible changes in a wave patterns in the frontal cortex, probably with respect to the state of drowsiness induced by THC. In the very long term (more than fifteen years) and with heavy daily use, d hyperfrontality and an increase in q frontal activity have been observed (Struve et al., 1990, 1994). The possible connection with behavioural changes and changes in neuropsychological tests is not in question, nor moreover is that which is possible with the anticonvulsive effects of THC. [57]

The results of studies reported by the collective expertise of INSERM are contradictory as some observe changes while others do not. Even when changes are observed, they are often of minor amplitude and are reversible after a period of abstinence. The INSERM report observes that studies using neuro-imaging techniques have not confirmed the neurotoxicity of cannabis in either man or baboon.[58] Therefore it is through observing functioning and behaviour that we are still best able to examine the question of the neurological effects of cannabis.

Unfortunately, studies are just as contradictory here and the results are inconclusive. Studies performed in the 1970s in countries where cannabis use is traditional (Jamaica, Costa Rica, India) did not point out any significant differences in cognitive functions of users and non-users, whereas more recent studies, in particular in Costa Rica in the 1980s, did show differences: [translation] *"In particular, long-term users recalled fewer words on a list they had been shown earlier and response time was longer."*[59] In the United States, studies conducted in the 1970s found contradictory results for memory functions, whereas more recent studies reported subtle deficits in cognitive functions of heavy users after a brief period of abstinence. Some studies also showed continued memory impairment in adolescents after six weeks of abstinence.[60]

Most studies tend to show that overall, ex-users recover all cognitive functions, but depending on the length of use, subtle impairments can persist, in particular with regard to the ability to process complex information.

Still according to the collective expertise of INSERM, the age when use begins can be a determining factor. Thus, a recent study shows the persistence of some visual scanning impairments (related to attention) in young people who began to use cannabis before age 16, whereas those who began use after age 16 show no difference from non-users.[61]

In all, we cannot really establish that cannabis use has negative consequences for brain functions, even in chronic users, unless use begins before age 16.

Motivation

Some studies suggest the presence of an amotivational syndrome in chronic cannabis users, a syndrome that could affect the performance of young people at

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[57] Roques, B., (1999) *op. cit*., page 187.
[58] INSERM, *op. cit*., page 206.
[59] *Ibid.*, page 204.
[60] *Ibid.*, page 205.
[61] *Ibid.*, page 206.

school and employees in a professional environment in particular. In its 1997 report, the WHO pointed out that our knowledge has not advanced since its previous report in 1981: the amotivational syndrome has still not been clearly defined, its effects have still not been clearly distinguished from the effects of intoxication itself, and the data available comes from clinical case reports with no control group.[62]

In order to evaluate the impact of cannabis on motivation, Canadian researchers developed a study where subjects received cannabis in exchange for work performed. Even though it is not recent, the study is no less interesting. They observed that subjects worked less efficiently immediately after using cannabis. However, their level of productivity then increased rapidly and exceeded levels achieved during periods of abstinence. Although working fewer hours, the subjects using cannabis were not less productive because they worked harder. Furthermore, over the course of the period of heaviest use, the subjects organized a strike and successfully negotiated a "salary" increase, after which they worked even harder.[63] [64]

Studies do not enable us to establish if motivational problems, when observed, preceded or followed cannabis use, or if other emotional or psychosocial factors played a greater role, or were even determining factors in the chronic use or abuse of cannabis in young people in particular. These conclusions are shared by the collective expertise of INSERM and by the authors of the report submitted to the International Scientific Conference on Cannabis in March 2002.[65]

Psychiatric disorders

Various psychiatric disorders have been associated with chronic cannabis use: mood disorders and depressive episodes, anxiety disorders, personality disorders, as well as more severe conditions, such as psychoses and schizophrenia. For each of these situations, the conclusion drawn by the authors of the report on mental health and cannabis prepared for the International Scientific Conference on Cannabis generally applies:

> *There are three possible ways to account for the relationship between cannabis and mood disorders. First, both may share common risk factors, so that their relationship is not causal. Second, mood disorders may predispose people to use cannabis. Third, cannabis use may trigger or increase depressive symptoms. As yet, there is no clear answer to this question of "which comes first".* [66]

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[62] WHO (1997), *op. cit*., page 18.

[63] Miles G.C. et al., (1974) *An Experimental Study of the Effects of Daily Cannabis Smoking on Behavioural Patterns*, Toronto: Addiction Research Foundation, Toronto.

[64] Campbell, I. (1976) *The Amotivational Syndrome and Cannabis Use With Emphasis on the Canadian Scene*, Annals of the New York Academy of Sciences 282, 33-36.

[65] INSERM, *op. cit*.; Hanak, C. et al., (2002) "Cannabis, mental health and dependence", Pelc, I. (ed.), *International Scientific Conference on Cannabis*, *op. cit*., page 61.

[66] Hanak, C. et al. (2002), *op. cit*., page 62.

Specifically with regard to mood disorders, depressive states and anxiety disorders, it seems probable that they precede chronic use. However, study results are extremely disparate: for mood disorders in so-called dependent people, the prevalence varies (depending on study methods), from 10% to almost 50%; with respect to major depressive episodes in clinical populations, studies report percentages varying from 4% to almost 20%. INSERM's report presents a review that we feel is much more enlightening with regard to the situation for adolescents:

> [Translation] *Acquiring new knowledge has allowed for a better assessment of the burden of "early onset depression" in terms of individual suffering and public health. Its prevalence, around 5% in adolescence, makes it one of the most common pathologies for this period. The risk of suicide is high, and the functional deficits inherent in depressive syndromes are a source of school and family problems, and cause withdrawal from peers, for which the psychosocial consequences can be severe, especially if the disorder is prolonged. Additionally, depression is rarely an isolated disorder in a young subject: anxiety or behavioural disorders often precede or accompany depressive episodes and can survive them; moreover, the existence of a depressive disorder is a risk factor for addiction (alcohol or any other psychoactive substance) and eating disorders.* [67]

With respect to psychotic disorders and schizophrenia, the two subjects are controversial, the methodologies weak, the data contradictory and the interpretations are often based on simplistic models of causality. If, in certain circumstances, cannabis can trigger psychotic episodes, they are most often short and resolve rapidly. As for schizophrenia, if it is true that cannabis use is more prevalent in these subjects than in the general population, some feel that it is self-medicating behaviour while others feel that the chronic use of cannabis is a trigger for the schizophrenic process. We feel that the conclusion of professor Roques' report agrees best with current data:

> [Translation] *No mental pathology directly related to the overuse of cannabis has been reported, which distinguishes this substance from psychostimulants such as MDNA, cocaine or alcohol, heavy and repeated use of which can give rise to characteristic psychotic syndromes. Similarly, cannabis does not seem to precipitate the onset of pre-existing mental dysfunctions (schizophrenia, bipolar depression, etc.).* [68]

As it is, most scientific reports come to the same conclusion: more research is needed, with more rigorous protocols, allowing in particular for comparison with other populations and other substances.

Behavioural and social consequences

The main behavioural and social consequences examined in scientific literature deal with social and family adjustment, aggression, and the ability to perform complex tasks.

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[67] INSERM (2001), *op. cit*., page 98.
[68] Roques, B., (1999) *op. cit*., page 186.

Social and family adjustment

According to some studies, chronic cannabis use could have consequences for social and family adjustment. Thus chronic users would have more difficulty keeping a job, would be unemployed more often and would have more interpersonal adjustment problems.[69]

However, most of these studies suffer from methodological problems and interpretation difficulties. Most studies involve samples of people who, by and large, come from underprivileged socio-economic backgrounds. Above all, beyond the statistical association, it is difficult to determine to what extent other factors play a preponderant role, of which cannabis is itself a symptom and not a cause.

Aggression

Unlike other psychoactive substances, alcohol and cocaine in particular, cannabis does not lead to aggression. When examining withdrawal symptoms once dependence is established, some authors note greater irritability; but this is even less significant proportionally than that caused by tobacco.

Performing complex tasks

No study on chronic cannabis use has been able to establish that cannabis causes long-term effects on the ability to perform complex tasks. This data is in keeping with cannabis' lack of neurotoxicity.

TOLERANCE AND DEPENDENCE

When we think drugs we think drug addiction since, as F. Caballero states, a drug is [translation] "*any substance likely to lead to addiction*".[70] In France and Europe, monitoring groups created in recent years are called monitoring centres for drugs and drug addiction. In Quebec, the advisory body created by the government is called the *"Comité permanent de lutte à la toxicomanie"* [standing committee on the fight against drug addiction]. The expression "drug addiction" is found everywhere: in legislation, in information documents, and in everyday language. However, since 1963, the WHO has recommended that we abandon this expression because it is imprecise and refer instead to states of physical and psychic dependence, defined as follows:

> *Psychic dependence is a "condition in which a drug produces a feeling of satisfaction and a psychic drive that requires periodic or continuous administration of the drug to produce pleasure or to avoid discomfort. Physical dependence is an "adaptive state that manifests itself by intense physical disturbance when the administration of the drug is suspended or its action is opposed by a specific antagonist. These*

[69] INSERM, (2001) *op. cit*., pages 206-207.

[70] Caballero, F. and Y. Bisiou (2000) *Droit de la drogue.* Paris, Dalloz, 2nd edition, page 3.

disturbances, that is the abstinence or withdrawal symptoms, consist of physical and psychic symptoms and signs that are characteristic for each drug. [71][translation]

Furthermore, with the extension of the notion of drugs to other substances (pharmaceutical products, tobacco, alcohol), and with the extension of international control of substances to psychotropic drugs, in 1969 the WHO created a new definition for the term drug dependence that, though its application was initially limited to medication only, has come to be more widely accepted over time:

Drug dependence. A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug. [72]

But it is even more interesting for our purposes to quote even older definitions from the WHO dealing with habituation and addiction:

Drug habituation (habit) is a condition resulting from the repeated consumption of a drug. Its characteristics include:

1. *A desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders;*
2. *Little or no tendency to increase the dose;*
3. *Some degree of psychic dependence on the effect of the drug, but absence of physical dependence and hence of an abstinence syndrome;*
4. *Detrimental effects, if any, primarily on the individual.*

Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include:

1. *An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;*
2. *A tendency to increase the dose;*
3. *A psychic (psychological) and generally a physical dependence on the effects of the drug;*
4. *Detrimental effect on the individual and on society.* [73]

This definition is important because, more than the previous two, it allows us to better distinguish between drugs that create primarily a habit and those that create an addiction, that is, the overwhelming need to use them. Now, as we will see in this

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[71] WHO (1964) *Expert Committee on Addiction-Producing Drugs*, Technical Report Series, no. 273, quoted in Caballero and Bisiou, *op. cit*., page 5-6.

[72] WHO (1969) *Expert Committee on Drug Dependence*, Technical Report Series, no. 407, quoted in Caballero and Bisiou, (2000), *op. cit*., page 6.

[73] WHO (1952) *Expert Committee on Drugs Liable to Produce Addiction*, Technical Report Series, no 57, quoted in Caballero and Bisiou (2000), *op. cit*., page 4-5.

chapter, cannabis corresponds much more to the criteria of a substance likely to create some degree of habituation and not an addiction.

In addition to drug addiction, thinking about drugs means also thinking about illicit substances. Now, as a wide range of works and an increasing number of practices have established, for practical purposes, the actual distinction is made on the combined levels of the substance's toxicity (its dangers) and the uses (use, abuse, heavy use) that characterize it, not on the level of its legal and symbolic status.

Cannabis dependence

Let us first establish that animal studies on dependence and withdrawal are not very pertinent since most of them use doses that have nothing in common with the doses used by humans, even chronic users. Moreover, we note that studies on naïve animals (no experience with other drugs) have not been able to establish self-administering behaviour and that is the only technique that allows for the direct assessment of the reinforcing properties of a molecule. One of the probable explanations stems from the long plasma half-life of Δ^9THC, which we know is eliminated slowly by an organism (up to 25 days as we saw in the Chapter 5).[74] We also note that even after administration of very high doses of Δ^9THC, somatic signs of spontaneous withdrawal were not observed in rodents, pigeons, dogs or monkeys.[75] Lastly, we note that all in all, we know little about the biophysiological and psychological mechanisms of dependence.

The idea of cannabis dependence has been the subject of criticism due to its overly medical aspect (having little regard for the differences in social context of the ways and situations in which it is used) and circular reasoning (for example, the fact that drugs are illegal means that their use is necessarily illegal, yet this is one of the criteria for dependence).[76] Nevertheless, when measured in accordance with the criteria of the DSM, a cannabis dependence syndrome presents no differences from an alcohol or heroin dependence syndrome. Furthermore, establishing the relative dangers of cannabis is not contrary to the objectives of public health.

The nosologic criteria of the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*) of the *American Psychiatric Association* undoubtedly remain the most widely used in studies on dependence, especially since the majority of drug research is conducted in the United States and Commonwealth countries (England, Australia, Canada…) that use this instrument.

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[74] INSERM, (2001), *op. cit*., pages 274-275.

[75] *Ibid*., page 270.

[76] Cohen, P. testimony before the Senate Committee; also Alexander B.K., professor, Department of Psychology, University Simon Fraser, testimony before the Senate Committee on Illegal Drugs, Senate of Canada, First Session of the Thirty-Seventh Parliament, April 23, 2001, Issue 1.

The DSM-IV distinguishes between criteria for substance abuse and criteria for dependence. We have reprinted them here in accordance with the INSERM report.

Diagnostic Criteria for Substance Abuse according to the DSM-IV
A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home;
2. Recurrent substance use in situations in which it is physically hazardous;
3. Recurrent substance-related legal problems;
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Diagnostic Criteria for Substance Dependence according to the DSM-IV
A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
1. Tolerance, as defined by either of the following:
a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect;
b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
a. The characteristic withdrawal syndrome for the substance;
b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended;
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects;
6. Important social, occupational, or recreational activities are given up or reduced because of substance use;
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

The existence of a cannabis dependence syndrome in humans can be inferred using various methods: epidemiological investigations and clinical studies (which usually use DSM criteria), and requests for treatment.

Epidemiological investigations

Some epidemiological studies show that cannabis use can lead to psychological dependence. In some cases, they estimate that half of chronic users would develop this kind of dependence.[77] People who use cannabis on a daily basis for several months would be at greater risk of becoming dependent.[78] Interpretation and intercomparison of the various studies is difficult because the denominator is not always common, or even specified (in some cases, it is the general population while in others it is cannabis users and in the latter case, there is not always a distinction among life-long, recent and regular users). The authors also do not always specify if the dependence is recent or life-long.

In the United States, several investigations were conducted into the frequency of use of various psychoactive substances and dependence. Through the *Epidemiological Catchment Area* study, close to 20 000 people were interviewed in five years during the 1980s. The prevalence (in the general population) of cannabis dependence was 4.4%.[79] The *National Comorbidity Survey*, an investigation to estimate the comorbidity between substance abuse and other mental disorders, undertaken between 1990 and 1992 and involving more than 8,000 subjects from the general population between the ages of 15 and 55, also estimated the prevalence of dependence. For the purposes of the investigation, DSM criteria were used and dependence was observed when respondents presented at least three of the nine criteria. According to this study, 4.2% of the 15-54 year olds presented cannabis dependence (14% were dependent on alcohol and 24% on tobacco). Of those who had used cannabis at least once during their life (46%), 9% were considered dependent, compared to 32% for tobacco and 15% for alcohol. Cannabis dependence was more common in men than women (12% versus 5.5% of users), and in those 15-24 than in the others (15% versus 8%).[80] Combining the results of three large investigations into the use of psychoactive substances conducted on households (nearly 88,000 respondents aged 12 and up) Kandel et al.[81] observed that 8% of those who had used cannabis in the previous year (0.7% of the sample) were considered dependent.

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[77] WHO (1997) *op. cit.*.

[78] Channabasavanna, M, et al., (1999) "Mental and behavioural disorders due to cannabis use", in Kalant H. et al. (eds.), *The Health Effects of Cannabis*, Toronto: CAMH.

[79] Anthony J.C. and J.E. Helzer (1991) "Syndromes of drug abuse and dependence", in Robins L.N. and D.A. Regier (eds.), *Psychiatric Disorders in America*, New York, Free Press, pages: 116-154.

[80] Anthony, J.C . et al., (1994) "Comparative epidemiology of dependence on tobacco, alcohol, controlled substances and inhalants: basic findings from the National Comorbidity Survey." *Experimental and Clinical Psychopharmacology*, 2: 244-268.

[81] Kandel, D. et al. (1997) "Prevalence and demographic correlates of symptoms of last year dependence on alcohol, nicotine, marijuana and cocaine in the US population." *Drugs, Alcohol and Dependency*, 44: 11-29. See also Kandel D. and M. Davies, (1992) "Progression to regular marijuana involvement: Phenomenology and risk factors for near daily use", in M. Glantz and R. Pickens (eds.), *Vulnerability to Drug Abuse*, 211-253, Washington DC, American Psychological Association.

In New Zealand, a longitudinal study involving a cohort of 1,265 children born in 1977 in an urban setting and followed since birth revealed that at age 21, not less than 70% had used cannabis. Of those, 13% had had a problem with dependence measured in accordance with the DSM-IV during their lifetime.[82] Another New Zealand study involving a cohort of 1,000 people found similar results: at age 21, 62% had used cannabis and at age 26, 70% had. The prevalence of dependence using DSM III-R criteria went from 3.6% at age 18 to 9.6% at age 21 (or nearly 15% of users).[83]

In Australia, an investigation involving more than 10,000 people from the general population who were over 18 years of age showed that approximately 1.5% of users during the previous year and 20% of current users showed signs of dependence based on the DSM-IV.[84]

In the Netherlands, a study involving a sample of the national population aged 18 to 65 (7,000 subjects) showed that 10% of users had had signs of dependence during their lifetime.[85]

Clinical studies

It is difficult to generalize based on the results of clinical studies, but it is interesting to see to what extent their results are similar to those of epidemiologic studies. Kosten examined the validity of DSM-III R criteria to identify syndromes of dependence on various psychoactive substances including cannabis. He observed that the criteria for syndromes of alcohol, cocaine and opioid dependence were strongly consistent. The results were more ambiguous for cannabis. A criterion-referenced analysis revealed that there were three dimensions to the cannabis dependence syndrome: (1) compulsion – indicated by a change in social activities attributable to the drug; (2) difficulty stopping – revealed by the inability to reduce use, a return to previous levels after stopping temporarily and a degree of tolerance of the effects; and (3) withdrawal signs – revealed by their disappearance with re-use and continuing use despite recognized difficulties.[86]

Studies on long-term users

In Canada, Hathaway conducted a study between October 2000 and April 2001 to identify problem use and dependence in long-term users based on the DSM-IV criteria.[87] The sample was made of 104 individuals (64 men and 40 women) aged 18 to

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[82] Fergusson, D.M. and L.J. Horwood (2000) "Cannabis use and dependence in a New Zealand birth cohort." *New Zealand Medical Journal*, 113: 156-158

[83] Poulton, R., et al., (2001) "Persistence and perceived consequences of cannabis use and dependence among young adults: implications for policy." *New Zealand Medical Journal*, 114: 13-16.

[84] Swift, W. et al., (2001) "Cannabis use and dependence among Australian adults: results from the National Survey of Mental Health and Well-being." *Addiction*, 96: 737-748.

[85] Van Laar, M., et al., (2001) *National Drug Monitor. Jaarbericht 2001*. Utrecht: NDM Bureau.

[86] T.R. Kosten et al., Substance-use disorders in DSM-III-R, *British Journal of Psychiatry*, 151, 8-19, 1987.

[87] Hathaway, A.D. (2001) "Cannabis effects and dependency concerns in long-term frequent users: a missing piece of the public health puzzle." Transmitted to the Senate Committee on Illegal Drugs

55 (mean age 34). 80% had used cannabis on a weekly basis, 51% on a daily basis during the preceding 12 months, and close to half (49%) had used one ounce (28 grams) or more per month. Reasons to use included: to relax (89%), to feel good (81%), to enjoy music or films (72%), because they are bored (64%) or as a source of inspiration (60%).

Respondents were asked if they had ever engaged in deviant activity related to cannabis use. The most frequent answer was to have been in an uncomfortable situation in order to get cannabis. Other activities included borrowing money, selling cannabis to support their own drug use, and taking on extra work to buy cannabis. Only 6% ever had recurring legal problems due to their use of cannabis. With respect to dependence, 30% reported a lifetime prevalence of three or more of the criteria, 15% during the 12 months prior to the interview.

> *In light of this finding, the most frequently encountered problems with cannabis have more to do with self-perceptions of excessive use levels than with the drug's perceived impact on health, social obligations and relationships, or other activities. Lending support to the highly subjective nature of his evaluative process, no significant correlations were found between amounts nor frequency of use and the number of reported DSM-IC items. For those whom cannabis dependency problems progress to the point of seeking out or considering formal help, however, the substantive significance of perceived excessive use levels cannot be overlooked.* [88]

The comparative study by Cohen and Kaal presented in the previous chapter also included data on dependency symptoms. Between 21% and 24% of the subjects presented 3 or more DSM-IV criteria in their lifetime as the following table shows.

Number of positive DSM IV answers
Amsterdam, San Francisco, Bremen [89]

	Ever experienced				Last twelve months			
Number of criteria	Amsterdam		San Francisco		San Francisco		Bremen	
	N	%	N	%	N	%	N	%
0	85	39	129	49	233	88	43	78
1	37	17	53	20	17	6	5	9
2	43	20	30	11	9	3	4	7
3	19	9	28	11	3	1	2	4
4	15	7	15	6	3	1	1	2
5	9	4	7	3				
6	8	4	3	1				

during the testimony of Professor Hathaway before the Senate Special Committee on Illegal Drugs, Senate of Canada, First session of the thirty-seventh Parliament, May 14, 2001, Issue 2.

[88] *Ibid*., page 15.

[89] Cohen, P.D.A. et H.L. Kaal, (2001) *The irrelevance of drug policy. Patterns and careers of experienced cannabis use in the population of Amsterdam, San Francisco and Bremen.* Amsterdam: University of Amsterdam, CEDRO, page 99.

Total	216	100	265	100	265	100	55	100
Average incl. 0	1,5		1,2		0,2		0,4	
Average excl. 0	2,5		2,3		1,8		1,9	

The authors observe a significant correlation between amount of cannabis use (in grams) during top period of use and the number of DSM-IV items ever experienced. However, no correlation was found between the amount of cannabis use during top period of use and number of criteria experiences in the last twelve months.

Requests for treatment

Lastly, we can examine dependence indirectly through requests for treatment. Obviously, this is a very indirect and definitely very imperfect means for several reasons. The very great majority of cannabis users use it irregularly and stop when they reach their twenties. Of those who continue and become regular users, we have just seen that between 10% and 20% will present the criteria for dependence. Most users do not think they need help, which their ability to stop without outside assistance would confirm. Lastly, those who ask for help could be influenced simultaneously by the availability of services as well as the interaction of other problem substances, alcohol, medication or other drugs, or other mental disorders. In fact, it seems that in a significant proportion of cases, requests for treatment related to cannabis come from people with multiple disorders.

Nevertheless, we have heard testimony to the effect that requests for treatment for problems with cannabis dependence are on the rise and that this increase could be related to the THC content.

In Europe, requests for treatment where the main problem is cannabis-related vary widely from country to country, ranging from 6% in Spain (one of the countries where use is most widespread and most tolerated) to 25% in Belgium. Sweden, which however has a relatively low rate of use, is at 14%, comparable to France (16%) which, however, has a much higher rate of use. In the United States, demand is just as variable depending on the state, from 5% to 30%.[90]

Severity of dependence

Severity of dependence has been evaluated in different ways. In the United States, a study examined approximately 1,100 subjects who had used cannabis more than six times and evaluated the severity of their dependence based on DSM-IV criteria. The level of dependence (low, intermediate or high) corresponded to the number of criteria met.[91] The following results were obtained:

Severity of cannabis dependence based on use[92]

Dependence (number of criteria)	Distribution of subjects based on type of use: Low			Intermediate			Heavy			Total		
	T	A	C	T	A	C	T	A	C	T	A	C
Nil (0-2)	18	88	85	14	45	53	5	8	35	13	47	59
Low (3-4)	28	8	11	30	22	21	22	12	34	27	14	18
Moderate (5-6)	34	3	2	39	15	14	51	19	23	40	12	13
Severe (7-9)	19	1	3	17	17	12	23	61	17	20	27	10

T = tobacco; A = alcohol; C = cannabis

We see a consistent situation in which the link between heavy use and dependence is lower for cannabis than for tobacco and alcohol, and in which, over all, dependence on cannabis is the lowest of the three substances.

For his part, professor Roques proposes three classes of products based on their dangers. The first includes heroin, cocaine and alcohol; the second psychostimulants, hallucinogens, tobacco and benzodiazepines; and cannabis is set apart in a separate class. He classifies the dangerousness of drugs using a diverse set of criteria. We have reprinted his table of the dangerousness of drugs on the following page.

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90 Rigter, H. and M. van Laar (2002) "Epidemiological aspects of cannabis use." in Pelc I., (ed.) *International Scientific Conference on Cannabis*. Brussels.

91 Woody G.E. et al., (1993) "Severity of dependence: Data from the DSM-IV field trials" *Addiction* 88, 1573-1579.

92 Reprinted from INSERM (2001) *op. cit*., page 73.

Danger Factors of "drugs" (reprinted from Roques, B. (1999), page: 296								
	Heroin	**Cocaine**	**MDNA**	**Psycho-stimulants**	**Alcohol**	**Benzo-diazepines**	**Cannabi-noids**	**Tobacco**
Dopamine Overactivation	+++	++++	+++	++++	+	±	+	+
Hypersensi-tivity to Dopamine	++	+++	?	+++	±	?	±	?
Activation of Opioid System	++++	++	?	+	++	+	±	±
Physical Dependence	very high	low	very low	low	very high	average	low	high
Psychic Dependence	very high	high but intermittent	?	average	very high	high	low	very high
Neurotoxicity	low	high	very high (?)	high	high	0	0	0
General Toxicity	high	high	possibly very high	high	high	very low	very low	very high (cancer)
Danger to Society	very high	very high	low (?)	low (exceptions)	high	low	low	0
Replacement Therapy	yes	yes	no	no	yes	not researched	not researched	yes

In closing, we note that there is no known physical dependence on cannabis, even though in the most severe cases, withdrawal is sometimes accompanied by physical signs such as trembling, insomnia, irritability, etc.

Tolerance

From a technical standpoint, tolerance is defined as follows:

> *the property of the human organism to endure the administration of usually effective doses of a given substance without displaying a reaction. With respect to drugs, this tolerance can lead to increased doses in order to achieve the desired effect.* [93] [translation]

Development of tolerance is associated with pharmacodynamic changes. In some animal studies, chronic administration of THC reduced the density of receptors in some regions of the brain[94] and increased it in others; these effects were reversible.[95]

In man as in animals, studies have observed the phenomenon of cannabis tolerance. However, the data must be interpreted with care insofar as some studies and clinical cases have also found that regular users needed less cannabis to achieve the desired effect.[96] Nevertheless, a study by Wiesbeck et al. involving 5,611 subjects reported that 16% of frequent cannabis users had a history of a withdrawal syndrome.[97]

It is tolerance of a substance that leads to withdrawal symptoms. In recent years, clinical data has been accumulated on withdrawal symptoms in heavy cannabis users (several doses per day in an ongoing manner for several years). The symptoms observed include agitation, loss of appetite, nausea, disturbed sleep, irritability or hyperactivity and an increased body temperature.[98] These symptoms appeared after 24 hours of abstinence, peaked after two to four days and diminished within seven days. The symptoms were markedly less severe and of shorter duration than with other psychoactive substances. Furthermore, clinical studies showed that most subjects continued to perform their daily activities in a normal fashion.

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93 OMS (1969), in Caballero et Bisiou (2000), *op. cit*., page 6.

94 Rodriguez de Fonseca, F. et al., (1994) "Downregulation of rat brain cannabinol binding sites after chronic delta-9-THC treatment", *Pharm. Biochem. Behav*. 47, 33-40.

95 Westlake, T.M. et al., (1996) "Chronic exposure to delta-9-THC fails to irreversibly alter brain cannabinoid receptors" *Brain Research*, 544, 145-149.

96 Beardsley, R.M et al., (1986) "Dependence on THC in rhesus monkeys", *Journal Pharmacol. Exp. Ther*., 239 (2), 311-319.

97 Wiesbeck, G.A., et al., (1996) "An evaluation of the history of a marijuana withdrawal syndrome in a large population." *Addiction*, 91 (10): 1573-1579.

98 Kouri, E.M. et al., (2000) "Abstinence symptoms during withdrawal from chronic marijuana use." *Experimental and Clinical Psychopharmacology*, 8: 483-492.

To summarize

In Chapter 6, we have seen that use does not follow a single pattern, even less so a pattern inevitably leading to increased use. Even in chronic users, the use of cannabis is sometimes irregular and involves periods of abstinence and of more intensive use. We have also seen that current epidemiological studies are not sensitive enough to the complex interactions between the multiple factors that influence patterns of use. These various difficulties make it more difficult to estimate the number of problem users, even more so the number of persons who may become dependent.

In our view, it is clear that the term addiction, severely criticized for its medical and moral overtones, is inadequate to properly describe the different forms of at-risk and problem uses. It is even less useful when it comes to cannabis, whose addictive potential is low. It is therefore of lmited use to inform public policies aiming to prevent at-risk and problem use and to assist excessive users. Further, we are of the view that dependency is but one of the many consequences of excessive use of cannabis and that this possibility must not be overestimated.

For these reasons, we propose to distinguish between different uses on the basis of four criteria: context, quantity, frequency, and duration and intensity.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport…) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

Given the poor knowledge base on use patterns in Canada, we have no choice but to speculate on the number of persons falling in each of these types of uses. We propose the following broad parameters:

- In adults: we have estimated that approximately 100,000 persons over 18 would use cannabis daily.
    - If 30% to 40% use between 0.1 to 1 gram per day, this means that 30,000 to 40,000 may be at-risk;
    - If 5% to 10% use more than 1 gram per day, this means that 5,000 to 10,000 adults have excessive use patterns.
- In youth 12 to 17, we have estimated that as many as 225,000 use cannabis daily.
    - If it is agreed that any use below the age of 16 is excessive use, and that youths 12-15 who use cannabis may represent approximately 25% of this group, then about 50,000 may uses excessively;
    - Of the remaining 175,000, if 30% to 40% use 0,1 to 1 gram per day, approximately 50,000 to 70,000 would be at-risk;
    - If 5% to 10% of the remaining 175,000 use more than 1 gram per day, then approximately 8,000 to 17,000 use excessively.

We are aware that these estimates do not account other variables, such as context and duration of use. We can only hope that future epidemiological studies, which must be undertaken regularly, will help further explain the complexity and variability of these uses.

CONCLUSIONS

In total, based on all the data from the research and the testimony heard regarding the effects and consequences of cannabis use, **the Committee concludes that the state of knowledge supports the belief that, for the vast majority of recreational users, cannabis use presents no harmful consequences for physical, psychological or social well-being in either the short or the long term**.

More specifically, this conclusion is based on the following conclusions.

Conclusions of Chapter 7	
Acute effects of cannabis	➢ **The immediate effects of cannabis are characterized by feelings of euphoria, relaxation and sociability; they are accompanied by impairment of short-term memory, concentration and some psychomotor skills.**
Distinctions between uses	➢ **For purposes of public policy, the Committee does not feel that the traditional distinctions between acute and chronic effects are useful.** ➢ **Similarly, the Committee does not feel the dichotomy of use and dependence is useful.** ➢ **The research data does not allow for a clear distinction between use, at-risk use and heavy use.** ➢ **The amount consumed is an indicator, but other factors, psychosocial factors and factors relating to the context of use and the quality of the substance, are equally determining in the passage from use to at-risk use and heavy use.**
At-risk use and heavy use in adults	➢ **Nevertheless, the Committee feels that for people over the age of 16, at-risk use lies within the range of 0.1 to 1 gram per day; anything more than that is heavy use, which can have negative consequences on the physical, psychological and social well-being of the user.** ➢ **According to this distinction, and in accordance with the epidemiological data available, there is reason to believe that approximately 100,000 Canadians could be at-risk users and approximately 80,000 could be heavy users.**
Any use in those under age 16 is high-risk use	➢ **The Committee feels that, because of its potential effects on the endogenous cannabinoid system and cognitive and psychosocial functions, any use in those under age 16 is at-risk use;** ➢ **Our estimation would suggest that approximately 50,000 youths fall in this category.** ➢ **For those between the ages of 16 and 18, heavy use is not necessarily daily use but use in the morning, alone or during school activities;**
Consequences of heavy use	➢ **Heavy use of smoked cannabis can have certain negative consequences for physical health, in particular for the respiratory system (chronic bronchitis, cancer of the upper respiratory tract).** ➢ **Heavy use of cannabis can result in negative psychological consequences for users, in particular impaired concentration and learning and, in rare cases and with people already predisposed, psychotic and schizophrenic episodes.**

	➢ **Heavy use of cannabis can result in consequences for a user's social well-being, in particular their occupational and social situation and their ability to perform tasks.** ➢ **Heavy use of cannabis can result in dependence requiring treatment; however, dependence caused by cannabis is less severe and less frequent that dependence on other psychotropic substances, including alcohol and tobacco.**

CHAPTER 8

DRIVING UNDER THE INFLUENCE OF CANNABIS[1]

Stan Thompson was 18 when he and four other teenagers from Kanata were killed in a horrific car accident near Perth that summer day. A youth was found responsible for the fatal accident and served eight months of a 12-month sentence. Cannabis and alcohol-impaired driving was the cause. … The year following Stan's death, his father, Greg Thompson, went to local high schools to talk about the tragedy. He spoke to students about what went wrong and how the tragedy could have been prevented. … His message was that driving a vehicle and smoking marijuana does and will affect driving abilities. He pleaded with the kids not to do it. … Cannabis is not a benign substance. There is very little in the way of research that allows anyone to determine levels of impairment related to cannabis and driving ability, much less the levels of impairment related to cannabis and alcohol and driving ability. We have seen in the Manitoba survey, over one-half of the kids that are using cannabis do so in cars and during school hours. There is no technical or scientific ability to test for cannabis impairment. We do not have the technology, scientific data or the research. We do not have the proper legislation. Studies done in British Columbia indicate that 12 per cent to 14 per cent of the drivers involved fatal motor vehicle accidents had cannabis in their systems. The Government of Quebec and the insurance board in Quebec are presently doing road surveys where people are voluntarily submitting to urine or blood tests. The findings in these tests are that between 12 per cent and 14 per cent of those drivers has cannabis in their system while driving. [2]

If there is one issue, other than the effects of cannabis use on young people or the effects of substance abuse, that is likely to be of concern to society and governments, then it is certainly the issue of how it affects the ability to drive a vehicle. We are already familiar with the effects of alcohol on driving, and the many accidents involving injuries or deaths to young people. In spite of the decreases in use noted in recent years, it is not difficult to admit that one fatal accident caused by the use of a substance is already one accident too many.

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[1] In addition to the specific studies we consulted, which will be referred to appropriately, this chapter is largely based on the surveys carried out by INSERM (2001) *op. cit*., Ramaekers et al., for the International Science Conference on Cannabis in Pelc, I., *op. cit.*), and Smiley (1999) in Kalant (ed.) *op.cit.*

[2] R.G. Lesser, Chief Superintendent, Royal Canadian Mounted Police, testifying before the Special Senate Committee on Illegal Drugs, October 29, 2001, Issue 8, page 17.

As it happens, after alcohol, cannabis is the most widely used psychoactive substance, particularly among young people in the 16-25 age group. Casual use occurs most often in a festive setting, at weekend parties, often also accompanied by alcohol. People in this age group are also the most likely to have a car accident and are also susceptible to having an accident while impaired.

We have seen that cannabis affects psychomotor skills for up to five hours after use. The psychoactive effects of cannabis are also dependent on the amount used, the concentration of THC and the morphology, experience and expectations of users. But what are the specific effects of cannabis on the ability to drive motor vehicles? What are the effects of alcohol and cannabis combined? And what tools are available to detect the presence of a concentration of THC that is likely to significantly affect the psychomotor skills involved in vehicle operation?

Here again, the witnesses heard by the Committee vary in their interpretation of the study results. Thus, the Canadian Police Association told us:

> *Driving while intoxicated by drugs impairs judgment and motor coordination. In one study involving aircraft 10 licensed pilots were given one marijuana joint containing 19 milligrams of THC - a relatively small amount. Twenty-four hours after smoking the joint, they were tested in a flight simulator. All 10 of the pilots made errors in landing and one missed the runway completely.* [3]

Two weeks later, Dr. John Morgan of the City University of New York Medical School said in reference to the same study:

> *A California-based scientist named Jerome Yesavage wrote the study. It was done in the early 1980s, I think, and it attracted enormous attention. … Doctor Yesavage's study … was completely uncontrolled. … As you all have heard, it is difficult to control for marijuana use. When Doctor Yesavage was funded by the federal government to repeat the study with the simple controls that others and I had suggested, they were unable to show any impact of marijuana use after four hours in a similar group of people. Therefore, I believe that the truth is that marijuana use will impact airplane and driving simulators and to some degree driving performance for three hours to four hours after use; however there is no sustained impact. Any impact is relatively minor.* [4]

Making reference to Robbe's work, which we will be examining in greater detail in this chapter, Professor Morgan added:

> *A Dutch scientist who has for years worked on driving experiments found that marijuana using drivers have a little difficulty staying right in the middle of the road. That is most sensitive test. If you smoke marijuana, you tend to weave a little bit more than completely sober people do. That is important,*

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[3] Dale Orban, Detective Sergeant, Regina Police Service, for the Canadian Police Association, testimony given before the Special Senate Committee on Illegal Drugs, May 28, 2001, Issue 3, page 47.

[4] Dr John Morgan, Professor at the City University of New York Medical School, testimony before the Special Senate Committee on Illegal Drugs, June 11, 2001, Issue 4, page 40-41.

although there have been no studies to show that that amount of weaving had a gross impact on driving ability.
The Dutch scientist included in his report that the amount of weaving was approximately the same in individuals consuming very small amounts of alcohol, very small doses of bensodiazopenes and very small doses of antihistamines. [5]

On the same day, Professor Kalant of the University of Toronto responded as follows:

Dr. Morgan referred to some experimental studies this morning. A number of studies, reviewed by Dr. Smiley in the report of the World Health Organization Committee on Health Effects of Cannabis, indicate a fair measure of agreement on what the predominant effects on driving are. The lane control, as Dr. Morgan mentioned, is impaired. The person does not steer as accurately. In addition, there was slower starting time and slower braking time. There was decreased visual search. In other words, when you drive, you must monitor for sources of danger to both sides and not just ahead of you. There was decreased monitoring, decreased recognition of danger signals. The effects were synergistic with those of alcohol. The one favourable thing about cannabis compared with alcohol was that there was less aggressiveness in the cannabis smokers than in the drinkers, so they were less likely to pass dangerously or to speed. Nevertheless, driving ability was impaired not just by weaker, poorer steering control, but also by less alertness to unexpected things that might happen and pose a hazard.
I will not go into the statistics of actual field studies of the involvement of cannabis in driving accidents. However, I would like to say that a number of studies have shown that there has been evidence of cannabis presence in the blood or the urine of people who have been stopped for impaired driving who did not have alcohol present. [6]

As we can see, and as was the case with respect to the effects and consequences on the health of users, there are divergent opinions about the interpretation of studies and their meaning in connection with the specific effects of marijuana on driving.

This chapter is divided into three sections. The first considers the ways of testing for the presence of cannabinoids in the body. The second analyses studies on the known prevalence of impaired driving, in both accident and non-accident contexts. The third and last summarizes what is known about the effects of cannabis on driving based on both laboratory and field studies. As in the other chapters, the Committee will then draw its own conclusions.

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[5] *Ibid.*

[6] Dr Harold Kalant, Professor Emeritus, University of Toronto, testimony before the Special Senate Committee on Illegal Drugs, June 11, 2001, Issue 4, page 75.

FORMS OF TESTING

There are five known media for testing the presence of cannabinoids in the organism: blood, urine, saliva, hair and perspiration.

Blood is the most appropriate medium for detecting recent cannabis use because only a blood analysis can distinguish between the active ingredients of cannabis and metabolites that have no psychoactive effects. However, as we have already seen, blood concentrations of Δ^9THC peak 9 minutes after smoking; after 10 minutes only two-thirds of the concentration remains, and it is down to 5 to 10% at the end of an hour; after two hours, it becomes difficult to detect. Thus not all methods are appropriate for testing because of the strong possibility of obtaining false negatives and false positives. The most reliable method, gas chromatography using mass spectrometry for detection, is extremely sensitive and can also estimate the time that has elapsed between the most recent use and the taking of the blood sample.

We saw in Chapter 7 that there was a dose-response relationship: 25 puffs affect cognition more than do 10 puffs, and 10 have more of an effect than 4. But not much data is available on the relationship between concentration and effects on people, and the ability to answer the key road safety question, namely at what concentration can one consider that faculties are impaired? In France, the Δ^9THC level that constitutes testing positive has been set at 1ng/ml[7] for drivers involved in fatal accidents. Another author has come up with a formula that establishes a relationship between Δ^9THC, 11-OH Δ^9THC and Δ^9THC-COOH to determine a cannabis influence factor with a positive threshold of 10ng/ml. An equal concentration of Δ^9THC and COOH suggest use approximately 30 minutes beforehand, and hence a very high probability of psychoactive effects, whereas a higher concentration of COOH than Δ^9THC suggests that use was more than 40 minutes beforehand. However, a concentration of COOH in excess of 40 µg/l would indicate a chronic user, and hence it becomes impossible to determine when the last use occurred. Other research has established that a blood concentration of 10 to 15 ng/ml suggests recent use, without however being able to give an exact figure.[8]

Urine tests are also frequently employed and remain the most appropriate method for rapidly determining whether subjects have been using. On the other hand, traces of cannabis can remain in urine for weeks. Furthermore, the traces that remain are of Δ^9THC-COOH, an inactive metabolite. Consequently, urinalyses are primarily useful for epidemiological measurements of cannabis use, and cannot contribute to information about impaired driving.

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[7] In this chapter, ng means nanogram (i.e. one billion of one gram) and µg means microgram (one million of one gram)

[8] INSERM (2001), *op. cit*., pages 152-153.

The levels of concentration of Δ^9THC-COOH in urine are very high: for someone who smokes a joint a day, the level is between 50 to 500 ng/ml and may reach several thousands ng/ml in heavy users; the currently recommended threshold level for testing positive is 50ng/ml urine.

Saliva is a very promising option for road safety because it is non intrusive and can indicate recent use with some accuracy. The presence of Δ^9THC in saliva essentially results from the phenomenon of bucco-dental sequestration during inhalation. Concentrations are very high in the few minutes following absorption, varying between 50 and 1,000 ng/ml, but then decline very quickly in the hours that follow, though they remain detectable for an average of four to six hours. The European ROSITA project compared the reliability of samples taken from urine, perspiration and saliva compared to that taken from blood. Saliva is by far the most reliable, showing an exact correlation in 91% of cases. However, the low level of concentration during the period when the psychoactive effects are active means that sensitive analytical methods are essential. There is unfortunately not yet a sufficiently accurate and reliable rapid detection tool that can be used in driving situations. Hence the driving detection tools correctly identified only 18 to 25% of cases and led to many false negatives.[9]

Perspiration is generally considered poor for detection purposes, because of the persistence of Δ^9THC in sweat, and the fact that it is also excreted into sweat in small quantities.

Hair looks very promising because the significant amount of Δ^9THC can determine time since and level of use (low, moderate, high). However, concentrations are only a few ng per mg of hair, which requires highly efficient testing.

The following table, taken from the INSERM report, summarizes the main characteristics of the various biological testing media; where available, we have added the threshold detection level adopted.

[9] Ramaekers, J.G. et al., 2002 "Performance impairment and risk of motor vehicle crashes after cannabis use" in Pelc, I. (ed.) *International Scientific Conference on Cannabis*, Brussels, page 81.

Main Characteristics of Biological Testing Media					
	Primary cannabinoids	Maximum detection period	Useful for	Methodologies available	Threshold for positive test
Urine	THC-COOH (inactive)	Occasional use: 2 to 7 days Regular use: 7 to 21 days	Identifies use	Yes, many rapid tests	50ng of Δ^9THC-COOH per ml
Saliva	THC (active)	2 to 10 hours	Identifies recent use	No, no rapid tests	not determined
Perspiration	THC	Highly variable	Not useful	No, no rapid tests	not useful
Hair	THC	Infinite	Identifying & monitoring regular user	Yes, CPG-SM	not determined
Blood	THC 11-OH THC THC-COOH	2 to 10 hours	Confirmation, identification, dosage	Yes, CPG-SM	1ng/ml (France)

In all instances, the handling and transportation of samples and the toxicological dosages are essential to the quality of the analyses.

There is still considerable uncertainty about thresholds that make it possible to affirm that the presence of Δ^9THC would impair the driver. Furthermore, there is still no reliable rapid screening test to identify recent use (urine tests cannot do this). Moreover, other drugs besides alcohol, including many types of prescription medicines, may have an impact on driving. That is why many authors, and a number of witnesses, suggested to us that Canada adopt the Drug Evaluation and Classification Program (DEC) and recognize police officers trained as Drug Recognition Experts. This practice has now been adopted in most U.S. states (at least 34, as well as the District of Columbia), British Columbia, Australia, Norway and Sweden.

The typical scenario for driving under the influence of psychoactive substances other than alcohol is as follows: a vehicle attracts the attention of a police officer, who pulls the vehicle over and questions the driver; if there are reasonable grounds to believe that the driver is intoxicated, a breathalyser test is administered; however, when the test yields a result below the legal limit, the police officer may still not be convinced that the driver is capable of driving, but how is this to be proven? Before, more often than not, the police officer had to release the driver. As we have just seen, there are no equivalents to the breathalyser test for drugs and medicines, and, for cannabis in particular, traces found in urine in no way establish that use was recent. It was in this context that the police officers working for the Los Angeles Police Department developed the Drug Recognition Expert System (DRE) in the early 1980s. Police

officers are given specific training in the detection of people driving under the influence of psychoactive substances and in the use of the DEC.

The system allows police officers who have reason to believe that drivers are intoxicated to call on an officer specially trained in drug recognition, who can then evaluate the driver on the basis of a set of systematic and rigorous factors that are recognized as signs of the presence of drugs. The process involves 12 steps:

- Breath alcohol test: This test will have been conducted by the police officer who stopped the vehicle. The Drug Recognition Expert is only called in when the test is negative.
- Interview by the arresting officer: The DRE asks the arresting officer a series of conventional questions: in what condition did he or she find the suspect, what he or she had observed, if he or she found drugs in the vehicle, suspect's statement, etc.
- Preliminary examination (the first of three pulse measurements): This involves determining whether there are reasonable grounds to suspect the presence of drugs, and hence eliminate the possibility that there is a medical condition. The DRE observes the suspect's overall condition, and questions the suspect about health, examines the pupils and gaze, and takes the first of three pulse measurements. If the DRE feels that there are no signs, the suspect is released. If the condition is medical, a medical evaluation is requested. However, if drugs are suspected, the examination continues
- Examination of the eyes: This consists of three tests: horizontal gaze, vertical gaze and convergence. Apparently when under the influence of any drug, it is impossible to have an involuntary jerky movement of the pupils on the vertical axis without first provoking such movements on the horizontal axis. Thus if there are only vertical jerky pupil movements, it is likely a medical condition (e.g. brain damage). If there is horizontal jerkiness, there are likely drugs involved. To determine horizontal movements, the DRE moves a pen or other object horizontally in front of the suspect's eyes. For vertical movement, the pen is moved from top to bottom. Furthermore, as certain drugs prevent eyes from being able to converge towards the bridge of the nose, the DRE performs a convergence test by placing the pen or object on the person's nose and asking the suspect to look at it
- Divided attention psychophysical tests: The tests include balancing, walking, standing on one leg and the finger-to-nose test
- Vital signs examination: This is the second of three pulse measurements, as well as a measurement of blood pressure and body temperature
- Dark room examination: This involves examining the pupils under four different lighting conditions: room lighting, darkness, indirect light and direct light
- Examination of muscle tone: arm movements

- Examination for injection sites
- Questions about suspect's drug use and living habits
- Opinion: On the basis of all the evidence, the DRE forms an opinion based on a reasonable amount of certainty
- Toxicological examination: The purpose of this examination is to corroborate the analysis by the DRE officer. The decision concerning prosecution is made only when the analyses are returned.

The system was standardized in the early 1980s with the assistance of the U.S. National Highway Traffic Safety Administration. It was first tested in a laboratory study.[10] In the study, four Drug Recognition Experts evaluated subjects who had received either a placebo or a dose of drugs. Neither the subjects nor the officers knew who had received the drugs. In 95% of cases, the officers correctly identified the subjects who had not been given drugs. In 97% of cases, they correctly identified the subjects who had been given drugs and in 98.7% of cases, they were able to determine which subjects were under the influence of drugs.

A field study was then conducted in 1985, once again with the assistance of the Highway Traffic Safety Administration.[11] In the study, blood samples of 173 drivers arrested for driving under the influence of drugs were analyzed by an independent laboratory. The study showed that the analyses carried out by the Drug Recognition Expert officers correctly predicted the presence of drugs other than alcohol in 94% of cases. In 79% of the cases, the analyses of the officers identifying the presence of a specific drug turned out to be accurate.

The most complete study was carried out in Arizona in 1994. In this study, the files of over 500 persons arrested for driving under the influence of drugs were analyzed, and toxicological analyses were conducted. The study showed that the toxicological analyses corroborated the conclusions of the officers in 83.5% of cases. Similar studies conducted in other states yielded comparable results: 81.3% in Texas, 84.5% in Minnesota, 88.2% in California, 88.2% in Hawaii and 88% in Oregon.

With respect specifically to cannabis, the expected signs listed in the system are generally the following: no horizontal or vertical shaking, but no convergence in gaze, dilated pupils, accelerated pulse and high blood pressure.

In short, given the limits of detection in the field of the influence of cannabis and the results of these studies, **it would appear that it would be highly desirable to adopt the DEC and train police officers in drug recognition**.

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[10] Bigelow, G.E. (1985) *Identifying types of drug intoxication; laboratory evaluation of a subject procedure.* Cited in Sandler, D. (2000) "Expert and Opinion Testimony of Law Enforcement Officers Regarding Identification of Drug Impaired Drivers." *University of Hawaii Law Review* 23 (1), 150-181.

[11] Compton, P.R. (1986) *Field Evaluation of the Los Angeles Police Department Drugs Detection Procedure.* Cited in Sandler, *op. cit*., page 151.

EPIDEMIOLOGICAL DATA

According to a number of the witnesses we heard, more than 40% of people whose driving abilities are impaired would drive under the influence of cannabis. Others have said that approximately 12% of accidents causing injury could be attributed to the use of cannabis. What do the studies reveal?

Data on the frequency of driving under the influence of cannabis (whether on its own or together with other substances) are, for obvious reasons, difficult to obtain. First, for drivers involved in an accident, a positive breathalyzer test means most of the time that no other measurements are taken because a blood alcohol level above the legal limit is enough to take legal action. Second, the methods available to detect the presence of THC are intrusive (blood, urine), unlike the breathalyzer, and hence pose specific legal and ethical problems. Other forms of measurements, such as saliva samples, do not, for the time being, allow roadside detection. Lastly, in studies of all drivers, the consent of drivers is required to take a blood or urine sample, thus limiting the possibility of generalizing results. Nevertheless, we will summarize the main points of a number of studies conducted in recent years.

Studies not involving accidents

Two types of studies were conducted: surveys of all drivers selected at random from the flow of traffic at various times of the day and week, and studies where it was presumed that the people were driving under the influence during police checks. The following table, drawn from the various data available from INSERM, summarizes these studies.

Detection and prevalence of cannabis in Europe and Quebec where no accidents are involved[12]				
Reference country	Population	Detection method	Sample	Prevalence (%)
No presumption of driving under the influence of psychoactive substances				
Germany, Kruger et al., 1995	All drivers	Screening: FPIA saliva Confirmation: CG/SM saliva	2 234 (of 3 027)	0.6
Netherlands, Mathtijssen, 1998	Night drivers on weekends	Screening: combined saliva, perspiration and urine test	293 (of 402)	5
Italy, Zancanner et al., 1995	Night drivers on weekends	Clinical screening, clinical and toxicological check (blood, urine)	1 237	1.5

[12] Table reproduced from INSERM (2001), *op. cit*., page 175.

Detection and prevalence of cannabis in Europe and Quebec where no accidents are involved[12]				
Reference country	Population	Detection method	Sample	Prevalence (%)
Canada Dussault et al., 2000	Highway drivers (representative survey)	Urine Saliva Breathalyzer (alcohol)	2 281 2 260 5 281	5 (in progress) > 0.8 : 0.8
With presumption of driving under the influence of psychoactive substances				
Norway, Skurtveit et al., 1996	Drivers	Screening: immunoassay blood; Confirmation: CG/SM blood	2 529	26
Denmark, Worm and Steentoft, 1996	Drivers	Screening: RIA blood Confirmation: CG/SM blood	317 221	10 17
United Kingdom, Scottland, Seymour and Oliver, 1999	Drivers	Screening: immunoassay blood; Confirmation: CG/SM blood	640	26

In all, it was observed that the detection rates for the presence of cannabis varied between 1% and 5% when there was no presumption of impaired driving. However, the missing data, which likely resulted from refusals to supply a sample, made it impossible to draw clear conclusions. The studies with presumption of driving under the influence of drugs had clearly higher results: between 10 and 26%. These results do not necessarily reveal a much higher prevalence of driving under the influence of psychoactive substances, but rather a higher level of vigilance by the police. Indeed, as we shall see immediately, the prevalence of cannabis detection in fatal accidents is no higher in Norway (7.5%) than in other countries.

Studies where an accident was involved

It is difficult to compare studies between countries because the detection methods, even in an accident context, varies widely from country to country. We wish to note once again that simply finding traces of cannabis in drivers involved in accidents is not necessarily a sign that its use was the cause of the accident. Nor does the absence of any screening result mean that no one was driving under the influence of cannabis.

The following table, adapted from INSERM results, refers to a number of recent studies in Europe, America and Australia.

Prevalence of impaired driving(ID) when there are accidents [13]				
Country	Population	Detection method	Sample	Prevalence of cannabis (%)
Belgium Meulemans et al., 1997	Casualty accidents (2-wheeled and cars)	Screening: urine Confirmation: urine CG/SM and urine blood comparison	1 879	6 (urine) 3.6 (blood)
Spain Alvarez et al., 1997	Fatal accidents with suspected ID	Screening: immunoassay blood Confirmation: CG/SM blood	979	1.5 not reliable
France, Mura et al., 2001	Casualty accidents (control group: patients)	No screening Confirmation: CG/SM blood	420 (381)	11.2 (10.8)
France, Kintz et al., 2000	Casualty accidents	Screening: urine Confirmation: CG/SM urine and blood, saliva and perspiration tests Screening: EMIT urine	198	13.6 (urine) 9.6 (blood)
Italy, Ferrara, 1990	Injuries Friday night checks		4 350 500	5.5
Norway, Christophersen, 1995	Injuries, non-fatal accidents	Screening: immunoassay blood Confirmation: CG/SM blood	394	7.5
United Kingdom, Tunbridge, 2000	Fatal accidents (including 516 drivers)	Screening: immunoassay urine Confirmation: CG/SM blood	1 138 516	12 10
Australia, Longo, 2000	Injuries (non-fatal accidents)	Screening: immunoassay blood Confirmation: CG/SM blood	2 500	11
Canada, Cimburra, 1990	Killed		1 169	11
United States, Logan, 1996	Killed		347	11

Three of these studies are particularly interesting. The Mura et al. study (2001) shows a significant difference by driver age: among 18-20 year olds, the Δ^9THC was present in 18.6% of drivers, and in 50% of cases it was present alone (without alcohol). An earlier study by Mura (1999) had shown that cannabis was particularly common among young drivers: from 35% to 43% in the under 30 age group, with an even higher prevalence (43%) for the under 20s, whereas past the age of 35, the prevalence drops to 3%.[14]

[13] Adapted from INSERM (2001) *op. cit*., pages 171 and 174.
[14] See INSERM, (2001), *op. cit*., page 172.

The study by Kintz et al. (2000) is interesting primarily because it clearly shows that, after alcohol (13.6%) cannabis is the substance most frequently present among drivers involved in accidents (9.6%). This study also shows that in the whole sample, the incidence of cannabis as measured by taking a blood sample (9.6%) is close to the level of driving under the influence of alcohol (10.6%).[15]

Then, Longo's study is of special interest because of the size and representativeness of the sample and the fact that separate analyses were done of Δ^9THC and Δ^9THC-COOH. The study detected the presence of cannabinoids in 10.8% of drivers: 8% for Δ^9THC-COOH alone and 2.8% for Δ^9THC-COOH and Δ^9THC together, thereby showing a lower percentage of positive tests for Δ^9THC than the other studies. Furthermore, as in the other studies, subjects testing positive to Δ^9THC were younger and more often men.

Closer to home, Mercer and Jeffery examined the toxicological analyses for 227 drivers killed in traffic accidents in British Columbia between October 1999 and September 1991.[16] Samples had been taken during autopsies within 24 hours of death, which according to the authors, may indicate an under-estimation of the presence of alcohol or drugs. Of the 227 people killed, 186 (43%) showed no signs of either alcohol or drugs, 83 (37%) alcohol only, 23 (11%) alcohol and drugs, and 21 drugs only. As for cannabis, 29 of the people killed (13%; 26 men and 3 women) tested positive to Δ^9THC-COOH, showing an average concentration of 15.9 ng/ml. In the +alcohol/+drugs group, (23 subjects), 17 tested positive to THC metabolites and 8 were also positive to Δ^9THC (13%). For the 0alcohol/+drugs group, (21 subjects), 8 (all men) were positive to Δ^9THC–COOH, and 4 to Δ^9THC. Even though the authors concluded that Δ^9THC /Δ^9THC-COOH was present in 13% of cases, which is a percentage comparable to most of the other studies, only 12 subjects killed tested positive to Δ^9THC with or without alcohol and only 4 without alcohol.

Lastly, a more recent epidemiological study dealt with 1,158 cases of fatal accidents (391) or of cases of driving under the influence of psychoactive substances when the percentage of alcohol in the blood was below 0.1 (767) reported in Canadian forensic laboratories on November 12, 1994.[17] The most frequent substances identified were benzodiazepines (590 cases), alcohol (580), cannabis (551), stimulants (224), opiates (176) and barbiturates (131). For cannabis, we get the following table:

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[15] *Ibid.*

[16] Mercer, W.G. and W.K. Jeffery (1995) "Alcohol, Drugs and Impairment in Fatal Traffic Accidents in British Columbia" *Accid. Anal. And Prev.*, 27 (3), pages 335-343.

[17] Jeffery, W.K. et al. (1996) "The involvement of drugs in driving in Canada: An update to 1994." *Can. Soc. Forens. Sci. J.*, 29 (2), pages 93-98.

Presence of cannabis in Canada (1994)			
	Total	with alcohol	without alcohol
THC			
➢ **Impaired driving**	181	129	52
➢ **Death**	198	98	100
THC-COOH			
➢ **Impaired driving**	127	29	98
➢ **Death**	45	24	21

In all, cases in which Δ^9THC without alcohol was present accounted for 13% of the total, which is close to the figure found in the other studies.

Out of all the studies, it was found that the presence of cannabis among drivers who were injured or killed varies between 3.6% (confirmed by blood analysis) and 13% (unconfirmed). Where there was confirmation of the presence of Δ^9THC compared to Δ^9THC-COOH, the presence of the active substance decreases by half. In addition, the risk of testing positive is much higher for young men than other drivers. These conclusions are largely shared by other authors.[18]

Epidemiological studies on youth

In recent years, epidemiological studies on youth in the school environment have asked questions about the frequency of driving under the influence of psychoactive substances, cannabis in particular. In Ontario, the 2002 OSDUS study described in Chapter 6 shows that 19.3% of the students had driven their car one hour or less after having taken cannabis at least once in the past twelve months.[19] More interesting is that this compares with 15% who said they had taken their car less than an hour after one or two drinks. In Manitoba, the survey of youths in school reveals that almost 20% see nothing wrong in driving after taking cannabis.[20]

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[18] Including the INSERM report (2001), *op. cit.*; Ramaekers, J.G. et al., (2002) "Performance impairment and risk of motor vehicle crashes after cannabis use" in Pelc, I. (ed.) *International Scientific Conference on Cannabis*, Brussels.

[19] Adlaf, E.M. et A. Paglia (2001) *Drug Use among Ontario Students 1997-2001. Findings from the OSDUS.* Toronto: Centre for Addiction and Mental Health, page 134.

[20] Patten, D., et coll., (2000) *Substance Use among High School Students in Manitoba*. Winnipeg: Addictions Foundation of Manitoba.

Finally, the Cohen and Kaal study on long term consumers had shown that no less than 42% of the respondents in Amsterdam and 74% in San Francisco had driven their car under the influence of cannabis.[21]

Risk assessment

Given the difficulties of conducting reliable epidemiological studies on driving under the influence of cannabis, a number of authors have analyzed the probability of responsibility and the risk ratio involved in the use of cannabis. These studies distinguish between drivers who are responsible for accidents and those who are not. The former are the subjects and the latter the control group. Comparisons are then made of their intoxication to various substances. Clearly, placing drivers into the two categories of responsible/not responsible may depend on an investigator's perception of whether or not psychoactive substances are present.

The following table, which is reproduced from the Ramaekers et al. report (2002) for the International Scientific Conference on Cannabis summarizes the results of various studies.[22] It should be pointed out that the probability of responsibility for drivers showing traces of cannabis (Δ^9THC and/or Δ^9THC–COOH, whether measured in blood or urine) is compared to the responsibility of drivers involved in an accident not testing positive to any substance (including alcohol). The risk ratio for drivers not testing positive to any substances is 1.0 and is used as a point of comparison to determine the statistical significance of observed change in the risk level of impaired drivers. When the reference value is above the statistical confidence level of 95%, the obvious conclusion is that the drug is 95% associated with an increased risk of responsibility.

Level of culpability relative to driving under the influence of cannabis				
Authors	Substance	Odds ratio	Confidence interval at 95%	N of drivers culpable / not culpable
Terhune & Fell (1982), U.S.	Drug free cases	1.0		94/179
	Alcohol	5.4*	2.8 – 10.5	45/16
	THC	2.1	0.7 – 6.6	9/8
	Alcohol/THC	-		-
Williams et al. (1985), U.S.	Drug free cases	1.0		55/23
	Alcohol	5.0	2.1 – 12.2	120/10
	THC or THC-COOH	0.2	0.2 – 1.5	10/9
	Alcohol/THC or THC-COOH	8.6*	3.1 – 26.9	123/6

[21] Cohen, P.D.A. et H.L. Kaal (2001) *The Irrelevance of Drug Policy. Patterns and careers of experienced cannabis use in the populations of Amsterdam, San Francisco and Bremen.* Amsterdam: University of Amsterdam, CEDRO, page 68.

[22] Ramaekers et al. (2002), op.cit., page73.

Terhune et al. (1992), U.S.	Drug free cases	1.0		541/258
	Alcohol	7.4*	5.1 – 10.7	587/38
	THC	0.7	0.2 – 1.8	11/8
	Alcohol/THC	8.4*	2.1 – 72.1	35/2
Drummer (1994), Australia	Drug free cases	1.0		392/140
	Alcohol	5.5*	3.2 – 9.6	261/17
	THC-COOH	0.7	0.4 – 1.5	29/14
	Alcohol/THC-COOH	5.3*	1.9 – 20.3	59/9
Hunter et al. (1998), Australia	Drug free cases	1.0		944/821
	Alcohol	6.8*	4.3 – 11.1	173/22
	THC			
	➢ £ **1.0 ng/ml**	0.35	0.3 – 2.1	2/5
	➢ **1,1 – 2,0 ng/ml**	0.51	0.2 – 1.4	7/12
	➢ > **2 ng/ml**	1.74	0.6 – 5.7	12/6
	THC-COOH			
	➢ **1 – 10 ng/ml**	0.69	0.5 – 2.2	19/24
	➢ **11 – 20 ng/ml**	1.04	0.4 – 2.1	18/15
	➢ **21 – 30 ng/ml**	0.87	0.6 – 4.8	12/12
	➢ > **30 ng/ml**	1.62	0.6 – 4.8	13/7
	Alcohol/THC	11.5*	4.6 – 36.7	66/6
Lowenstein & Koziol-McLain (2001), U.S.	No substance	1.0		114/126
	Alcohol	3.2	1.1 – 9.4	17/6
	THC-COOH	1.1	0.5 – 2.4	17/17
	Alcohol/THC-COOH	3.5*	1.2 – 11.4	16/5
Drummer et al. (2001) & Swann (2000), Australia	No substance	1.0		1209/372
	Alcohol	5.7*	4.1 – 8.2	720/39
	THC	3.0*	1.2 – 7.6	49/5
	THC > 5 ng/ml	6.4*	1.3 – 115.7	24/0
	THC-COOH	0.8	0 – 1.3	68/26
	Alcohol/THC	19*	2.6 – 136.1	65/62

The study findings show that cannabis alone does not increase the likelihood of responsibility in an accident. However, most of the studies used a measurement of THC-COOH, an inactive metabolite that can remain in urine for several days. When the authors separated out THC alone, the risk ratio was slightly higher, even though it did not reach the required level of significance. In addition, as the concentration of THC increases, the more the ratio increases, once again suggesting a dose-response relationship. Furthermore, the cannabis and alcohol combination significantly increases risk. Without being able to draw any definite conclusions, there are some signs that their effects are in synergy and not merely additive.

Studies on injured drivers (Terhune (1982) and Hunter (1998)) have ratios somewhat higher than in the other studies on fatal accidents. According to Bates and Blakely (1999), the apparent reduction in the risk of a fatal accident stems from the fact that drivers under the influence of cannabis drive less dangerously, for example by reducing their speed.[23]

To conclude, we are rather in agreement with INSERM concerning these studies:

> [translation] *The findings definitely confirm the significant risk of alcohol, but generally fail to demonstrate that there is an effect of cannabis alone on the risk of being responsible for a fatal accident or an accident involving serious injury. The methodological difficulties that make such a demonstration difficult contribute considerably to the absence of statistically indisputable results. Analyses of responsibility nevertheless suggest that the association between alcohol and cannabis increases the risk of being responsible for an accident, compared to drinking alone; however, this finding needs to be consolidated. Lastly, the most recent data tend to show that there is a risk of becoming responsible at heavy concentrations of D^9THC. This involves using cannabis immediately before driving, and perhaps applies also to chronic users.* [24]

EXPERIMENTAL STUDIES

Epidemiological studies indicate a relatively high level of driving under the influence of cannabis, between 5% to 12% of drivers, mostly among young men. At the same time, neither these studies nor the responsibility/risk analyses reach clear conclusions concerning the role of cannabis in dangerous driving. Hence the interest in studies on how cannabis affects driving ability and driving itself. Studies on the psychomotor and cognitive skills needed to drive vehicles have measured factors such as: motor coordination, reaction time, attention, visual attention and deductive reasoning. There are two types of studies on driving: simulated studies and field studies, whether on a track, in the city or on a highway. Most studies focus on single doses for recreational users. They use control group protocols and cross-linked protocols, including placebos and comparisons with alcohol. However, they are limited by the fact that they mainly measure the acute effects of single doses, making it difficult to determine whether more experienced users would react in the same way. The following sections examine both types of study.

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[23] Cited in INSERM (2001), *op. cit*., page 192.
[24] INSERM (2001), *op. cit*., page 194.

Non-driving activities

In 1985, Moskowitz published a remarkable synthesis of studies on the psychomotor and cognitive effects of cannabis.[25] In this synthesis, he examined motor coordination, reaction time, tracking and sensory functions. The author observed the following:

- motor coordination, measured by hand stability, body balance and movement accuracy was significantly affected. However, the application of these results to driving a car is limited, except in driving situations that require considerable coordination, such as emergency situations. The limits in terms of dose and number of subjects tested (between 8 and 16) also need to be noted
- reaction time was not significantly changed: "*There are a sufficient number of experiments involving both simple and complex reaction time situations to leave us relatively well assured that neither the speed of initial detection nor the speed of responding are, per se, impaired by marihuana. Rather, when marihuana produces a reaction time increase, there is some dimension of the information processing task which the subject must execute which bears the brunt of the experiment.*"[26] Attention rather than reaction time was affected by marijuana use
- straight line: this dimension was particularly sensitive to the effects of marijuana, and the vast majority of studies showed a significant reduction in the ability to go in a straight line or correct deviations from the line
- the sensory functions (hearing and visual) are often affected, but the studies did not yield precise results concerning the distinction between simple tasks and complex tasks.

Ramaekers et al. (2002), reported a meta-analysis on 87 controlled laboratory studies on the psychomotor effects of cannabis conducted by Berghaus et al. (1998). These authors found that the number of psychomotor functions linked to driving (following, reaction time, perception, hand-eye coordination, body balance, signal detection and divided and continuous attention) affected by THC reached a maximum during the first hour after smoking, and one to two hours after oral ingestion. The maximum figures were comparable to those obtained with an alcohol concentration equivalent to > 0.05 g/dl. The number of functions affected reached zero after three to four hours, and only higher doses continued to have an effect. The studies surveyed also showed that THC concentration in the blood is highly correlated to psychomotor effects: a concentration of between 14 ng/ml and 60 ng/ml affected between 70% and 80% of tasks.[27]

The following table summarizes these data:

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[25] Moskowitz, H., (1985) "Marihuana and Driving." *Accid. Anal. Prev.*, 17 (4), pages 323-345.
[26] *Ibid*., page 330.
[27] Ramaekers J.G. et al. (2002), *op. cit*., page 77.

Deterioration of performance on psychomotor tests by dose, time and method of ingestion										
THC dose	**Time (in hours)**									
	< 1		**1-2**		**2-3**		**3-4**		**4-5**	
	Tests (n)	% affected	Tests (n)	% affected	Tests (n)	% affected	Tests (n)	% affected	Tests (n)	% affected
Smoked										
< 9mg	271	61%	33	36%	10	30%	10	0%	11	0%
9 – 18 mg	193	53%	48	38%	8	38%	6	0%	2	0%
³ 18 mg	64	64%	28	36%	10	40%	15	53%	3	67%
Total	528	58%	109	37%	28	36%	31	26%	16	13%
Oral										
< 9mg	3	33%	49	14%	37	8%	13	8%	-	-
9 – 18 mg	3	0%	41	39%	45	18%	17	18%	-	-
³ 18 mg	3	0%	45	60%	15	33%	15	33%	11	45%
Total	9	11%	135	37%	97	20%	45	20%	11	45%

More recently, after surveying the studies carried out in recent years, the reports prepared by INSERM and the International Scientific Conference on Cannabis reached largely similar conclusions: cannabis affects reaction time where choice is involved, road tracking, shared attention and continuous attention, as well as memory processes, but does not significantly affect simple reaction time or visual or eye-movement functions.

While driving

One of the weaknesses of the laboratory studies is the difficulty of relating psychomotor and cognitive tasks directly to driving. Several tests measured in these studies are short and relatively simple and do not necessarily reflect real situations. The advantage of simulated driving studies and field driving studies is that it brings the conditions closer to reality.

Most contemporary studies have similar characteristics: subjects have had a driver's licence for at least three years. They are often regular cannabis users. The subjects receive either cannabis or a placebo in a double-blind situation that is very strictly timed to control the level of THC transmitted. In some instances, the experimenters also include comparisons with alcohol and an alcohol placebo. However, it is impossible to control how much subjects inhale and actually absorb. The cannabis prepared by the U.S. National Institute of Drug Abuse (NIDA) varies between 1.75% THC for low doses, 2.67% for moderate doses and 3.95% for strong doses. Converted into µg/kg of weight, the doses correspond to 100, 200 and 300 µg/kg, whereas the heavy dose usually preferred by regular users is generally 308 µg/kg. The subjects are

familiarized with the equipment used and the tasks to be performed, and are accompanied by instructors on actual driving studies. Measurements include the standard deviation of lateral position in relation to the road, the control over longitudinal position (distance) in relation to the vehicle ahead, decision-making in emergencies, style of driving and risk taking.

The following table, adapted from INSERM data, summarizes a number of the more recent studies.

Effects of cannabis on car driving[28]				
Reference / environment	**Subject / Dose / Protocol**	**Tasks**	**Measurements**	**Results**
Simulator				
Liguori et al., 1998	10 users Placebo Cigarette 1.77% THC smoked in 5 mn Cigarette 3.95% THC smoked in 5 mn Test: 2 mn after Duration: 1 hour	Avoid a barrier that suddenly appears by braking (55 to 60mph)	Total braking time	? Slightly significant at 1.77 THC, slightly more at 3.95
			Lag time to take foot off accelerator and step on brake	No difference
		Judgment: maintain speed of 30mph on marked road and select widest lane at intersection	Average speed Number of cones knocked over Number of successful choices	No effect
Sexton et al., 2000	15 users Placebo Grass, low dose 1.77% THC Heavy dose: 2.67% THC 1 resin cigarette: 1.70% THC Blood and saliva sample 10 mm after start Test 30 mn Duration: 25 mn	Highway section with vehicle ahead passing	Average reaction time	? At low dose (high level of variability at heavy dose: ns)
		Highway section with vehicle ahead braking	Average reaction time	? At low dose (ns)
		16.7 km of highway section	Maximum, minimum and average speed	? Average of 6mph at low and heavy dose
		Left and right turns	Standard deviation for perfect line	? Variation at heavy dose versus low dose or placebo
		Intersection with traffic lights, with 4 lane road	Response time in going through amber	? At heavy dose

[28] Table adapted from INSERM (2001) *op. cit.*, pages 183-184.

Effects of cannabis on car driving[28]				
Reference / environment	**Subject / Dose / Protocol**	**Tasks**	**Measurements**	**Results**
			Average waiting period at a point 10m from the stop line	? At heavy dose (high level of variability: ns)
Actual driving				
Robbe, 1998 study No. 1 Closed portion of highway (cannabis)	24 users Placebo 100, 200 and 300 Test: 40 mm and 1 hour 40 mm after	Constant speed at 90km/hr and tracking over 22km	Standard deviation of lateral position	? Instability at all 3 doses
			Average lateral position deviation	No effect
			Average speed and standard deviation	No effect
Study No. 2 Normal traffic on highway (cannabis)	16 users same doses as study 1 Test: 45 mn after	Tracking control (Ibid.) 64km, 50 mn	Same measurements	Same effects
		Following cars over 50m at variable speed (between 80 and 100km/h) over 16 km, 15 mn	Average reaction time	? ns
			Average distances and standard deviations	Distance increased by 8, 6 and 2 m for 100, 200 and 300 THC
Study No. 3 City driving (cannabis)	16 users Placebo 100 Test: 30 mn after	City driving 17.5 km Dense, moderate or light traffic	External observations	No significant change
			Internal observations: skill, manoeuvres, turns…	No effect
Study No. 3 City driving (alcohol)	16 users Placebo Alcohol level: 0.5 g/l	Ditto	External observations	No significant change
			Internal observations: skills, manoeuvres, turns…	0.34 g/l alcohol level modifies control and manoeuvres
Robbe, 1998 Highway driving (cannabis and alcohol)	18 users THC: 100, 200 Alcohol: 0.4 g/l Preparation: Alcohol 0 + THC 0 Alcohol) + THC 100 Alcohol 0 + THC 200 Alcohol 0.4 + THC 0 Alcohol 0.4 + THC 100	Tracking: speed at 100km and constant lateral position	Standard deviation of lateral position	? Tracking variability; low alcohol alone, THC 100 alone; Moderate: THC 200 Heavy: alcohol 0.4 and THC two doses

Effects of cannabis on car driving[28]				
Reference / environment	**Subject / Dose / Protocol**	**Tasks**	**Measurements**	**Results**
	Alcohol 0.4 + THC 200 Alcohol plus cannabis 60 mn after Tests between 9:00 p.m. and 11:15 p.m.	Following: follow a vehicle over 50 m with speed varying by ± 15km/hr every 5mn	Reaction time	? Reaction time for 0.4 alcohol and THC 200
		Driving in traffic	Average distances and standard deviations	? Variability in distance between cars in all cases
Lamers and Ramaekers, 2000 City driving (cannabis and alcohol)	16 users THC 100 Alcohol 0.5 g/l 4 preparations: Alcohol 0 + THC 0 Alcohol 0.5 + THC 0 Alcohol 0 + THC 100 Alcohol 0.5 + THC 100 Tests: 15 mn after Duration: 45 mm	City driving 15 km	Frequency of appropriate eye movements	No effect with alcohol alone or cannabis alone
		Visual search monitoring	Quality of driving	? Performance if alcohol + cannabis No effect

It is interesting to recall that one of the first driving studies on the road was conducted for the Le Dain Commission.[29] In this study, on a closed track, 16 subjects were each given the 4 following preparations: placebo, marijuana 21 and marijuana 88 µg/kg THC and a dose of alcohol equivalent to BAC 0.07. The tests were conducted immediately after use and three hours later. The subjects were to complete six circuits of the track (1.8 km) with manoeuvres involving slowing down while going forward and backwards, maintaining a trajectory and weaving through cones. The alcohol and heavy dose of marijuana decreased driver performance in tests conducted immediately after use. At the heavy cannabis dose, drivers drove more slowly. On the second test, the differences were less clear.

When the results of this study are compared to those conducted more recently using much more sophisticated methods, it can be seen that the results are remarkably similar.[30] Thus the following was observed:

- lateral control: this is the variable that is most sensitive to the effects of THC, but the effects are variable, depending on the dose and time; only heavy doses significantly affected lateral control over the vehicle. In comparison,

[29] See Hansteen, R.W, et al. (1976) "Effects of cannabis and alcohol on automobile driving and psychomotor tracking." *Annals of the New York Academy of Science*, 282, pages 240-256.

[30] See notably the survey of studies and the discussion in Smiley, A., (1999) "Marijuana: On-Road and Driving Simulator Studies" in Kalant, H. et al., (ed) *The Health Effects of Cannabis.* Toronto: Addiction Research Foundation, pp. 173 passim.

alcohol has a greater effect on vehicle lateral control and speed (linked variables)

- speed control: in almost all cases, the use of cannabis significantly decreases speed
- risk-taking: in addition to decreasing speed, it is generally found that there is an increase in distance between vehicles among marijuana users, and less of a tendency to pass or attempt dangerous manoeuvres
- decision time: this variable is particularly important in actual driving situations. The results do not appear to be very consistent. Smiley suggests that reaction time is unaffected when the subjects are told that they need to respond rapidly, whereas on the other hand, when the obstacles are completely unexpected, the subjects who used cannabis do not perform as well
- combined effects of alcohol and cannabis: when the researchers checked the effects of the two substances, the combined effects of cannabis and alcohol were systematically greater than alcohol alone or, even more so, than cannabis alone.

Lastly, with low doses, subjects had the impression that their driving was not as good as observers felt it was, which was not necessarily the case with higher doses, where the perceptions of both the drivers and the observers agreed.

CONCLUSIONS

The Committee feels it is likely that cannabis makes users more cautious, partly because they are aware of their deficiencies and they compensate by reducing speed and taking fewer risks. However, because what we are dealing with is no longer the consequences on the users themselves, but the possible consequences of their behaviour on others, the Committee feels that it is important to **opt for the greatest possible caution** with respect to the issue of driving under the influence of cannabis. Given what we have seen in this chapter, we conclude the following.

Conclusions of Chapter 8	
Epidemiological data	➢ **Between 5% and 12% of drivers may drive under the influence of cannabis; this percentage increases to over 20% for young men under 25 years of age.** ➢ **This in itself does not mean that drivers under the influence of cannabis represent a traffic safety risk.** ➢ **A not insignificant percentage of drivers test positive for cannabis and alcohol together.**

Data on effects on driving	➢ **Cannabis alone, particularly in low doses, has little effect on the skills involved in automobile driving.** ➢ **Cannabis, particularly in the doses that match typical doses for regular users, has a negative impact on decision time and trajectory.** ➢ **Cannabis leads to a more cautious style of driving.** ➢ **The effects of cannabis when combined with alcohol are more significant than for alcohol alone.**
Testing	➢ **Blood remains the best medium for detecting the presence of cannabinoids.** ➢ **Urine cannot screen for recent use.** ➢ **Saliva is promising, but rapid commercial tests are not yet reliable enough.** ➢ **The visual recognition method used by police officers has yielded satisfactory results.**
Further studies	**It is essential to conduct studies in order to:** ➢ **Develop a rapid testing tool.** ➢ **Learn more about the driving habits of cannabis users.**

CHAPTER 9

USE OF MARIJUANA FOR THERAPEUTIC PURPOSES

There has been renewed interest in the issue of the use of marijuana for therapeutic purposes in recent years, particularly in Canada. In the wake of an Ontario Court of Appeal ruling which found the provisions of the *Controlled Drugs and Substances Act* to be unconstitutional pertaining to the therapeutic use of marijuana, the federal Health Minister made new regulations in July 2001 that give people with specified medical problems access to marijuana under certain conditions. Later that same year, an international conference on medicinal cannabis held in The Hague, Netherlands, drew delegates from Canada and several other Western countries.[1] Earlier, in 1999, the National Institute of Medicine in the United States published an assessment of the science base of marijuana and medicine.[2]

However, the scientific community – the medical community in particular – is divided on the real therapeutic effectiveness of marijuana. Some are quick to say that opening the door to medical marijuana would be a step toward outright legalization of the substance. Witness the following two quotes, the first of which is from a former director of the National Institute on Drug Abuse (NIDA) in the United States:

> *It is primarily the political muscle of the marijuana legalization proponents that today creates the motivation to do additional research on marijuana smoke. […] There is one explanation for the strident insistence of marijuana legalization proponents that only smoked marijuana will do as 'medicine'. They appear to be determined to have sick medical patients smoking marijuana in the public eye. They want that outcome because that act legitimizes the use of marijuana by changing the common public perception of marijuana from a harmful drug to a useful medicine.* [3]

> *Although many who champion medical marijuana use do so on compassionate grounds, with the firm conviction that smoked marijuana provides benefits unavailable by other means, much support comes from those who advocate the liberalization of drug policy and the decriminalization of drug use.* [4]

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[1] *International Conference on Medicinal Cannabis*, November 22-23, 2001, The Hague, Netherlands.

[2] Joy, J.E., S.J. Watson and J.A. Benson (1999) (eds.), *Marijuana and Medicine: Assessing the Science Base.* Washington, D.C.: National Academy Press.

[3] DuPont, R.L. (1999), "Examining the Debate on the Use of Medical Marijuana", *Proceedings of the Association of American Physicians*, Volume 111, No. 2, page 169.

[4] Rosenthal, M.S., and H.D. Kleber (1999), "Making Sense of Medical Marijuana", *Proceedings of the Association of American Physicians*, Volume 111, No. 2, page 159.

It is true, as Professor Mark Ware pointed out in his testimony before the Committee, that in the current legal and political context, it is difficult to conduct studies and, more importantly, do so without being influenced by the heated debate over marijuana.

> *Let us look at the effect that current drug policy has had on our understanding of cannabis. All our data on the health effects of cannabis have been collected under a paradigm of prohibition. This may seem self-evident but it constitutes an important source of bias. In examining the health effects of cannabis, an estimate of the use of cannabis in the healthy population is important. […] Surveys of illicit drug use are notorious for poor response rates. It hampers our ability to draw conclusions on what cannabis does, if we don't really know who is doing it. It is important to estimate the size of the bias, and the effect it has had, and good research will always try to minimize it. However, in my experience of critically reviewing the literature on cannabis effects on health, examples exist where important estimates of risk are based on studies which have inappropriate control selection. […] The question therefore changes from 'how has cannabis policy affected health?' and becomes 'has cannabis policy affected our understanding of the health effects of cannabis?'* [5]

It is also true that the issue of medicinal marijuana challenges us on the very concept of modern medicine and its links with the pharmaceuticals industry, since research on cannabinoids has already led to the development of synthetic THC compounds. Drug companies are known to have played a major role in international negotiations leading to the adoption of the first international conventions on the control of psychoactive substances.[6] Moreover, the marijuana plant itself, because it cannot be patented, is of no interest to major pharmaceutical research groups.

Beyond the scientific "proof" that marijuana is effective and the prospect of physicians prescribing marijuana with sufficient confidence, many people believe, based on personal experience, that marijuana has a direct impact in terms of improving their well-being with minimum adverse effects. That view is what led to the creation of "compassion clubs", organizations that distribute marijuana to growing numbers of clients. One of the questions this raises is how much evidence is needed before people can be allowed to freely use marijuana to relieve a medical condition. Indeed, do we have to think of marijuana in strictly medical terms?

We saw in Chapter 7 that the long-term effects of using marijuana, even on a regular basis, are limited and that even the most serious effects, such as lung cancer, have yet to be clearly demonstrated. We also saw that the adverse effects of prolonged use on cognitive function are more prevalent in people who are already vulnerable because of their young age when they started using, for example, or their personal condition (for example, psychotic predispositions). We also saw that, even assuming

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[5] Dr. Mark Ware, Assistant Professor of Family Medicine and Anesthesia, McGill University, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, May 31, 2002.

[6] See in particular the study by W.B. McAllistair, *Drug Diplomacy in the 20th Century*. This point will be discussed later in chapter 19.

some tolerance and a certain level of psychological dependency, those effects are minor, the signs of withdrawal minor, and treatment shorter and less often necessary than for other drugs. To a degree, it appears that the psychoactive properties of marijuana, which some see coupled with rejection of society, others with a weak personality and still others with immoral behaviour, make the substance suspect, whether in medical or non-medical applications.

In that sense, the issue of medical marijuana is not so much a question of legalization through the back door as it is a question of open examination of each person's underlying conception of the "drug". In a way, it is a prime opportunity to explore our preconceptions and prejudices. Stating, as we did in Chapters 6 and 7, that the psychological, physiological or social effects of marijuana use are by all indications relatively benign says nothing about the therapeutic benefits of the plant in the same way that medical uses of the poppy say nothing about the individual or social harm that can be caused by heroin. Dr. Kalant echoed this view:

> *The separation of the control methods between medical and non-medical use is generally clearly understood. Both heroin and cocaine have limited but recognized medical uses. […] Yet, nobody argues that, because these drugs have some limited medical use, that they should therefore be legalized for non-medical use. […] Cannabis is perhaps the one exception in which possible medical uses are often claimed by some proponents of legalization of cannabis as a justification for legalization for non-medical use. This to me seems quite irrational. There is no logical reason why having a medical use should be any argument at all, either for or against, availability for non-medical use.* [7]

However, as Dr. Ware reiterated, "*the safety of cannabis in humans has been extensively studied, thanks in part to the massive Western cohort of 'healthy human volunteers' of the last 40 years. Cannabis may have undergone the most extensive and unorthodox Phase I clinical trials of any drug in history*."[8] While it is true that research protocols to allow medical use of a substance are and must remain rigorous, there is no clear boundary between the two areas of research. This was illustrated to some extent in the review in Chapter 7 of studies on the effects and consequences of marijuana. Indeed, the opposite approach struck us as more common, where, based on the presumed harmful effects of marijuana on psychological and physical health, the therapeutic usefulness of marijuana becomes at least suspect. We take as an example the position of the Canadian Medical Association.

In his testimony before the Commission, current CMA president Dr. Henry Haddad said:

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[7] Dr. Harold Kalant, Professor Emeritus at the University of Toronto, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, June 11, 2001, Issue 4, pages 70-71.

[8] Dr. Mark Ware, *op.cit.*

While our understanding of all the possible long-term health effects that prolong Canada's use is still evolving, what we do know is troubling. The health risks range from acute effects such as anxiety, dysphoria, or the feeling of being ill; cognitive impairment to the chronic effects such as bronchitis, emphysema and cancer. Canada's youth have also been subject to pulmonary damage comparable to that produced by tobacco use but the effects are much more acute and rapid. Evidence suggests that smoking two or three cannabis cigarettes a day has the same health effect as smoking 20 cigarettes a day. Therefore, the potential long-term health effects of cannabis use could be quite severe.

The CMA's concerns regarding the impact of cannabis are in part why we are opposed to the federal government's current medical marijuana access regulations. In our May 7, 2001, letter to the Minister of Health, the CMA noted 'lack of credible information on the risks and benefits of medical marijuana.'

During discussions on the government's medical marijuana regulations, we highlighted the health concerns and research that indicates that "marijuana is an addictive substance that is known to have psychoactive effects and in its smoke form is particularly harmful to health."

We have concluded that while benefits of medical marijuana are unknown, the health risks are real. Therefore, it would be inappropriate for physicians to prescribe marijuana to their patients, a position that was supported by the Canadian Medical Association.

[…]

The CMA is concerned that this debate concerning decriminalization and the medical marijuana issue has, to some extent, legitimized its use for recreational purposes. It is important that our message to you regarding decriminalization be clear and understood. Decriminalization must be tied to a national drug strategy that promotes awareness and prevention and provides for comprehensive treatment in addition to research and monitoring of the program.

[…]

The CMA believes that any changes regarding illegal drug policy should be gradual. Like any other public health issue, education and awareness of the potential harms associated with cannabis and other illegal drug use is critical to reducing drug usage. [9]

If we were to succeed in showing that the effects are not as bad as had been thought, would it change in any way the issues related to medical use of marijuana? The acute effects identified by the CMA are possible but relatively rare and often the product of personal predispositions, context or a particular crop of marijuana. In fact, the primary acute reactions, the reactions documented by most of the research, are pleasant and help the user relax. If we were to convince the medical association that marijuana is not particularly addictive and that even where it is, the effects are relatively benign, would that clear the way for medical use of marijuana? Aside from the fact that

[9] Dr. Henry Haddad, President, Canadian Medical Association, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, March 11, 2002, Issue 14, pages 52-53 and 54-55.

marijuana is only tenuously linked to "drug addiction", there is by no means consensus in the scientific community on the very notion of drug addiction, viewed primarily as a disease.

The question lies elsewhere – in two places, in fact. First, knowledge of the potentially harmful effects of marijuana says nothing about the qualities of the plant as a medicine. To be sure, knowledge of the secondary effects of drugs, including their addictive potential, is essential to the pharmacopoeia. However, those substances must first be established as drugs, particularly in terms of effectiveness and reliability. Second, the whole issue is broached as if resistance to medical use of marijuana were based not so much on the absence of medical knowledge *per se* – which is the case to some extent, as we will see later in this chapter – as on the link between marijuana and drug addiction. From that perspective, the issue is quickly resolved: in keeping with the medical maxim *"first do no harm"*, a physician will not prescribe a treatment the effects of which could lead to an illness at least as serious as the illness being treated in the first place. If marijuana is listed as an illegal drug, banned in some contexts because of its harmful effects and capable of leading to drug addiction, what compelling arguments could be put forward to "save" medical marijuana?

But none of that should matter to physicians or scientists. It is not a question of defending general public policy on marijuana or even all illegal drugs. It is not a question of sending a symbolic message about "drugs". It is not a question of being afraid that young people will use marijuana if it is approved as a medicine. The question – the only question – for physicians is whether, to what extent and in what circumstances, marijuana serves a therapeutic purpose. Physicians would have to determine whether people with certain diseases would benefit from marijuana use and weigh the side effects against the benefits. If they decide the patient should use marijuana, they then have to consider how he or she might get it. The issue of deciding whether cannabis has therapeutic benefits is obviously clouded by the current legal context on cannabis. This may be inevitable, but those who take public positions on cannabis for therapeutic purposes should say so.

The rest of this chapter is devoted to the history of the use of marijuana for therapeutic purposes and the status of contemporary knowledge of marijuana and synthetic cannabinoids. We then give a brief account of compassion clubs and other organizations that supply marijuana for therapeutic use, as well as various public policy regimes. We conclude with our views on medical use of marijuana. In a later chapter, we discuss which public policy regime would be most appropriate given the status of medical use of marijuana.

HISTORY

The therapeutic potential of marijuana has apparently been known since the beginning of recorded history. In fact, marijuana was likely used for medicinal purposes even before its psychoactive properties were tapped.

The medical history of marijuana is closely related to its analgesic properties, as noted by Ethan Russo:

> *Cannabis has a history as an analgesic agent that spans at least 4000 years, including a century in mainstream Western medicine. […] The reasons lie in the remarkable pharmacological properties of the herb and new scientific research reveals the inextricable link that cannabinoids possess with our own internal biochemistry. In essence, the cannabinoids form a system in parallel with that of the endogenous opioids in modulating pain. More important, cannabis and its endogenous synthetic counterparts may be uniquely effective in pain syndromes in which opiates and other analgesics fail.*[10]

According to Russo, written documents and ethnographic traces of medical use of marijuana have been found in many countries. In China, a second-century medical paper reported that marijuana was used as a surgical anaesthetic. In India, marijuana was been used to treat migraines and chronic pain 2000 B.C. In Egypt, where most scholars thought that marijuana had not been introduced, there is evidence that it had been in use in medicine since the days of the pharaohs; traces of marijuana were found in the tombs of Amenophis IV and Ramses II. Marijuana was apparently used to treat glaucoma and labour pain. Marijuana was administered orally, rectally or vaginally, applied to the skin, inserted in the eyes and smoked.

In Assyria, Babylonia and Arcadia, marijuana was apparently used as an analgesic to treat migraines and menstrual pain and for its psychoactive properties. Evidence of marijuana use to control labour pain has also been found in Palestine and Israel. The Greeks and Romans used marijuana for general pain control and specifically for gout and rheumatism. In the Muslim world, there are references to therapeutic use dating back to the ninth century.

In the mid 17th century, western medicine discovered the medicinal properties of marijuana. A compendium of plants published in 1640 in England made reference to marijuana being used in the form of a paste containing essence from the plant and other ingredients. In France, the work on hemp published by Mercandier described a number of uses: dried and applied as a plaster, it eased the pain associated with tumours; boiled and applied as a plaster, it helped ease the pain of rheumatism, gout and various muscle inflammations; crushed into a powder and mixed with butter, it

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[10] Russo, E.B. (2002), "The role of cannabis and cannabinoids in pain management", in Weiner, R.S. (ed.), *Pain Management. A Practical Guide for Clinicians*, Boca Raton, London, New York, Washington: CRC Press.

soothed burns. In his classification of plants, Linnée recognized the medicinal properties of marijuana as a pain reducer.

Medical use of marijuana became more widespread in England in the middle of the 19th century when the plant was brought back from India. Even the personal physician of Queen Victoria, Russell Reynolds, used it: he treated his celebrated patient for dysmenorrhea throughout her adult life using cannabis extract. In an 1868 paper, he wrote that unlike opiates, marijuana could be used today without causing problems tomorrow.[11]

Between 1890 and 1940, English, Irish, French and then American physicians and pharmacists testified in different ways to the usefulness of various marijuana preparations in relieving pain. One British pharmacologist even reintroduced the smoking of marijuana in 1899, pointing out that smoking was particularly useful if an immediate effect was desired.[12]

Marijuana is still part of the pharmacopoeia, at least informally, of many countries in southeast Asia. Marijuana use in India was recently described as follows:

> *Charas is the resinous exudation that collects on the leaves and flowering tops of plants (equivalent to the Arabic hashish); it is the active principle of hemp; it is a valuable narcotic, especially in cases where opium cannot be administered it is of great value in malarial and periodical headaches, migraine, acute mania, whooping cough, cough of phtisis, asthma, anaemia of brain, nervous vomiting, tetanos, convulsion, insanity, delirium, dysuria, and nervous exhaustion; it is also used as an anaesthetic in dysmennorhea, as an appetizer and aphrodisiac, as an anodyne in itching of eczema, neuralgia, severe pains of various kinds of corns, etc.* [13]

It is also used in Colombia, Jamaica and Brazil.

It is tempting, of course, enamoured as we are with our modern science, to dismiss these traditional uses as “home remedies” – and the stuff of quacks. However, the fact that marijuana has been used so long for the same types of condition, that it has sometimes been described so accurately, that it has transcended cultures and histories, and that modern medicine suggests that marijuana could in fact be useful in treating the chronic pain associated with various medical conditions should stop us from being too cynical about these “old-fashioned” uses.

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11 Quoted in Russo, *op. cit.*, page 359.
12 *Ibid.*, page 360.
13 *Ibid.*, page 361.

CONTEMPORARY KNOWLEDGE

Two questions strike us relevant here. The first is whether marijuana in fact has the therapeutic effects that have been ascribed to it traditionally and more recently in the personal stories of people suffering from chronic pain and other conditions. If those benefits are real, the second question, altogether different and based on different criteria, is whether marijuana should be considered a drug.

Therapeutic uses

Knowledge of the mechanics of cannabinoids and the endogenous cannabinoid system allows a number of observations to be made. Generally, and bearing in mind what was written in Chapter 5, the action of cannabinoids can be described as follows:

> *[…]the overall effect is that of a cellular inhibition rather than cellular activation. It settles down nerve firing through a number of different types of reactions, primarily through changes that lead to changes in the flow of ion channels, which changes the firing behaviour of the cell which then changes how it communicates with other cells down the line.*
>
> *Opening of potassium channels with decreased cell firing and closing of calcium channels with decreased release of neurotransmitters or overall cellular inhibition, which quiets things down. Those could have major therapeutic implications in certain clinical situations, such as pain and spasticity. They have implications in settling down nerve firing within pain conducting systems.* [14]

More specifically, cannabinoids act on various neurophysiological systems associated with pain, either alone or in combination with the endogenous opiate system.[15] Cannabinoids affect the release of serotonin, which is itself associated with different types of pain, migraines in particular. Anandamide and other cannabinoid antagonists block the release of serotonin and ketanserin, both of which are linked to migraines, suggesting the potential effect of THC. Cannabinoids are also related to the dopamine system, which has been linked with migraines and other types of pain. Further, cannabinoids inhibit prostaglandin, producing an anti-inflammatory effect. Some studies have shown that THC is in that sense a more powerful analgesic than aspirin or even cortisone. Interacting with the endogenous opioid systems, cannabinoids increase the production of beta-endorphins, which reduce the effect of migraines. According to some studies, THC may have greater therapeutic potential than

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[14] Dr. Mary Lynch, Director, Canadian Consortium for the Investigation of Cannabinoids, Professor, Dalhousie University, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, June 11, 2001, Issue 4, page 49.

[15] The following information is taken primarily from Russo, *op. cit.*, Hartel, C.R., "Therapeutic Uses of Cannabis and Cannabinoids", in Kalant, H. (ed.), *The Health Effects of Cannabis*, Toronto: Addiction Research Foundation, and INSERM (2001), *op. cit.*

morphine, either because the applications would be more specific in some cases, because in other cases morphine aggravates some symptoms, or because THC lacks the sedative properties of morphine. Moreover, THC may have an antinociceptive effect on the periaqueductal grey. Finally, THC acts as a glutamate blocker and thereby reduces muscle and inflammatory pain.

> *Italian researchers Nicolodi, Sicuteri and colleagues have recently elucidated the role of NMDA antagonists in eliminating hyperalgesia in migraine, chronic daily headaches, fibromyalgia, and possibly other mechanisms of chronic pain. Gabapentin and ketamine were suggested as tools to block this system and provide amelioration. Given the above observations and relationships, it is logical that prolonged use of THC prophylactically may exert similar benefits, as was espoused in cures of chronic daily headache in the 19th century with regular use of extract of Indian hemp.* [16]

In real terms, these mechanisms mean that cannabinoids can be beneficial in a number of situations that involve pain, but not pain alone The following are foremost among them.

- **Emisis**: Nausea is a common condition in cancer patients undergoing chemotherapy. As a result of a series of clinical trials involving people who reported using marijuana to relieve their vomiting, synthetic dranobinol (or Marinol) and nabilone (or Cesamet) were developed and tested primarily in the United States and Great Britain beginning in the 1970s. According to Dr. Lynch, *"cannabinoids are thought to be modest antiemetics. There are more effective antiemetic agents available. However, because antiemetics work through a number of different mechanisms and because often we need to be able to target more than one mechanism to treat nausea and vomiting, cannabinoids are looking like they may be useful because they may offer us another option."*[17]

- **Cachexia**: A significant number of people with AIDS/HIV suffer progressive anorexia coupled with weight loss. Some studies show that cannabinoids can help improve their situation, mainly because THC increases appetite. Some reservations have been voiced regarding the harmful effects of smoked THC on the immune system: *"More recently, Nieman et al (1993) have shown that cigarette smoking by HIV seropositive individuals is associated with a more rapid development of AIDS because smoking increases the incidence of Pneumocystis carinii pneumonia (PCP)."*[18] Others, however, have come to different conclusions: *"A particular public health concern surrounds cannabis effects on HIV/AIDS. Four studies among others may reduce related concern. Kaslow et al. (1989) demonstrated no evidence that cannabis accelerated immunodeficiency parameters in*

[16] Russo, *op. cit.*, page 365.
[17] Dr. Mary Lynch, *op. cit.*, page 52.
[18] R.D. Hartel, *op. cit.*, page 465.

HIV-positive patients. DiFranco et al. (1996) ascertained no acceleration of HIV to full-blown AIDS in cannabis smokers. Whitfield, Bechtel and Starich (1997) observed no deleterious effects of cannabis usage in HIV/AIDS patients, even those with the lowest CD4 counts. Finally, Abrams et al. (2000) studied the effects of cannabis smoking on HIV-positive patients on protease inhibitor drugs in a prospective randomized, partially blinded placebo-controlled trial. No adverse effects on CD4 counts were observed secondary to cannabis."[19]

- **Glaucoma**: Glaucoma is an eye disease in which intraocular pressure builds because the fluid in the eye has difficulty draining and which leads to gradual destruction of the ocular nerves. Marijuana, in particular paste made from cannabis leaves, has been used to reduce intraocular pressure since ancient times, as we saw in the previous section. Recent studies suggest that marijuana – including smoked marijuana – helps reduce the effects of glaucoma. However, there have been some reservations because of some of the side effects of smoking marijuana (redness and drying of the eyes). In a case study by Russo *et al.* on four patients who smoked marijuana, one patient with glaucoma stated in court that the marijuana saved her sight.

- **Spasms and convulsions**: The anticonvulsive properties of marijuana that help control epileptic seizures and the antispasm properties that are useful in treating multiple sclerosis are well known in Canada; marijuana use for epilepsy gave rise to the Ontario Court of Appeal decision in Parker. Smoked marijuana and synthetic cannabinoids appears to be effective in controlling these conditions. However, because of the bioavailability of synthetic compounds (between 20% and 30%) and their delayed effect relative to smoked marijuana, patients seem to prefer smoking.

- **Pain**: The analgesic effects of marijuana in easing different types of pain have also been known since ancient times. We described the analgesic effect of marijuana above. More importantly, marijuana has specific effects on some types of pain that opiates do not.

Marijuana as a drug?

In order for a product to be recognized as a drug in the pharmacopoeia, it must meet at least three criteria:

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[19] Russo, E.B., *et al.* (2002), "Chronic cannabis use in the compassionate investigational new drug program: An examination of benefits and adverse effects of legal clinical cannabis", *Journal of Cannabis Therapeutics*, Vol. 2, No. 1, page 45.

- Quality: the dosage must be determined based on a constant and known composition that is easy to administer to the patient;
- Effectiveness: rigorous clinical trials must have demonstrated the effectiveness of the drug; and
- Safety: studies must show the known and foreseeable side effects of the drug.

Because of the lack of rigorous clinical studies using recognized protocols, whole marijuana has not yet met these criteria. There are a number of reasons for this. First, the research protocols needed to test drugs involve double-blind tests with control groups and randomly selected subjects, all conditions that are hard to achieve with marijuana. Second, the current legal climate limits the potential for such studies in terms of both the availability of marijuana and test conditions. Third, the marijuana provided by the National Institute of Drug Abuse (NIDA) for medical research – including research conducted by Health Canada – is of dubious quality:[20] THC concentration may be a determining factor in the quality of the therapeutic effects, yet NIDA marijuana contains only 1.8% to 5% THC. Moreover, weaker marijuana requires more draws and releases more CO than marijuana with a higher THC content. Other cannabinoids are not measured, yet they are known to also have a bearing on the medical properties of marijuana. The paper in which the marijuana is rolled is of poor quality. The marijuana is often more than two years old and may not have been stored under conditions that would preserve all its qualities. Finally, the marijuana contains many seeds and other plant debris. Fourth, it is difficult to control the amount of marijuana actually absorbed by the subjects: the way a person draws on the cigarette, whether or not the person is accustomed to smoking, the subject's preferences and the length of time the subject inhales are factors which can affect the test conditions and which researchers have not yet been able to measure accurately.

It must also be possible to answer the following and other questions:

- Is there a difference between synthetic cannabinoids and whole marijuana?
- What is the optimum marijuana profile in a given situation?
- Do different doses and different forms of ingestion produce significantly different effects?

[20] Russo, *op.cit*, discusses these weaknesses in greater detail.

In recent years, analyses of the scientific literature have been conducted by the Institute of Medicine in the United States and the British Medical Society and in various government reports in England, the Netherlands and elsewhere. The Institute of Medicine concluded that there is evidence of the therapeutic potential of marijuana as an analgesic, antiemetic and appetite stimulant. It noted, however, that smoking is a difficult way to control the ingestion of marijuana and also has side effects related specifically to its carcinogenic potential and the link with respiratory diseases. The institute also found that the psychoactive effects of marijuana are sometimes, but not always, beneficial for some patients. Finally, the institute pointed out that smoking marijuana should not be recommended over the long term because of the potential mental effects, but could be prescribed for persons with terminal or degenerative diseases, where long-term considerations are secondary. In the Netherlands, the National Health Council issued a notice in 1995 stating that scientific evidence on medical use of marijuana was insufficient because of poor research and uncertainty as to the properties of smoked marijuana. The council also noted that marijuana could have therapeutic applications in the following areas: nausea and vomiting related to chemotherapy, appetite stimulation for people with AIDS or cancer, multiple sclerosis and glaucoma. In 2001, the Netherlands created a medical marijuana bureau in the ministry of health and began clinical studies. In England, the House of Lords has taken a position similar to that of the Institute of Medicine in the United States, and the Ministry of Health is currently conducting at least one clinical study.

Clearly, **not enough is known about marijuana to establish it as a drug in the strict sense of the word, and we only have partial knowledge of cannabinoids**. Most cannabinoids are a single cannabinoid compound, whereas marijuana contains many substances the effects of which interact to produce the therapeutic effects. Yet researchers have still not specifically identified the role of the various cannabinoids. Patients who use synthetic dronabinol or nabilone-based compounds generally report not feeling the same beneficial effects as when they smoke marijuana. It may take longer for the effects to be felt, and the effects may be less specific. Further, isolating only one of the components of marijuana could, according to some studies, increase the risk of panic attacks and even marijuana-induced psychosis.

> *A significant benefit of whole marijuana is that it can be delivered in smoked format, with a rapid onset of action and a tritable effect by the patient. […] In practice, both patients and oncologists report that smoked marijuana is somewhat more effective than and as safe as the legally available oral cannabinoids. Another major difference between marijuana and THC, besides the availability of a smokeable, titratable delivery system with whole marijuana, is that 9-THC alone can produce the relatively common effects of anxiety disorder and panic attack. […] The adverse effects can also occur with marijuana use,*

> *but are felt to be diminished by the presence of cannabidiol, a nonpsychoactive compound with antipsychotic properties.* [21]

Finally, the cost of synthetic compounds, which is much higher, has to be taken into account.

The advantages of smoked marijuana are that patients can determine the necessary dose on their own and feel the effects more quickly, while limiting the adverse side effects other than the effect on the respiratory system. It should be noted in passing the importance of self-regulation by patients: most of the clinical cases reported and most of the testimony from compassion club representatives agree that patients prefer to use marijuana with a higher THC content than recreational marijuana but only ingest the quantity they need to achieve the calming effects. However, the problems related to specific knowledge of the effectiveness and quality of marijuana limit the ability of physicians to prescribe the appropriate dose. More advanced knowledge of smoked marijuana pertains to the degree of safety, although there is variation in interpretation of the data. We generally concur in the finding of Professor Scholten:

> *Cannabis use for medicinal reasons by patients with a somatic disease is relatively safe, on condition that it is not smoked; when smoked it has the same carcinogenic potential as tobacco. The alternatives are oral administration or inhalation using a vaporiser.*
> *The acute toxicity of cannabis is very low; it is almost impossible to die of an overdose (users would have to eat or smoke their own weight in fresh cannabis, or 7,500 grams of dried cannabis to achieve this).*
> *The principal side effects in therapeutic use are psychosis and euphoria. Little is known about this drug's addictive effect in medical use, though experience with the use of morphine for pain relief has shown that the risk of psychological addiction is low – much lower than when used as a stimulant. As the addictive effect of cannabis is also quite low when used as a stimulant, it may be assumed that this will always be very low in a medical setting.*
> *When estimating the chronic toxicity of cannabis, it should be borne in mind that the doses used in therapeutic applications will probably be lower than those used for "recreational" purposes, decreasing the risks of side effects.* [22]

Does this mean that medical use of marijuana, smoking in particular, should be discouraged or even banned? The last section addresses this question.

CURRENT THERAPEUTIC PRACTICES

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[21] Gurley, R.J., R. Aronow and M. Katz (1998), "Medicinal marijuana: A comprehensive review", *Journal of Psychoactive Drugs.* Vol. 30, No. 2, page 139.

[22] Scholten, W.K. (2002), "Medicinal cannabis: A quick scan on the therapeutic use of cannabis", in Pelc, I. (ed.), *International Scientific Conference on Cannabis*, Brussels.

The main reservations about therapeutic use relate to the lack of comprehensive knowledge based on controlled medical studies and also to the long-term impact on the respiratory system and carcinogenic potential. In some cases, reservations have been expressed regarding the psychoactive properties of marijuana. There is a growing consensus on the therapeutic potential of marijuana, particularly smoked marijuana. While marijuana cannot, strictly speaking, be considered a drug, at least for the time being, it still has therapeutic properties. How then do we classify and regulate it?

Canada, the United States and many other countries have developed a parallel practice of allowing people with certain conditions to use marijuana. The most familiar example in Canada is without question the Vancouver Compassion Club.

In its mission statement, the club advocates a holistic approach to health. It not only supplies marijuana, but also delivers other forms of natural medicine (herbal therapy, acupuncture, massage, etc.). The club is built on the values of compassion, emancipation and complementarity between approaches.

In the six years since the Compassion Club was founded, an intimate knowledge of the therapeutic effects of marijuana has been acquired. The club offers a daily menu comprising seven to ten varieties of marijuana, one or two varieties of hashish, cannabis tincture, and baked goods containing marijuana. It sells marijuana for $3 to $10 a gram, depending on the variety. It currently serves more than 2,000 members/clients.

> *Our members have a huge range of symptoms and conditions such as HIV and AIDS, cancer, multiple sclerosis, arthritis, chronic pain, fybromyalgia, seizure disorders, glaucoma, hepatitis C, anxiety, depression, insomnia, eating disorders and many others. […]*
>
> *It is important that medicinal users have access to a variety of strains, as the effect of cannabis varies depending on which strain is being used and the method of ingestion. Our members are made aware of the differences and can then select the best strain of cannabis to most effectively treat their symptoms.*
>
> *Indica and sativa are the two main varieties of the cannabis plant used as medicine. Many strains are crosses of those two varieties. Within each of those varieties and crosses there are a huge number of individual strains, each with a different cannabinoid profile and effect.*
>
> *According to the anecdotal evidence, the indica strains are a relaxant, effective for anxiety, pain, nausea, appetite stimulation, sleep, muscle spasms and tremors, among other symptoms. The sativa strains are more of a stimulant, effective in appetite stimulation, relieving depression, migraines, pain and nausea. We are now aware of specific strains that are effective for specific conditions and symptoms. Members keep track of their use in order to find the most effective strain for themselves. We also keep close records monitoring members' purchases in order to assist members to track their own consumption and for us to prevent reselling and to encourage responsible use.* [23]

[23] Hilary Black, Director, Vancouver Compassion Club, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, November 7, 2001, Issue 10, page 36.

Having read that testimony and the documents given to us by the club, visited the club's premises and examined its records, and heard the testimony of other people who work for similar organizations in Montreal and Toronto, we can safely say that there are links between this therapeutic practice and the data produced by research on medical uses of marijuana.

We also observe that this organization, like others that provide a similar service in Canada, keeps detailed records of their clients and their marijuana use; these records allow treatment to be monitored, but could also be excellent material for empirical research. **We can only lament the fact that Health Canada has not undertaken clinical research in cooperation with this organization**. We share the reservations voiced by Hilary Black regarding the traditional protocols used in research on therapeutic use of marijuana:

> *We created a research proposal with a team of research scientists from Vancouver. However, we were turned down because we refuse to facilitate a study using a placebo or low-quality, low-potency cannabis imported from the US National Institute on Drug Abuse. Any study attempting to prove the efficacy of cannabis as a medicine using such a low-potency herb, or unknown strains such as those currently being grown in Canada by Plant Prairie Systems, is destined to fail. There is no need to import cannabis for research, considering the high quality and huge quantity of cannabis being produced in Canada. The information we could gather is being requested by doctors, patients, pharmaceutical companies, Plant Prairie Systems and Health Canada, yet we are not financially empowered to facilitate this research.* [24]

No one will deny that research on therapeutic uses of marijuana, whether smoked or synthetic, must continue in an effort to further clarify the key elements of quality, effectiveness and safety. Everyone agrees that we should learn more about the strains and doses appropriate to various conditions. For all that, do we have to think of marijuana as a drug like the other drugs listed in the pharmacopoeia? Do we have to have the same requirements as those applicable to prescribed drugs, or should we relax the rules to view marijuana a natural health product? Were it not for the legal system and the international conventions governing marijuana, would the plant not be considered more a natural health product like other plants and herbs?

Casting the issue in those terms forces us to think differently about the therapeutic use of marijuana. If the aim is to make it a approved therapeutic product, the reservations of the medical profession, or at least of some representatives of the profession, are understandable: they cannot endorse the approach until the proper controlled studies are carried out so that physicians can prescribe marijuana as confidently as they prescribe other approved therapeutic products. If marijuana is recognized as having therapeutic uses in some cases – at least as proven as any other plant used in homeopathy or herbal therapy – the aim is instead to give it the same status as other natural health products.

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[24] *Ibid.*, page 39.

CONCLUSIONS

The Committee is of the opinion that the potential therapeutic uses of marijuana have been **sufficiently documented to permit its use for therapeutic purposes**. It should be acknowledged that smoking marijuana can have harmful side effects, particularly for the respiratory system, and users should be informed accordingly. It should also be acknowledged that research is needed to further clarify the specific field of marijuana use and the long-term effects of marijuana.

Conclusions of Chapter 9	
Therapeutic applications	➢ **There are clear, though non-definitive indications of the therapeutic benefits of marijuana in the following conditions: analgesic for chronic pain, antispasm for multiple sclerosis, anticonvulsive for epilepsy, antiemetic for chemotherapy and appetite stimulant for cachexia.** ➢ **There are less clear indications regarding the effect of marijuana on glaucoma and other medical conditions.**
Marijuana as a drug	➢ **Marijuana has not been established as a drug through rigorous, controlled studies.** ➢ **The quality and effectiveness of marijuana, primarily smoked marijuana, have not been determined in clinical studies.**
Marijuana and synthetic compounds	➢ **There have been some studies of synthetic compounds, but the knowledge base is still too small to determine effectiveness and safety.** ➢ **Generally, the effects of smoked marijuana are more specific and occur faster than the effects of synthetic compounds.** ➢ **The absence of certain cannabinoids in synthetic compounds can lead to harmful side effects, such as panic attacks and cannabinoid psychoses.** ➢ **Smoked marijuana is potentially harmful to the respiratory system.** ➢ **People who smoke marijuana for therapeutic purposes self-regulate their use depending on**

	their physical condition and do not really seek the psychoactive effect ➢ **People who smoke marijuana for therapeutic purposes prefer to have a choice as to methods of use.**
Therapeutic practices	➢ **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**
Research	➢ **The studies that have already been approved by Health Canada must be conducted as quickly as possible.** ➢ **The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards.** ➢ **The studies should focus on applications and the specific doses for various medical conditions.** ➢ **Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs.**

CHAPTER 10

CANADIANS' OPINIONS AND ATTITUDES

One of our main objectives throughout our study was to get Canadians involved. We wanted people to share their opinions, experiences and fears regarding marijuana. We also wanted to provide access to the information we held so as to contribute, within our modest means, to better knowledge of the realities of marijuana, if only to raise the level of public debate. At the start of each public hearing the Committee Chair stated:

> *The second thrust is the sharing of knowledge. This is definitely our most noble objective. The committee wants all Canadians to become informed and share the information we collect. Our challenge will be to plan and organize a system to ensure that the knowledge is available and distributed. We would also like to hear what people think about this knowledge. In order to do this, in the spring of 2002, we will be holding public hearings in various parts of Canada.*

This was indeed a major challenge. It is one thing to passively make available such information as proceedings of our hearings and our commissioned research reports. It is another thing to actively disseminate that information widely, having the means to do so. And it is another thing again to take the pulse of Canadian society.

To convey the information to Canadians, we chose to make full use of our Internet site, posting all of our documents as they were ready. To boost circulation, we used two main tools. The first was a conventional tool: the media. We worked to get as much media coverage as possible in order to promote our work or simply let people know the Committee existed. With the same goal in mind, some members of the Committee took part in conferences, round table discussions and open-line shows. The second tool, one we considered essential in promoting our work, was the discussion paper we released in May 2002. The paper laid out some of our preliminary research findings on eight key issues, put forward a number of public policy options and proposed questions for the public hearings. The main aims of the paper were to convey our knowledge and generate public interest. A third objective was to provide a backdrop for the public hearings we held throughout the country in May and June 2002.

Only time will tell whether and to what extent we were successful in promoting our work and, more importantly, in increasing public knowledge of marijuana. We did not have the financial means to conduct a far-reaching public information campaign or

an opinion poll before and after the release of the discussion paper to determine whether we had any impact on Canadians.

It is much harder to gauge the public's opinions, attitudes and concerns. The traditional method of surveying a representative sample of the population was too expensive. Surveys also have limits, which we will discuss in more detail later. However, we did commission a qualitative study using focus groups, the results of which will be presented in this chapter. We will also report the results of other surveys that came to our attention. As well, many Canadians wrote to us or sent us e-mails, and some came out to our public hearings. We obviously cannot draw any conclusions from this: the only people who wrote to us were probably people to whom the issue is very important, regardless of which way they lean. Some will be cited but we reiterate that nothing is to be drawn from these opinions in terms of representativeness.

No account of Canadians' opinions on and attitudes toward drugs in general would be complete without an examination of the role of the media in shaping those opinions and attitudes. In recent years, as a result of this Committee's work and other initiatives, various Canadian newspapers and magazines have run stories or written editorials on the issue. These will be the focus of the first part of the chapter. The next part presents the results of surveys and polls, including the survey we commissioned and surveys conducted in different provinces. The last part covers our understanding of what Canadians told us.

THE MEDIA

At the start of the century, the media played a key role in creating a moral "panic" over illegal drugs. First it was the "Yellow Peril" and the opium crisis in the early 20th century, primarily in Vancouver.[1]

> *[…] tolerance for the habit of smoking opium lasted only as long as British Columbia's tolerance for the Chinese. In the early years of the twentieth century, both a labour surplus and anti-Asian resentment developed […] If you look at the Vancouver Province, virtually any front page in the first five years of the 20th century, there are racist cartoons warning about the yellow peril, about how British Columbia is going to be swallowed up by the Chinese, and about another boatload arriving.* [2]

[1] See the analyses by Giffen, P.J., *et al.* (1991), *Panic and Indifference. The Politics of Canada's Drug Laws*, Ottawa: Canadian Centre on Substance Abuse; Boyd, N. (1991), *High Society: Illegal and Legal Drugs in Canada*, Toronto: Key Porter Books.

[2] Boyd, N., *op. cit.*, pages 27-29.

The following appeared in *Canadian Magazine* in 1900:

> *It was quite evident he (the Chinese servant) had had his share and a night of it, for there are Chinese dens in Vancouver where opium is smoked and unspeakable infamies are practised, and no matter how meek and mild your Chinaman may look, no matter how gentle his voice or confiding his manner, Saturday night is almost certain to find him 'doped' in his bunk, weaving dreams under the poppy's subtle spell.* [3]

Then it was the cocaine plague in Montreal as described by the following article in the Montreal *Witness* in 1910:

> *This curse of cocaine […] has existed for a short time in the city. It is a real evil. It is a social plague, and it goes on spreading so fearfully that it is time for society to take marked notice. Alcoholism and morphia are nothing to cocaine. It is the agent for the seduction of our daughters and the demoralization of our young men. […] Those who know what cocaine is and what its evils are, are those who can hurt society most.* [4]

This vision of the decay and degeneration of the working class and, more broadly, Anglo-British and Christian civilization, would subsequently be picked up by temperance movements. A key figure in women's history in Canada, Emily Murphy, would play a leading role in the 1920s in articulating this apocalyptic vision. Murphy, a writer and journalist, was president of the Canadian Women's Press Club (1913-1920), the founding president of the Federated Women's Institute and a member of the National Council of Women of Canada before becoming a judge in Alberta. She also fought to have women's rights recognized in the Canadian constitution. She was a tireless fighter in the war on drugs. In a series of articles published in *MacLean's* magazine in 1920, she attacked the "plague" of drugs.

> *[…] whatever form these drugs are taken, they degrade the morals and enfeeble the will. No matter what their status has been, inveterate users of drugs become degraded. All are liars: nearly all become dishonest. Being deprived of the drug, they will go any length to get it, even to thievery and prostitution. While sober they are uncomfortable, and prolonged abstemiousness hurts them like nails driven into the flesh.* [5]

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[3] Quoted in Giffen, P.J., *op. cit.*, page 61.
[4] Quoted by McKenzie King in Hansard, House of Commons, January 26, 1911, pages 2641-2642.
[5] Murphy, E., (1920), "The underground system", *MacLean's*, March 15, 1920.

In 1922, in her book *The Black Candle*, she also attacked marijuana, which she described as follows:

> *Persons using this narcotic smoke the dried leaves of the plant, which has the effect of driving them completely insane. The addict loses all sense of moral responsibility. Addicts to this drug, while under its influence, are immune to pain, and could severely injured without having any realization of their condition. While in this condition they become raving maniacs and liable to kill or indulge in any form of violence to other persons, using the most savage methods of cruelty without, as said before, any sense of moral responsibility. When coming under the influence of this narcotic, these victims present the most horrible condition imaginable. They are dispossessed of their natural and normal will power and their mental is that of idiots. If the drug is indulged in any great extent, it ends in the untimely death of the addict.* [6]

Beyond the verbal impact of these articles and racism toward Asians, there is some similarity between the messages being conveyed at that time and some contemporary messages about drugs: drugs attack the moral roots of society, the family in particular. They put young people at risk and cause crime and violence. Dealers are everywhere, especially around schools, ready to do whatever it takes to expand their client base. And drugs, by definition, lead to drug addiction.

That does not mean, of course, that the newspaper articles were the main reason why drugs were criminalized. Nor does it mean that people ultimately believed what was written. Still, analysts of the evolution of drug laws in Canada agree that the media played an important role in shaping Canadian drug legislation.

Where do Canadian media stand on drugs today? We did not analyse all the press coverage of drugs in Canada, although the exercise would probably have been interesting in sociological terms in identifying key notions and seeing just how public opinion is shaped. All we do here is examine two main types of media article. The first is news related to criminality, the second, feature stories and editorials.

News stories on illegal drugs usually focus on police operations: raids, seizures, dealer arrests and dismantling of organized crime rings. The best-known modern example was surely the 2001 arrest in Quebec of more than 70 Hells Angels members known to be involved in narcotics trafficking and other illegal activities. And then there are seizures, month after month, of kilograms – even hundreds of kilograms – of drugs, more and more often marijuana.

We do not know how this information helps shape public opinion on drugs or what impact it has on the public's demands concerning drugs. However, these articles probably give people the impression that the "drug problem" is first and foremost an organized crime problem. But while there may have been an impression until the mid 1980s, shall we say, that marijuana was a problem exported into Canada from other countries, the growing number of articles on raids of domestic producers – as opposed

[6] Murphy, E., (1922) *The Black Candle.* Toronto: Thomas Allans, pages 332-333.

to shipments from overseas – is giving more and more people cause to think of marijuana as a home-grown problem.

Other news stories focus on the relationship between drugs and crime, especially prostitution, residential break-ins, and "incivilities" experienced by street youth and the homeless. Some of these activities are at least in part associated with drugs. For prostitution, it is the fact that people, mostly women, are forced to work as street prostitutes in order to support their habit. Residential break-ins are also tied to supporting drug habits, although the perpetrators are different: most break-ins are committed by young men. For street youth, the main problem is intravenous drug use and the risk of spreading AIDS. None of this is directly related to marijuana. Except for schools. Virtually every big city in Canada – and every not-so-big city, too, for that matter – has seen some kind of police operation in schools. School raids usually elicit two types of reaction, both rooted in indignation: people are indignant when they learn that drugs are so much a part of the school environment while others think the police are abusing their authority and failing to respect young people's rights.

Several years ago, there were a number of feature reports in newspapers and the electronic media. The series written by journalist Dan Gardner of the *Ottawa Citizen* in 2000, which was picked up by most of the newspapers in the Southam chain, is surely the best-known example. In his 10-article series, Gardner explained why the "war on drugs" is a patent failure. He began his series as follows:

> *Uncle Sam's global campaign to end drug abuse has empowered criminals, corrupted governments and eroded liberty, but still there are more drug addicts than ever before. On June 6, 1998, a surprising letter was delivered to Kofi Annan, secretary general of the United Nations. 'We believe' the letter declared, 'that the global war on drugs is now causing more harm than drug abuse itself. The letter was signed by statesmen, politicians, academics and other public figures. Former UN secretary general Javier Perez de Cuellar signed. So did George Shultz, the former American secretary of state, and Joycelyn Elders, the former American Surgeon General. Nobel laureates such as Milton Friedman and Argentina's Adolfo Perez Esquivel added their names. Four former presidents and seven former cabinet ministers from Latin American countries signed. And several eminent Canadians were among the signatories. The drug policies the world has been following for decades are a destructive failure they said. Trying to stamp out drug abuse by banning drugs has only created an illegal industry worth $400 billion US. 'or roughly eight per cent of international trade.' […] This powerful statement landed on Mr. Annan's desk just as the United Nations was holding a special assembly on global drug problems. Going into that meeting, the governments of the world appeared all but unanimous in the belief that the best way to combat drug abuse was to ban the production, sale or possession of certain drugs. […] Still, the letter to Mr. Annan showed that this view is far from unanimous. In fact, a large and growing number of world leaders and experts think the war on drugs is nothing less than a humanitarian disaster.* [7]

[7] Gardner, D., "Why the war on drug has failed: Uncle Sam's war", *Ottawa Citizen*, September 5, 2000.

In a way, Gardner's series echoed editorials that ran in the *Ottawa Citizen* in 1997 calling for the decriminalization of drugs.[8] The following appeared in the second article in the series: *"The recent history of drug enforcement, in both Canada and the United States, is largely a record of failure. Tax dollars are lavished on enforcement. Police powers are expanded at the expense of civil liberties. Criminal gangs grow richer. And drug use goes on regardless."*

In 1998, the Toronto *Globe and Mail* expressed a similar view under the headline "*What are G8 Leaders Smoking?*" The newspaper wrote, *"Prohibition does not work and cannot work, and its costs are higher than those of a policy of properly supervised and regulated access to drugs. Given that the elimination of drugs from our society is not an option, the G8 leaders should have been asking themselves how they can minimize the harm that drugs represent. As it is, their policies maximize the damage."* The *Globe and Mail* did the same thing in a two-part editorial in July 2001, recommending decriminalization of marijuana. The *Vancouver Sun* followed suit in October 1998, and the *National Post* also called for an end to the prohibition on marijuana. More recently still, in the wake of the tragic events of September 11, 2001, the *Citizen* editorial staff responded to those who suggested that money from drug trafficking was being used to finance terrorism. The editorial read:

> *The latest drug-war scare, from Solicitor General Lawrence MacAulay and others, is that terrorists may be using drug money to finance their evil deeds. If so, you can see why. Terrorism, like any real crime, produces victims rather than satisfied customers, so it's not exactly self-financing. The drug trade, by contrast, turns a regular profit because it involves transactions so mutually satisfactory that buyers and sellers will risk jail to conduct them. […] In short, the drug war not only brings the law into contempt and threatens public safety, it also funnels money to terrorists and helps them move between countries. And people want more of it? I say a virtuous choice must be a choice to be virtuous, so I'd repeal the drug laws on moral grounds. But put aside my distaste for paternalism. If fighting the war on drugs increases the danger of losing the war on terror, surely it's doing far more harm than good.* [9]

These editorials and features are interesting for many different reasons. First, they mark a major shift from the positions that were more tentative or simply favoured prohibition that had held sway since the beginning of the century. They were also part of a constant questioning of the government's role and the appropriateness of government spending and reflected growing concern for individual freedoms.

We do not know how they affect public opinion. We are not in a position to say if they reflect views held widely among the public or whether they are skewed. Only one thing strikes us as relatively certain: most major media outlets in Canada have distanced themselves quite significantly from prohibitionist policies.

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[8] Editorial, "Decriminalizing Drugs", *Ottawa Citizen*, April 12, 1997, April 14, 1997, April 15, 1997, and April 16, 1997.

[9] John Robson, "How many burbs must the drug war burn, before we call it a bust?, *Ottawa Citizen*, May 17, 2002.

SURVEYS

According to one of our witnesses:

> *From public opinion data assembled over the last 10 years, some by Health Canada, we know that more than two thirds of Canadians think that no one should go to jail for cannabis use, and approximately half of Canadians explicitly advocate the decriminalization or depenalization of cannabis use. This has been consistently the case over the last 25 years. In other words, there has been a public opinion message for a quarter of a century that so far has been ignored by lawmakers and policy-makers.* [10]

One of the biggest limitations of opinion polls is their superficial nature: the questions are often inserted into more general surveys covering a variety of subjects, there is little opportunity to ask multiple questions, and the meaning of the terms is rarely explored. For example, the terms "legalization" and "decriminalization" do not necessarily mean the same thing to all respondents. But general surveys are not able or rarely have the means to bring those differences to light. If the survey asks a single question about marijuana along the lines of "are you in favour of decriminalizing the possession of small quantities of marijuana?", there is no way of knowing what the respondents think when they hear "decriminalizing" and "small quantities". For some, decriminalization may mean no penalty; for others, it may mean a fine. And the difference between 5 grams and 30 grams is enormous.

Like the media, and in an equally complex way, surveys help shape public views. And also like the media, it is hard to determine the role they play in changing attitudes and, more importantly, behaviour. With those reservations out of the way, we provide in the following paragraphs a sample of data from a number of different surveys.

In the 1994 national survey on alcohol and drugs, the respondents were asked to give their opinion on marijuana: 27% said that possession of small quantities should be legal; 42% said it should be illegal but should not result in a penalty or should result in a fine only; and 17% said that possession of marijuana should lead to a possible prison sentence for a first offence. Men and younger people are more inclined to favour legalization of marijuana, as are residents of British Columbia, Quebec, Alberta and Ontario.[11]

In 2000, the *National Post* reported the results of a survey which showed that almost two thirds of Canadians were in favour of decriminalizing marijuana and that the punishment for possession of small quantities for personal use should be a fine.[12]

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[10] Dr. Benedikt Fischer, Professor, Department of Public Health Sciences, University of Toronto, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session of the thirty-seventh Parliament, September 17, 2001, Issue 6, page 13.

[11] Canadian Centre on Substance Abuse (1999), *Canadian Profile, 1999: Alcohol, tobacco and other drugs*, Ottawa: author, pages 214-215.

[12] National Post, "Two-thirds favour decriminalizing pot", May 15, 2000.

More recently still, in a May 2001 survey, 47% of Canadians said they favour legalization of marijuana, up from 31% in 1995 and 26% in 1975.[13]

A smaller survey of public perceptions was conducted in Quebec in 2001 using a sample of 2,253 respondents (response rate 70%).[14] The survey focused solely on drugs, drug addiction and HIV and measured knowledge, perception of risk, perception of drug addicts, and possible policies and measures. What makes this type of study interesting is that because the questions were limited to drug addiction and drugs, it provides clearer and more comprehensive information on certain issues.

The study showed that the majority (66%) of Quebeckers think that drug use is increasing. It also showed that "[translation] *marijuana is in a class of its own*" in terms of perception of risk because "[translation] *only one in four people felt that marijuana is dangerous the first time it is used, which is less than the opinion reported for tobacco, even though tobacco is legal. Moreover, marijuana is the only substance that a relatively large number of respondents described as never harmful to health. […] People consider it less dangerous than tobacco.*"[15] The surveys also show that marijuana is the substance least likely to lead to addiction: approximately 15% of respondents think that marijuana creates a dependency the first time it is tried, whereas more than 40% said it would have to be used every day and 8% said that marijuana never creates dependency.[16]

As to opinions on public policy, the study showed a clear preference for prevention and education over controls and repressive measures. Almost 35% of those asked what measures would be likely to eliminate drug problems said that the controlled sale of marijuana and hashish would help reduce the adverse effects. According to the authors, the public "[translation] *is very open to some form of legalization of hashish and marijuana. More than 90% said that people with certain serious illnesses should be allowed to get prescription hashish and marijuana in order to relieve their pain. Far fewer people, although still a majority (60%), would be willing to allow those drugs to be used under certain conditions perhaps like alcohol.*"[17] Fewer than 40% thought that current laws help prevent people from using (and approximately 60% disagreed somewhat or completely with that statement).[18]

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[13] Julian Beltrame, "Reefer Madness: The Sequel", *MacLean's*, August 6, 2001, Vol. 114, pages 22-25.

[14] Hamel, D., *et al.* (2001), *Perceptions de la population québécoise en lien avec les programmes de prévention de la toxicomanie et du VIH*, [public perceptions in Quebec regarding substance abuse and HIV prevention programs], Quebec City: Institut national de santé publique du Québec.

[15] *Ibid.*, page 3.

[16] *Ibid.*, page 27.

[17] *Ibid.*, page 4

[18] *Ibid.*, page 38.

In Ontario, the school survey also looked at students' perception of risk and disapproval of marijuana use. The results are shown in the following table.

Perceptions of Ontario high-school students, 1989-2001 [19]

	1989	1991	1993	1995	1997	1999	2001
Disapprove of experimentation							
Total	40.8%	43.2%	37.1%	28.8%	23.4%	26.0%	28.6%
Grade 7	58.9%	58.0%	48.6%	44.9%	40.8%	44.3%	48.2%
Grade 9	38.0%	48.3%	38.8%	30.1%	21.6%	25.7%	23.7%
Grade 11	33.0%	32.5%	30.2%	16.3%	13.2%	18.2%	19.4%
Grade 13	26.7%	28.4%	27.7%	25.7%	18.8%	13.4%	20.7%
Disapprove of regular use							
Total	61.0%	60.8%	55.9%	47.2%	45.2%	43.1%	41.7%
Grade 7	73.7%	72.1%	66.6%	62.3%	58.7%	63.6%	64.0%
Grade 9	59.8%	62.5%	54.3%	48.6%	41.1%	43.6%	34.3%
Grade 11	54.9%	52.4%	50.9%	33.6%	30.9%	31.2%	29.8%
Grade 13	50.1%	56.1%	51.1%	48.6%	42.6%	32.8%	40.7%
Associate high risk with experimentation							
Total	27.8%	30.7%	27.3%	18.5%	17.1%	18.4%	18.6%
Grade 7	39.2%	37.0%	35.3%	30.7%	26.2%	28.4%	27.0%
Grade 9	29.7%	35.4%	29.3%	18.6%	14.3%	16.6%	18.5%
Grade 11	18.0%	25.2%	21.8%	10.5%	12.8%	15.2%	11.1%
Grade 13	19.2%	21.2%	19.7%	14.2%	16.4%	12.5%	17.7%
Associate high risk with regular use							
Total	75.4%	73.3%	69.3%	58.1%	56.1%	52.0%	48.2%
Grade 7	72.6%	72.1%	69.8%	67.6%	60.5%	63.6%	61.1%
Grade 9	79.1%	74.0%	73.7%	60.8%	59.3%	53.1%	47.8%
Grade 11	74.7%	73.9%	66.9%	50.8%	49.4%	44.9%	36.8%
Grade 13	73.3%	73.1%	63.4%	50.6%	55.7%	45.2%	47.8%

These results show that Ontario high-school students' attitudes on all indicators are either less alarmist or more liberal, depending on one's point of view. Fewer students disapproved of experimentation (one or two times) with marijuana and regular use in 2001 than in 1989. However, more students still disapproved of regular use than occasional use. The level of disapproval decreases as level of schooling increases. Further, fewer Ontario students associated a high risk with marijuana use in 2001 than in 1989, but still almost three times as many associated a high risk with regular use than with experimentation. It bears noting that students who associate a high risk with

[19] Adlaf, E.M., and A. Paglia (2001), *Drug Use among Ontario Students 1977-2001. Findings from the OSDUS*, Toronto: Centre for Addiction and Mental Health.

regular marijuana use now make up less than half the student population, down from three quarters in 1989.

By and large, these data are in line with the results of the study the Committee commissioned from the firm Léger Marketing.[20] The objective of this qualitative study using focus groups was to determine whether it was possible to identify elements that could serve as the basis of a social consensus on the use of cannabis. More specifically, the study was designed to determine the overall perception of drug use in general and cannabis in particular; the images associated with cannabis; attitudes and social behaviour toward the use of cannabis for recreational purposes; fears and prejudices; knowledge of the legislative framework; and the expectations of citizens with regard to a public policy on the use of cannabis for recreational purposes. Léger held 16 focus groups and conducted 15 in-depth interviews in Montreal, Trois-Rivières, Halifax, Winnipeg, Vancouver, Toronto and London. In all, more than 130 people took part in the study. In each city, there were at least two focus groups, one with adults over the age of 18, and one with youth 14 to 17 years of age.

The participants in the focus groups did not spontaneously mention drugs as everyday concerns; they reported being more concerned about health, education, employment and poverty. When the subject was raised by the interviewers, the participants first named crime related to the sale of drugs and drug smuggling as primary concerns, not drug use by Canadians. In some cities (Montreal, Vancouver), the participants also voiced concern about the impact illegal drugs have on quality of life and safety in some neighbourhoods.

Questioned about marijuana, almost all of the participants spontaneously made a distinction between soft drugs (marijuana, hashish) and hard drugs (cocaine, heroin); some even thought the word "drug" was inappropriate in reference to marijuana. That distinction is based on two major elements: composition and effect. Hard drugs are more closely associated with chemical products that have destructive effects, particularly a greater tendency to develop an addiction. Marijuana and marijuana derivatives are associated with plants or natural products, and the risk of dependency is virtually nil, except among people who are especially predisposed or vulnerable. There were many comparisons with alcohol: alcohol can be used in reasonable quantities without a problem, and only a small proportion of users develop dependency problems. Nor was marijuana associated with crime: *"I can't picture a guy robbing the corner store to buy himself a joint. This is something heroin addicts would do. First, pot is cheap, second it doesn't make you want it desperately."* The only exception more common in Quebec than elsewhere was the association with organized crime, that is, motorcycle gangs.

In contrast to "hard" drugs, which are considered part of a world of moral and physical distress and social decay, the participants generally associated marijuana with relaxation and pleasure, a drug used primarily in social settings, like alcohol.

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[20] Léger Marketing (2002), *An Exploratory Study Among Canadians About the Use of Cannabis*, Montreal: author. Available on line at the Committee's site.

In any event, recreational use of marijuana was generally well accepted: *"it doesn't bother me that people do marijuana. As long as they are aware of their decision and what they are doing, I respect it."* In fact, several participants in each group spontaneously mentioned their own past or current experiences with marijuana use: *"I sometimes smoke pot and it doesn't keep me from being a productive guy at work or a good family man."* And like alcohol, the difference lay more in the notions of abuse and responsibility, although the participants were harder on alcohol abuse, which they associate with violence. *"I used to go out to bars a lot. Every night there would be a fight. A guy gets drunk and then starts insulting somebody else or feels another is flirting with his girlfriend. At one point punches get thrown around. But you know what? I have never seen a guy stoned on pot go nuts and want to knock somebody out."* While they did not associate marijuana use with violence or crime, the participants did express concern about people's behaviour when under the influence of marijuana. Finally, the participants did not associate marijuana use with a particular social class: young people use marijuana, but so, too, do professionals, artists, lawyers, government employees and others.

The researchers did not observe any generational differences in recreational use of marijuana. If there were a difference, it would be rooted more in socio-occupational features: people with less education and people in rural areas appear to be more resistant. Further, people who oppose recreational use of marijuana do so more for moral and sometimes even religious reasons. Another difference is that women with school-age children said they were very concerned about how readily available marijuana is in schools. [translation] *"I don't care if they legalize it or not. All I want is for marijuana to be kept away from children. It makes me furious that they sell it in primary school, because that gets them hooked at a very young age."*

As the public opinion surveys discussed earlier showed, the participants generally supported the legalization of marijuana for medical use. However, some of the respondents said they would like to see a clear distribution structure put in place in health care establishments and that dosages should be geared to the intensity of the pain.

Generally, the participants felt that occasional use had no adverse health effect. Spontaneously making a comparison with alcohol and tobacco, they felt that marijuana was not the most dangerous of the three substances. Further, most of the respondents were not afraid of people getting hooked on marijuana, noting that dependency is a function of the person's maturity and frequency of use. *"This is the key question. I don't think you can get hooked on it really. Not as much as booze or nicotine for sure. But that's the kind of proof or medical evidence I would like to have if you want me to make up my mind on it."* The participants also did not think that marijuana is a gateway to other drugs or "hard drugs", because the user's personality and maturity have more influence than the marijuana itself.

The interview guide asked the participants to react to two research findings: the proportion of Canadians who have used marijuana in the past 12 months is approximately 10%, and about 30,000 charges are laid a year for simple possession of

marijuana. In both cases, the participants were incredulous. Regarding the proportion of users, all the participants felt that there were far more: "[translation] *I'm surprised that only 10% of the population are users. I would have said 50% or 60%.*" Regarding the number of charges, the participants unanimously felt that police should focus more on fighting crime rings: "*30,000 people charged per year seems like a waste of taxpayers' money, if it is just for possession. It's a lot of money to prosecute and they all get thrown out anyway.*" [translation] "*When you think about other, more serious crimes, when you think how it clogs up the courts, I think it's ridiculous.*" Nevertheless, the participants felt that Canada is a relatively tolerant society when it comes to recreational use of marijuana, at least in comparison with other countries, and spontaneously named the United States and Saudi Arabia as repressive and Switzerland and the Netherlands as tolerant; Canada fell somewhere in between.

The interviews were conducted after the Committee released its discussion paper in which it set out a number of public policy options. The focus group participants were first urged to freely voice their opinions on the public policies they would prefer to see and were then presented with the Committee's proposals and asked to react.

By and large, the response from the participants fell somewhere between decriminalization and legalization. That position was most prevalent in Montreal, Toronto, Vancouver and Halifax; more participants in Vancouver and Montreal favoured legalization with government controls: "*The best option is decriminalization leaning towards government legalization. The worst option would be depenalization: to legalize without getting involved.*" According to the participants, those options would make it possible to increase the ability to provide information about risk, user health, public safety, respect for individual rights and freedoms, and the effectiveness of government spending, and would reduce illegal trafficking and the involvement of organized crime. They also said they would anticipate an increase in recreational use of marijuana but did not think that there would necessarily be an increase in use or abuse among young people. On the contrary, several participants felt that decriminalization would lead to a decrease in use among young people because the appeal of the forbidden fruit would be gone.

There is still a hard-core minority who think that current laws are not harsh enough and that society should move toward greater criminalization of recreational use of marijuana. That position was voiced most loudly in Winnipeg among persons over 40 and in Trois-Rivières.

Finally, the participants said they would like to be informed and "educated" about marijuana use and in particular would like to be made aware of scientific knowledge of the short- and long-term effects, the real risk of dependency and escalation, ways of protecting children against early use, and the impact of decriminalization on the war on organized crime.

The authors of the study identified the following key factors:

- the protection of youth and children is central to any discussion of a public policy on marijuana;

- decriminalization of use is the preferred option, as it would make it possible to recognize the social reality and at the same time focus on the "real" problems;
- some participants expressed support for legalization but wondered about the nature and control of production and quality standards, methods of distribution and marketing, and the establishment of quotas in order to prevent abuse.

Because this was a qualitative survey, we cannot extrapolate the results to the entire Canadian population. Our financial resources did not allow us to conduct a comprehensive study using a representative sample of the population, which would have allowed us to validate these "hunches". Still, we are able to state the following: 1. these results are similar in many ways to the data from the opinion polls; and 2. the commonalities between the focus groups in most of the cities and between age groups suggest there is some validity to these hunches.

ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE

Hundreds of Canadians from all over the country wrote to us, and dozens appeared at our public hearings in the regions. They came to recount their personal experiences, state their opinions and voice their fears. They represented rights and freedoms advocacy groups, compassion clubs, which distribute medical marijuana, treatment and prevention organizations, and women's groups. They were mayors, police chiefs, users of medical marijuana, parents, educators, physicians, lawyers and recreational marijuana users, young and old alike. They often spoke from the heart, and we were moved by what they said. Appendix 2 is a list of all the people the Committee heard during its public hearings. We would like to thank all those who took part in our proceedings.

It is impossible to present in this report all the contributions to our discussions and highlight their extraordinary worth. Fortunately, the transcripts of the hearings will remain on our Internet site. The following will summarize the opinions conveyed to us in reaction to our discussion paper.

We should point out first of all that the people who shared their views were for the most part very happy with the diligence of our work and, more specifically, were very appreciative of the opportunity they were given to take part in this social debate.

> *I have followed with great interest the proceedings of the Special Committee on Illegal Drugs and would like to thank the person who decided to publish the brief so completely and honestly. This speaks volumes of transparent government, which is a key element in resolving the debate.*

I would first of like to commend the Senate for its Special Committee on Illegal Drugs and its impartial and ground-breaking work on marijuana.

Thank you for taking the time to review my submission. I would like to commend the Senate Committee on Illegal Drugs for its excellent research on the facts and criticism of the myths surrounding illegal drugs.

First of all, I would like to thank the Committee for skilfully separating the facts from the propaganda surrounding this issue. […] Thank you for taking the time to get public input on the issue. I only hope that this will not fall on deaf ears as was the case with the Le Dain Commission before you. Again, I believe the Committee is trying to do its best for the people of Canada.

I read your discussion paper on marijuana and the accompanying documentation and found the material to be most interesting. I would like to commend you for your willingness to launch a public debate in this area of policy.

Most of the people who took the time to respond to us also said they found the discussion paper to be well done, useful and balanced. Moreover, the respondents said they agreed with the research data we presented in the paper. Where there were reservations, they pertained to:

- biased interpretation of the data: for some people, marijuana is unquestionably a gateway drug;
- an overly cautious side: saying that marijuana is a drug and therefore should not be used was perceived as "politically correct";
- a lack of compassion and concern for youth and children.

Many Canadians from different walks of life shared with us their concerns about the prospect of marijuana being decriminalized and about the message that that kind of decision would send to young people.

[Translation] *It doesn't make any sense to use to legalize a drug with all the question marks and solid facts that are seen as consequences of marijuana use. If we had to do it over again, I don't think with the information we currently have that we would want to legalize nicotine or even alcohol. Once we consider legalizing a drug, we can assume that the drug will become more readily available and that there will therefore be more use and more problems. Remember: marijuana is not harmful because it is illegal; marijuana is still illegal because it is harmful.* [21]

Informed public debate is healthy and valuable, but it requires exposure to a full range of viewpoints. Regrettably, this is not the case in regard to the non-medical use of drugs. Rather, we have had constant and copious representation of the view that the only way to deal with the drug problem is to accept its inevitability and even its normalcy. (…)

[21] Brief from A. Maillet and C. Cloutier-Vautour to the Special Senate Committee on Illegal Drugs, Moncton, June 5, 2002.

In discussion about drug strategies, the harm of illegal drugs is usually identified , not with the drug's intrinsic chemical effects on the human body, especially on brain function and behaviour, but rather on extrinsic consequences of the illegality of the drug. Thus, the general havoc wreaked on the lives of addicts and their families is ignored in favour of deploring the harm that a criminal record can do to self-esteem. Further, the property crime and violence carried out by drug users are attributed to the illegality of the drugs rather than to the diminished work habits and lack of earning capacity which result from drug use. [22]

Our concerns with the Discussion Paper released by the Committee centre primarily on cannabis policies and the resulting effects on youth and families. (…) We suggest to the Committee that rather than focusing on reforming our drug laws, efforts would be much better spent on examining strategies focused on prevention. (…) Much rhetoric exists around the supposed 'war on drugs': have we lost the war, what do we do now and were we really fighting a war to begin with? The challenge presented to this Committee is not an easy task: to recommend workable, feasible policies regarding cannabis use. To this end, we trust that the Committee will be prudent in its decisions, innovative in its policy recommendations and resistant to the urge to simply give sway to 'hemp mania'. We owe it to our young people. [23]

Please, ladies and gentlemen, please do not just rely on research and the experts. There are many well-financed documents and experts that are paid to promote legalization. THC, the active ingredient of cannabis can be taken in pills, we do not have to promote smoking in another form. […] If I could suggest the following: 1. Provide more treatment resources and services; 2. Change our system of incarceration when it comes to drug-induces crime – mandatory treatment; and 3. Have our country adopt a zero tolerance to illegal drugs and provide the ability to our police to enforce the policy and mandate our courts to address the issue. Please do not provide another avenue for our children to escape reality. [24]

That said, most of the people who responded to the questionnaire also said they were in favour of decriminalization or controlled legalization of marijuana and marijuana derivatives. For that reason, we have to be very careful still regarding the meaning of the comments we received: most of those who wrote to us are probably interested, for personal reasons, in seeing the current legislation amended to introduce more tolerance. That view probably coloured their assessment of our discussion paper and the quality of our research findings.

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[22] Brief from Real Women, submitted to the Senate Special Committee on Illegal Drugs, June 6, 2002, pages 1-2.

[23] Brief from Focus on the Family to the Special Senate Committee on Illegal Drugs, Richmond, May 14, 2002.

[24] Letter from Kathy Bedard, Prince Rupert, British Columbia, May 15, 2002.

CONCLUSIONS

What is the status of public opinion in Canada? We are not able to come up with firm answers to that question. We do think, however, that:

Conclusions of Chapter 10	
Opinions on marijuana	➢ **Public opinion on marijuana more liberal than it was 10 years ago.** ➢ **Tendency to think that marijuana use is more widespread than it used to be.** ➢ **Tendency to think that marijuana is more available than it used to be.** ➢ **Tendency to think that marijuana is not a dangerous drug.** ➢ **Relatively significant concern about organized crime.** ➢ **Strong support for medical use of marijuana.**
Opinions on public policy options	➢ **Tendency to favour decriminalization or, to a lesser degree, legalization.** ➢ **Critical attitude toward law enforcement for simple possession of marijuana.** ➢ **Concern for youth and children.**

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME II : PART III

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

TABLE OF CONTENTS

INTRODUCTION **1**

PART I - GENERAL ORIENTATION **5**

CHAPTER 1 - OUR MANDATE **7**
WORDING 7
ORIGINS 9
INTERPRETATION 10

CHAPTER 2 - OUR WORK **13**
TWO WORKING PRINCIPLES 14
STATE OF KNOWLEDGE 15
Research Program 18
Expert Witnesses 19
The Challenge of Synthesis 21
TAKING OPINIONS INTO ACCOUNT 22
INTERPRETING IN LIGHT OF PRINCIPLES 23

CHAPTER 3 - OUR GUIDING PRINCIPLES **25**
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY 28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS 32
Collective governance 34
Governance of the self 35
The role of governance 37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION 38
Requirement for distinctions 38
Criteria for distinction 40
Application to illegal drugs issues 44
SCIENCE OR APPROXIMATE KNOWLEDGE 45
CONCLUSIONS 49

CHAPTER 4 - A CHANGING CONTEXT **51**
CHANGES IN THE INTERNATIONAL SPHERE 51
Globalization and Integration 51
Difficulties of the Security Debate 55
From Anti-Drug Policies to Drug Policies 57
CHANGES IN CANADA 58
Judicial Activism 58
A National Crime Prevention Strategy 59
The Fight Against Organized Crime 59
A SOCIETAL DEBATE 60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES 63

CHAPTER 5 - CANNABIS: FROM PLANT TO JOINT 65
ONE PLANT, VARIOUS DRUGS 66
CANNABIS ROADS 69
PROPERTIES OF CANNABIS 77
Δ^9THC Concentrations 78
Pharmacokinetics 83
CONCLUSIONS 87

CHAPTER 6 - USERS AND USES: FORM, PRACTICE, CONTEXT 89
PATTERNS OF USE 90
Consumption by the population as a whole 91
Consumption among young people 94
Use patterns in other countries 101
To summarize 108
PATTERNS AND CIRCUMSTANCES OF USE 111
Cannabis in History 111
Trajectories of Use 113
Factors Related to Use 119
To summarize 124
STEPPING STONE TOWARDS OTHER DRUGS? 125
CANNABIS, VIOLENCE AND CRIME 127
CONCLUSIONS 128

CHAPTER 7 - CANNABIS: EFFECTS AND CONSEQUENCES 131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD 134
ACUTE EFFECTS OF CANNABIS 139
CONSEQUENCES OF CHRONIC USE 143
Physiological Consequences of Chronic Use 143
Cognitive and Psychological Consequences 148
Behavioural and Social Consequences 152
TOLERANCE AND DEPENDENCE 152
Cannabis Dependence 154
Severity of Dependence 160
Tolerance 162
To summarize 163
CONCLUSIONS 164

CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS 167
FORMS OF TESTING 170
EPIDEMIOLOGICAL DATA 175
Studies not involving accidents 175
Studies where an accident was involved 176
Epidemiological studies on youth 179

Risk assessment 180
EXPERIMENTAL STUDIES 182
Non-driving activities 183
While driving 184
CONCLUSIONS 188

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES 191
HISTORY 196
CONTEMPORARY KNOWLEDGE 197
Therapeutic uses 198
Marijuana as a drug? 200
CURRENT THERAPEUTIC PRACTICES 203
CONCLUSIONS 205

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES 209
THE MEDIA 210
SURVEYS 215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE 221
CONCLUSIONS 224

PART III - POLICIES AND PRACTICES IN CANADA 225

CHAPTER 11 - A NATIONAL DRUG STRATEGY? 227
PHASE I - DEVELOPMENT AND IMPLEMENTATION 228
Creation of the Canadian Centre on Substance Abuse 233
Creation of Canada's Drug Strategy Secretariat 236
PHASE II - RENEWAL 237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING 240
CANADA'S DRUG STRATEGY – A SUCCESS? 241
CONCLUSIONS 243

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT 245
1908-1960: HYSTERIA 248
Opium Act, 1908 252
The Opium and Narcotic Drug Act, 1911 253
Amendments to the Opium and Narcotic Drug Act (1920-1938) 255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954 263
Senate Report of 1955 264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS 268
Narcotic Control Act (1961) 268
An Act respecting Food and Drugs and Barbiturates (1961) 270
The Le Dain Commission (1969-1973) 272
Bill S-19 and Cannabis 283
AFTER LE DAIN: FORGING AHEAD REGARDLESS 284
Controlled Drugs and Substances Act 286
CONCLUSIONS 295

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS 297
BACKGROUND TO THE RECENT REGULATIONS 298
Section 56 – Controlled Drugs and Substances Act 298
Charter Challenges – Therapeutic Use of Marijuana 299
Government Reaction 302
MARIHUANA MEDICAL ACCESS REGULATIONS 302
Authorization to Possess 303
Licence to Produce 306
Other Provisions 307
COMPASSIONATE ACCESS? 308
Eligibility 309
Access to cannabis 312
Products 316
Costs 316
RESEARCH PLAN 317
Scientific Research 318
Research-Grade Marijuana 320
CONCLUSIONS 321

CHAPTER 14 - POLICE PRACTICES 323
ENFORCEMENT AGENCIES 323
RCMP 323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999 326
TheCanada Customs and Revenue Agency 326
Provincial and Municipal Police 328
COSTS 328
POLICE POWERS 333
Searches and Seizures 335
Entrapment and Illegal Activity 347
Conclusion 352
STATISTICS 353
Reported Incidents 353
Charges 356
Concerns 359
Customs Act - Fines 361
SEIZURES 362
CONCLUSIONS 364

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM 367
PROSECUTION 367
COURTS 368
Drug Treatment Courts 369
DISPOSITION AND SENTENCING 372
CORRECTIONS 376
CRIMINAL RECORD 379
COURT CHALLENGES 382
CONCLUSIONS 387

CHAPTER 16 - PREVENTION **389**
INITIATIVES THAT FALL SHORT OF THE MARK **393**
Not enough prevention **394**
Prevention lacks focus **396**
There is not enough evaluation of preventive measures **397**
Preventive and social messages in contradiction **398**
There is a body of knowledge on which we have to draw **399**
PREVENTING WHAT AND HOW? **400**
RISK REDUCTION AND HARM REDUCTION **410**
CONCLUSIONS **412**

CHAPTER 17 - TREATMENT PRACTICES **415**
CANNABIS DEPENDENCY **415**
FORMS OF TREATMENT **421**
EFFECTIVENESS OF TREATMENT **423**
CONCLUSIONS **426**

CHAPTER 18 - OBSERVATIONS ON PRACTICES **427**
DIFFICULTIES IN HARMONIZING THE PLAYERS **427**
INCONGRUITIES OF APPROACH **429**
SIGNIFICANT ECONOMIC AND SOCIAL COSTS **431**

PART IV - PUBLIC POLICY OPTIONS **437**

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT **439**
A GENEALOGY 440
The 1909 Shanghai Conference 443
The 1912 Hague International Opium Convention 444
The 1925 Geneva Opium Conventions 446
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement 447
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs 448
The Second World War 449
The 1946 Lake Success Protocol 449
The 1948 Paris Protocol 450
The 1953 New York Opium Protocol 450
THE THREE CURRENT CONVENTIONS 451
The Single Convention on Narcotic Drugs, 1961 451
Convention on Psychotropic Substances 455
Protocol amending the Single Convention on Narcotic Drugs, 1961 460
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 462
SOME LEEWAY? 464
CONCLUSIONS 468

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES **469**
FRANCE 470
Different Forms of Logic 470
An Integrated Public Policy 472
Legislative Framework 474
Key Reports 477
Statistics on Use and Offences 481
Costs 483
THE NETHERLANDS 485
Dutch Pragmatism? 486
Essential Experts Reports 488
Legislation 493
The Coffee Shop System 496
Data on Use 498
UNITED KINGDOM 502
Ten-Year Strategy to Battle Drugs 502
Legislative Framework 503
Other Relevant Legislation in the Field of Drug Misuse 505
Debate in the UK 506
Recent Key Reports and Studies 507
Administration 515
Costs 515
Statistics 516
SWEDEN 518
National Strategy 520
Legislative Framework 523
Debate in Sweden 525
Recent Reports 526
Costs 528
Administration 528
Statistics 529
SWITZERLAND 531
A Harm Reduction Policy 531
The Legal Framework 538
A Bill to Decriminalize Cannabis 539
Administration of Swiss Drug Policy 542
Statistics on Narcotics Use and Offences under the Narcotics Act 544
AUSTRALIA 546
National Drug Strategy 546
Legislative Framework 551
Decriminilization in Australia 554
Administration 556
Statistics 557
UNITED STATES 560
The Federal-State Legislative Framework 560
Current Legislation and Enforcement 563
Federal Drug Policy Goals and Objectives 570
Administration of the Policy 572
Current Issues and Debates 575

Statistics 576

CHAPTER 21 - PUBLIC POLICY OPTIONS 581
INEFFECTIVENESS OF CRIMINAL POLICIES 583
Impact on Consumption 583
Impact on Supply 589
Conclusion 590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS 591
COMPONENTS OF A PUBLIC POLICY 593
Strong Decision-making Body 593
Interconnection 594
A Shared Definition of Shared Objectives 594
Information Tools 594
LEGISLATIVE OPTIONS 595
Clarification of criminology 595
Criteria for a Legal Policy on Cannabis 602

CONCLUSIONS AND RECOMMENDATIONS 607

LE DAIN – ALREADY THIRTY YEARS AGO 607
INEFFECTIVENESS OF THE CURRENT APPROACH 609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES 610
A CLEAR AND COHERENT FEDERAL STRATEGY 611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS 612
A PUBLIC HEALTH POLICY 614
A REGULATORY APPROACH TO CANNABIS 617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE 618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS 619
RESEARCH 620
CANADA'S INTERNATIONAL POSITION 621

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES 623

BIBLIOGRAPHY 627

GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see chapter 7). In the report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence. (toxicomanie a de l'information additionelle)

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators, THC increasing the liberation of dopamine in nucleus accumbens and cerebral cortex.

At-risk use
Use behaviour which makes users at-risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marihuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic

drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure decriminalization*, which entails an amendment to criminal legislation, and *de facto decriminalization*, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalisation
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical

or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states objective, reliable and comparable information within the EU on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate quickly the tissues. THC is highly fat-soluble.

Gateway (theory)
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then "hard" drugs. The theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate is from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces on inactive THC metabolites can be detected as many as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant and transformed into a paste.

International Conventions
Various international conventions have been adopted by the international community since 1912, first under the Society of Nations and then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organisation responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems resulting from a substance. Pharmacology generally distinguishes four levels: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC are more difficult, especially in trying to determine the therapeutic benefits of cannabis and to examine its effects on driving.

Legalisation
Regulatory system allowing the culture, production, marketing, sale and use of substances. Although none currently exist in relation to « street-drugs » (as opposed to alcohol or tobacco which are regulated products), a legalisation system could take two forms: without any state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become equivalent for cannabis.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of national drug control policy (ONDCP) USA
Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. More neutral than the term "drug" because it does not refer to the legal status of the substance, it is the term we prefer to use.

Psychotropic substance (see also psychoactive)
Much the same as psychoactive substance. More specifically however, the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytic, sedatives, neuroleptics, etc. More specifically, refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
Control system specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Society of Nations (SDN)
International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance
Reduced response of the organisms and increased capacity to support its effects after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs, including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO)
The World Health Organization, the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

PART III

POLICIES AND PRACTICES IN CANADA

CHAPTER 11

A NATIONAL DRUG STRATEGY?

There is no arguing that both licit and illicit psychoactive substances affect Canadians in many ways, both positively and negatively, both directly and indirectly. In addition, no one would dispute the fact that psychoactive substance use (again, both licit and illicit) is a widespread phenomenon, not only on the part of adults but also among the youths of this country. Because of the potential problems for those who abuse psychoactive substances, dealing with this issue should be a matter of serious concern for any government, and for society as a whole.

Based on the importance of the subject, it would probably surprise many Canadians to learn that only from 1987 to 1993 did Canada have a fully funded national drug strategy. It is true that Canada has had legislation dealing with the use of psychoactive substances since the passage of the *Opium Act* in 1908. This Act was followed by several pieces of criminal legislation over the years that increased federal enforcement powers over psychoactive substances and expanded the list of illicit substances.[1] These pieces of legislation have historically focused on the supply of psychoactive substances, adopting a prohibitionist approach to use. It is widely acknowledged, however, that a more balanced approach is required if one is to deal effectively with those who abuse psychoactive substances.

This chapter will recount the development and implementation of the 1987 National Drug Strategy, which had as an objective the promotion of a balanced approach to the problem of psychoactive substance abuse. This will be followed by a discussion of what became of the national strategy and whether its goals have been achieved.

[1] A discussion of Canada's legislative history in regard to psychoactive substances can be found in Chapter 12.

PHASE I - DEVELOPMENT AND IMPLEMENTATION

In May 1987, the federal government announced a $210-million, five-year action plan to curb drug abuse. The government stated that the action plan was in response to mounting concerns regarding increasing rates of drug-related problems. Others have suggested that *"(t)his strong political action was undoubtedly influenced by the latest American 'War on Drugs.'"*[2]

The National Drug Strategy (NDS), *Action on Drug Abuse*, was launched by the then Minister of National Health and Welfare, who was the lead Minister in the federal effort to curb drug abuse.[3] Several other departments also participated in the first interdepartmental attempt to co-ordinate Canada's response to its drug abuse problem. It was believed that there was a need for a coordinated, strategic approach to the problem of drug abuse in Canada. The overall objective of the NDS was *"to reduce the harm to individuals, family and communities from the abuse of alcohol and other drugs through a balanced approach that is acceptable to Canadians."*[4] Other partners included provincial and municipal governments, business, law enforcement agencies, and professional and voluntary organizations.

The federal government recognized that, in the past, the emphasis of its involvement in this area had been largely restricted to supply control measures. Meanwhile, communities, provinces and territories, and many professional and volunteer groups, had focused their efforts on reducing the demand for drugs, through prevention and treatment programs. Given the division of constitutional powers in Canada, this separation of responsibilities is not altogether surprising. It does, however, impose limits on the establishment of a comprehensive national framework.

> *The division of powers between Canadian provinces and the federal government has made concerted, comprehensive action against drug and alcohol abuse very difficult to achieve. For example, most program strategies aimed at prevention are generally seen as part of the health or education systems; matters of provincial jurisdiction over which the federal government has little direct control. However, while enforcement activities are controlled at the local level, for the most part, the authority derives from federal powers, and the control largely remains with the federal government.* [5]

In developing the NDS, the federal government noted that, within the provinces and territories, and at the community level, many innovative programs of drug counselling, therapy and rehabilitation had been initiated. It also recognized that much

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[2] Giffen, P.J., Endicott, S. and S. Lambert, (1991) *Panic and Indifference: The Politics of Canada's Drug Laws*, Ottawa: Canadian Centre on Substance Abuse, page 587.

[3] Government of Canada, News Release, *Federal Government Launches Co-ordinated Action on Drug Abuse*, 25 May 1987.

[4] Government of Canada, *Action on Drug Abuse: Making a Difference*, 1988, page 5.

[5] Giffen, P.J., *op. cit.*, page 585.

of the program expertise existed at the provincial level. What was lacking, however, was a strong mechanism for national collaboration. The government believed that the NDS provided such a comprehensive national framework and viewed it as *"a co-operative program that combines the efforts and resources of the federal government with those of all provincial and territorial governments and addiction agencies across Canada*."[6]

The government identified six core components of the NDS: education and prevention; enforcement and control; treatment; international cooperation; research and information; and national focus. Of the $210 million in new federal funds allocated to enhance existing programs and to fund new initiatives, $20 million was allocated for the first year, $40 million for the second year, and $50 million for the last three years of the strategy. A significant amount (70%) of the resources was committed to education and prevention (32%) and treatment and rehabilitation (38%); 20% was committed to enforcement and control; and the other 10% to information and research (6%), international co-operation (3%) and national focus (1%).[7] The government noted that, while enforcement agencies were given more resources to combat supply, most of the money was allocated to address the demand for psychoactive substances, thus providing a better balance between reducing both the demand for drugs and reducing their supply.[8] According to information received from Health Canada, the resources were generally spent as planned.

In order to illustrate the comprehensive nature of the NDS, the following sets out the goals and initiatives announced during the week of its launch:

Prevention, treatment, research, control components[9]

❖ To create improved public awareness and information:
- A media campaign, developed in consultation with provinces;
- Federal endorsement of Drug Awareness Week;
- Telephone information lines.

❖ To encourage involvement in prevention activities:
- Support for a range of prevention initiatives developed within local communities;
- Support for the development of innovative and improved treatment services at the community level;

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[6] Government of Canada, *Action on Drug Abuse: Making a Difference*, 1988, page 7.

[7] *Ibid*.

[8] From 1987 to 1991, an additional $19.5 million was provided for the Driving While Impaired (DWI) Strategy. The DWI strategy included national awareness programs, driver education curricula, national surveys and hundreds of local initiatives aimed at making drinking and driving socially unacceptable to Canadians.

[9] Government of Canada, *National Drug Strategy: Prevention, Treatment, Research, Control Components*, 25 May, 1987.

- Development and expansion of training and training materials;
- A National Action Conference on Drug Abuse.

❖ To encourage prevention initiatives targeted to particular groups:

- Efforts to encourage youth employment activities that improve life-skills development as well as employability;
- Support for demonstration projects by police to develop new prevention initiatives for youth in school, and for urban youth at risk and Aboriginal communities;
- A review of all current programming directed at drug abuse among Aboriginal people;
- New initiatives focussed particularly at Aboriginal youth;
- Support for northern communities wishing to exchange experiences with other Arctic Rim communities on drug abuse issues.

❖ To encourage more effective treatment services tailored to specific needs:

- An examination of future federal cost-sharing of new or expanded drug and alcohol treatment and rehabilitation programs;
- Measures to improve detection of drug abuse by health professionals and to support their rehabilitation;
- Establishment of an advisory committee on methadone and measures to prevent diversion of methadone;
- Development of training materials and information for health care professionals and others working in the addictions field;
- A review of current efforts to address the problem of drugs in the workplace;
- Continued efforts to eliminate the use of banned drugs in sport within Canada and internationally.

❖ To update and improve Canada's drug laws and regulations:

- New legislation to replace the outdated *Narcotics Control Act* and *Food and Drugs Act*;
- Improved co-ordination among federal organizations and with provinces to improve regulatory control of drug use;
- Increased federal capacity for drug identification, analysis and monitoring;
- Co-ordinated policies concerning illegal supply of drugs in Canada.

❖ To improve the knowledge base in the drug abuse field:

- Support research on patterns and trends in the drug abuse field and on prevention and treatment;
- A study and recommendations on priority data needs.

❖ To ensure a long-term commitment to the drug abuse field where long-term solutions are needed:
- A Task Force to review different means of ensuring that provincial expertise and experience can be made available for the benefit of the country as a whole and to ensure national ongoing commitment to promoting the study and prevention of drug abuse.

Enforcement components[10]

❖ To provide strengthened and co-ordinated drug law enforcement:
- Strengthening of the RCMP's drug intelligence capabilities and liaison with other forces;
- A co-ordinated approach to improved coastal enforcement against drug smuggling;
- Improved co-ordination of drug law enforcement at the federal level as well as between federal and provincial organizations.

❖ To help take the profit out of illegal drug trafficking:
- Expansion of the RCMP's Anti-Drug Profiteering Program and improved public awareness of program activities and objectives;
- Improved techniques for tracing illicit funds will be developed.

❖ To strengthen Canada's international efforts:
- RCMP special training in drug enforcement for police officers of selected drug source or transit countries.

❖ To create improved public awareness and information about drug abuse:
- An expansion in the RCMP's capacity across the country to promote drug awareness.

❖ To address the problems of drug abuse in federal correctional institutions:
- A study will be undertaken on drug use among inmates and on the effectiveness of current treatment programs in correctional institutions;
- Improved drug control in penitentiaries;

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[10] Government of Canada, *National Drug Strategy: Enforcement Components*, 26 May 1987.

- Development of programs for inmates with drug abuse problems to help them cope better after their release;
- Improved prevention through training for staff and development of information programs for inmates.

Interdiction components[11]

❖ To strengthen Canada Customs' capacity to interdict illegal drugs entering Canada:

- Expansion of Canada Customs resources to strengthen capability in the critical areas of targeting and examination of high-risk cargo shipments and travellers in all modes of transportation, and of high-risk mail;
- Development and acquisition of X-ray equipment to increase drug detection capabilities during the examination of cargo, baggage and mail;
- Expansion of the Canada Customs Detector Dog Service to provide service in all Customs regions across Canada, and increase our present capabilities at high-volume points of entry;
- Enhanced training to Customs Inspectors in the identification of drug couriers and high-risk commercial shipments: this training will increase the awareness of Customs Inspectors relating to the identification of indicators (characteristics) that may be present during the examination of a person or commercial shipment;
- Expansion of Canada Customs involvement in the Crime Stoppers programs of municipal police forces across Canada;
- Co-operation with airlines and shipping companies engaged in the international transport of people and goods, with a view to Canada Customs obtaining assistance in the detection of illicit drugs destined for Canada;
- Co-operation with foreign Customs services in targeting in-transit drug couriers.

❖ To ensure appropriate immigration policies:

- Review of immigration policy on drug traffickers.

International components[12]

❖ To ensure that Canada plays an active role in international forums on drug abuse:

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[11] Government of Canada, *National Drug Strategy: Interdiction Components*, 27 May 1987.
[12] Government of Canada, *National Drug Strategy: International Components*, 28 May 1987.

- Canada's active participation at the International Conference on Drug Abuse and Illicit Trafficking to be held in Vienna, 17-26 June 1987;
- Accession to the 1971 United Nations Convention on Psychotropic Substances;
- Increase in Canada's contribution to the United Nations Fund for Drug Abuse Control (UNFDAC) to a target level of $1 million by 1991;
- Inclusion of reduction of drug abuse as a factor in considering requests for assistance under Official Development Assistance;
- Hosting of an international conference of experts on Recommended Methods for Testing Drugs of Abuse.

❖ To improve public awareness and information:
- Information for Canadians travelling abroad about the hazards of illicit drug possession in other countries.

Proceeds of crime components[13]

❖ To take the profit out of illicit drug trafficking:
- Proceeds of Crime legislation to reduce the profitability of drug trafficking.

Creation of the Canadian Centre on Substance Abuse

The Canadian Centre on Substance Abuse (CCSA) was created by an act of Parliament in 1988. It is a non-governmental organization with the aim to promote "*increased awareness on the part of Canadians of matters relating to alcohol and drug abuse and their increased participation in the reduction of harm associated with such abuse, and to promote the use and effectiveness of programs of excellence that are relevant to alcohol and drug abuse*."[14] This is to be done by:

❖ Promoting and supporting consultation and co-operation among governments, the business community and labour, professional and voluntary organizations in matters relating to alcohol and drug abuse;
❖ Contributing to the effective exchange of information on alcohol and drug abuse;
❖ Facilitating and contributing to the development and application of knowledge and expertise in the alcohol and drug abuse field;
❖ Promoting and assisting in the development of realistic and effective policies and programs aimed at reducing the harm associated with alcohol and drug abuse; and

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[13] Government of Canada, *National Drug Strategy: Proceeds of Crime Components*, 29 May 1987.
[14] *Canadian Centre on Substance Abuse Act*, R.S., 1985, c. 49 (4th Supp.), s. 3.

- Promoting increased awareness among Canadians of the nature and extent of international efforts to reduce alcohol and drug abuse, and supporting Canada's participation in those efforts.[15]

Thus, the CCSA was created to provide a national focus and leadership in the area of reducing the harm associated with alcohol and other drug abuse. It works closely with federal and provincial partners, both governmental and non-governmental. As the NDS indicated, the government had recognized that a coordinated response including all partners was required if long-term solutions were to be found. Co-operation and coordination between all partners is a key function of the CCSA.

> *The CCSA works with the private sector, provincial addiction agencies, and many special interest groups to make it possible for all Canadians to benefit from the best prevention programs. One way of doing this is by keeping people working in the field in touch with what's happening across the country.*[16]

The CCSA is primarily responsible for providing "credible, objective information and policies on addiction to the federal government, the not-for-profit and private sectors, and provincial/territorial and municipal governments."[17] It has set out the following seven goals:

- Policy Formulation
  - Goal 1: To monitor significant research and policy developments, and to provide informed comment on issues of national significance.

- Information Development
  - Goal 2: To maintain and continually improve national information on the nature, extent and consequences of substance abuse, and problem gambling in Canada.

- Best Practices Development
  - Goal 3: To monitor significant programs and practices, and contribute to the identification and dissemination of best practices.

- Communications
  - Goal 4: To develop a communications strategy that includes a series of focused activities and information products aimed at increasing the

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15 *Ibid.*

16 Government of Canada, *Canada's Drug Strategy*, 1991, page 4.

17 *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 6.

awareness of Canadians of addictions issues, and influencing and informing CCSA's key target audiences.

- Network Development
  - Goal 5: To develop, co-ordinate and support networks that facilitate the sharing and application of information and expertise.

- Information and Reference Service
  - Goal 6: To maintain an efficient and responsive information and reference service.

- Administration/Management
  - Goal 7: To organize the policy, administrative and human resource functions in an effective and financially responsible manner.[18]

An important contribution of the CCSA is the establishment of a Clearinghouse on Substance Abuse, which links all major sources of information on alcohol and other drugs in a single computer network.

The CCSA, which is within the portfolio of the Minister of Health, is structured as a corporation, with a chair and a board of directors. It is funded by the NDS and through its own revenue-generating efforts. The CCSA was originally allocated an annual $2 million of core funding but the cuts that occurred as a result of Program Review in 1997 reduced its core funding to $500 000. This necessitated the release of almost all full-time staff. Michel Perron, the CCSA's chief executive officer, indicated that the budget cuts affected the CCSA's ability to carry out its mandate.

> *Since 1997, the CCSA has basically survived by working for a number of departments on contract. Those contracts ensured our survival, but significantly hindered our efforts to fulfill our legal mandate in a proactive way.* [19]

In early 2002, the government increased the CCSA's core funding to $1.5 million. We were told that, with this increase, the CCSA can stabilize its activities and Canada runs a lower risk of losing its only collective memory as well as the only drug addiction specialists working at the federal level.[20]

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[18] For more information or the CCSA, visit its website at http://www.ccsa.ca and see Government of Canada, *Canada's Drug Strategy - Phase II: A situation paper*, Canada, 1994, pages 38-40.

[19] Michel Perron, Executive Director, Canadian Centre on Substance Abuse, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament 2001-2002, 10 June 2002, Issue no. 22, page 69.

[20] *Ibid.*,

Creation of Canada's Drug Strategy Secretariat

In 1990, Canada's Drug Strategy Secretariat was given the mandate to coordinate activities within the federal government and with other governments (both nationally and internationally). The secretariat was given many responsibilities, including ensuring the visibility of the NDS, coordinating the evaluation of the NDS and examining the issue of substance abuse from a strategic standpoint. One of its key responsibilities was to act as a facilitator.

> *An important function of the Secretariat is to serve as an information source, a central point of entry to the federal government directing those with questions toward people with the answers. Members of the Secretariat also provide advice from outside groups to the federal partners. They attempt to bring groups together to facilitate issues of common concern.* [21]

The Secretariat was disbanded in 1996 during Phase II of the strategy. In the evaluation of Phase II of the CDS, it was suggested that the function of overseeing the coordination should be given to a body that is not an integral part of one of the partner departments–otherwise, such a body would be in a potential or perceived conflict of interest.[22] In the past, some had regarded the Secretariat as representing primarily the interest of Health Canada rather than representing the drug strategy itself.

Today, the Office of Canada's Drug Strategy is the focal point within the federal government for the drug strategy. It describes itself as follows:

> *The Office of Canada's Drug Strategy of Health Canada is the focal point within the federal government for harm reduction, prevention, and treatment and rehabilitation initiatives concerning alcohol and other drugs issues. Our efforts aim to prevent the use of drugs by those not currently using them, reduce the harm for those who use them, and promote effective and innovative treatment and rehabilitation for those affected by substance abuse. The Office works collaboratively with other federal departments and provincial and territorial governments, and provides national leadership and co-ordination on substance abuse issues, conducts research into the risk factors and root causes of substance abuse, synthesizes and disseminates leading-edge information and best practices to key partners, and collaborates with multilateral organizations to address the global drug problem.* [23]

The Auditor General, in her 2001 Report, indicated that there are limits on Health Canada's authority as coordinator and recommended that the government *"review the current mechanisms for leadership and co-ordination within the federal government as well as mechanisms for co-ordination with provincial/territorial and municipal governments in addressing the problem of illicit drugs."*[24] We agree with the Auditor General's assessment and recommend

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[21] Government of Canada, *Canada's Drug Strategy - Phase II: A situation paper*, Canada, 1994, pages 11-12.

[22] Health Canada, *Evaluation of Canada's Drug Strategy: Final Report*, June 1997, page 22.

[23] Information regarding the Office of Canada's Drug Strategy can be found on the Health Canada web site at http://www.hc-sc.gc.ca/hppb/cds-sca/cds/about.html (revised: 1 December 2000).

[24] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 24.

the creation of a position of National Drug Advisor, responsible for ensuring interdepartmental co-ordination at the federal level. In addition, the CCSA would be given a coordinating role with respect to the provinces and territories, cities and with research bodies and universities.

PHASE II - RENEWAL

In order to determine the future of the NDS, the federal government undertook a national consultation process in March and April 1991. The purpose of the consultations, held with local and provincial partners, was to prepare for the possible renewal of the NDS, obtain information on the strengths and weaknesses of the strategy and identify renewal priorities. During the consultations, alcohol abuse was identified as the major problem in Canada, and the abuse and misuse of pharmaceuticals was the second most frequently mentioned concern. Tobacco use was also seen as a major substance abuse and health problem. Street drugs, while still a concern, were not a major worry of those consulted. It was noted that cannabis use continued to be widespread.

Many at the consultations advocated incorporating the Driving While Impaired (DWI) Strategy into the NDS, and there was also strong support for a comprehensive national alcohol policy. It was also suggested that use of steroids by athletes and youth be included in the NDS. Finally, others called for a comprehensive tobacco policy and for tobacco's inclusion within the NDS. A long-term commitment to the drug strategy was one of the issues stressed by the participants.

> *To address many problems in substance abuse, participants in the consultation process stressed the need for a long-term commitment to CDS. Substance abuse has been a problem since the dawn of time. To expect significant changes in the level and nature of substance abuse over a five, or even a ten, year period is not realistic. The impact of initiatives to counteract the problem of substance abuse may not be visible for generations. Therefore, CDS must become an ongoing program with political and government support and endorsement. Bringing about fundamental long-term societal changes in attitude and behaviour requires base funding, without a sunset provision.* [25]

In 1992, the NDS was renewed under the designation Canada's Drug Strategy (CDS). Funding was increased to $270 million over the five-year period and the Strategy principally involved six federal departments.[26] As had been suggested, the DWI Strategy became a component of CDS, although the same could not be said for

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[25] Government of Canada, *Canada's Drug Strategy: Consultations 1991*, page 7. For more information on comments made regarding supply issues, demand issues and the role and impact of CDS, see pages 3-7.
[26] Health and Welfare Canada, Solicitor General Canada, Revenue Canada (Customs and Excise), Labour Canada, External Affairs and International Trade Canada and Justice Canada.

tobacco. Once again, CDS called for a balanced approach to reducing both the demand for drugs and their supply. The funding was to be allocated as follows: prevention (30%); treatment (30%); enforcement and control (28%); information and research (5%); national focus (5%); and international co-operation (1%). According to Health Canada, over the five-year period, about $104.4 million was actually provided.[27] In fact, resources that were originally approved were almost immediately reduced, and this reduction continued over the course of CDS as a result of budget cuts.

In renewing CDS, the federal government acknowledged the concerns of stakeholders and stated that solutions to substance abuse require long-term commitment–that to expect significant changes over five or even ten years was not realistic. Thus, it was stated that CDS should become an ongoing program. In addition, it was thought that a balanced approach between demand and supply reduction was critical to the success of CDS. Finally, it was recognized that partnerships (both governmental and non-governmental) at all levels (locally, nationally and internationally) were needed.[28]

On the whole, it was concluded that the strategy was working well and that it was important to maintain the momentum created by Phase I. The primary and overall objective of Phase II was to make Canada's alcohol and other drug interventions more effective at reducing harm to individuals, families, and communities caused by the problem use of alcohol and other drugs. This would be accomplished through the following secondary objectives:

- Improved program targeting through a focus on high-risk populations (especially young children, street kids, dropouts, off-reserve Aboriginals, the unemployed, seniors and women);
- Improved coordination and collaboration across federal departments and with external partners (provincial and territorial governments, non-governmental organizations, etc.);
- An improved information base on substance abuse-related issues, to assist policy-makers, program developers, researchers, professionals, and others concerned with substance abuse issues in addressing this problem; and
- Enhanced resources that would enable departments to continue certain ongoing activities and redirect attention to emerging issues or new activities.[29]

The decision to renew CDS was accompanied by a requirement for its evaluation. In June 1997 a report evaluating Phase II of CDS was published by Health Canada. Its main findings were as follows:

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[27] Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament 2001-2002, 10 June 2002, Issue no. 22, page 27.

[28] Government of Canada, *Canada's Drug Strategy – Phase II*, 1992, page 3.

[29] Health Canada, *Evaluation of Canada's Drug Strategy: Final Report*, June 1997, p. iv.

- Improved program targeting was implemented in all participating departments, with justifiable variation according to their respective mandates;
- Interdepartmental coordination at the working level and for task-specific initiatives was effective. However, interdepartmental co-ordination at the strategic planning level was identified as a concern over the course of Phase II and would not appear to have been resolved (clear coordination goals were not identified, nor was the role of the CDS Secretariat properly defined);
- CDS did not have national visibility at either political or public levels;
- The information available in Canada on the issue of substance abuse increased as a result of Phase II funding;
- Departmental resources were increased through Phase II. However, there were significant subsequent cuts to some departmental budgets that may have limited the potential achievements of Phase II; and
- Phase II resources were used in a manner consistent with a harm reduction approach, although a formal harm reduction policy was not in place during the course of the strategy.

The report also identified effective leadership, coordination and strategic planning as essential to the strategy, and found weaknesses in these areas during Phase II. In addition, a common vision and a set of clear and measurable objectives were also found to be fundamental requisites. Lack of accountability for strategy-wide objectives was also identified as a problem. As will be discussed later, most of these issues were again raised as concerns in 2001 (five years later) by the Auditor General of Canada

To coordinate the strategy, two groups were established at the federal level, both chaired by Health Canada: the Assistant Deputy Ministers' Steering Committee on Substance Abuse, and the Interdepartmental Working Group on Substance Abuse. Their purpose has been described as follows:

> *The Steering Committee is mandated to meet at least twice a year to improve the overall effectiveness of the strategy and provide direction to the Working Group. Its aims are to co-ordinate federal activities, develop consensus on priorities, address emerging issues, and monitor implementation of the federal strategy.* [30]

PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING

In 1997, the *Controlled Drugs and Substances Act* (CDSA) was enacted. This legislation formed part of CDS; it was focused, according to the government, on

[30] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 6.

modernizing and enhancing the drug abuse control policy underlying the previous legislation and on fulfilling Canada's international obligations. It should be noted that since the introduction of the CDSA, most changes to federal legislation dealing with illicit drugs have focused on supply reduction.

In 1998, CDS was renewed in principle but without any specified funding, despite warnings of possible negative consequences. An evaluation of Health Canada's contributions to CDS stated that:

> *We must conclude that short-term initiatives such as the CDS Phase II are useful in that they inspire a higher sense of priority for a certain issue; at the same time, they hold inherent disadvantages in addressing an issue such as substance abuse, that is widely recognized to require a longer-term intervention than time-limited initiative funding will allow.* [31]

The following was also added:

> *The CDS Phase II Health Canada Component made a considerable investment in research and program development, and information monitoring systems. In many areas, Health Canada is now poised to reap benefits from the knowledge gained – however it is feared that this will not be the case due to non-renewal.*
>
> *There are also concerns that the sunsetting of the Health Canada component of the CDS will not only leave a void but see the balance in the federal harm reduction policy list too far in the direction of supply reduction, and that Canada's international credibility will also suffer.* [32]

The signatories were limited to federal departments and agencies, with Health Canada again responsible for providing national leadership and coordination. CDS still states that it reflects a balance between reducing the supply of drugs and reducing the demand for drugs. The long-term goal of the strategy remains unchanged: it is to reduce the harm associated with alcohol and other drugs to individuals, families and communities. The goals of CDS are to:

- Reduce the demand for drugs;
- Reduce drug-related mortality and morbidity;
- Improve the effectiveness of and accessibility to substance abuse information and interventions;
- Restrict the supply of illicit drugs and reduce the profitability of illicit drug trafficking; and
- Reduce the costs of substance abuse to Canadian society.[33]

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[31] Health Canada, *Evaluation of Health Canada's Contributions to Canada's Drug Strategy: Final Report*, December 1996, pages 33-34.
[32] *Ibid*., pages 34-35.
[33] Government of Canada, *Canada's Drug Strategy*, 1998, pages 4-5.

The strategy states that it is built on four pillars: prevention; enforcement and control; treatment and rehabilitation; and harm reduction. Within this general framework, seven separate components have been identified: research and knowledge development; knowledge dissemination; prevention programming; treatment and rehabilitation; legislation, enforcement and control; national coordination; and international co-operation.[34]

The Drug Strategy and Controlled Substances Program, within the Healthy Environments and Consumer Safety Branch of Health Canada, currently spends $34 million annually on substance abuse.[35] The Office of Canada's Drug Strategy currently manages $16.5 million of the $34-million total budget. The Alcohol and Drug Treatment and Rehabilitation program, which was originally managed by HRDC, was transferred to Health Canada in October 1997. It is currently managed by the Office of Canada's Drug Strategy, which provides $14 million to the provinces for treatment and rehabilitation programs. The other $2.5 million is allocated to the CCSA ($1.5 million) and for research and program management ($1.0 million). The remaining $17.5 million is allocated by the Healthy Environments and Consumer Safety Branch as follows: administration of regulations other than the Marijuana Medical Access Regulations ($5.0 million); Medical Marijuana Program ($5.0 million); drug analytical services ($4.5 million); policy, research and international affairs ($3.0 million).[36]

Health Canada does spend other resources on substance abuse through the department's varied activities. For example, the Population and Public Health Branch allocates resources to deal with HIV/AIDS and Hepatitis C, and to deal with FAS/FAE.

CANADA'S DRUG STRATEGY – A SUCCESS?

This section does not claim to provide an in-depth analysis of CDS since its implementation and development in 1987. Certain key objectives, however, will be reviewed in order to determine whether or not the CDS can be deemed a success. It is important to note that, despite the considerable amounts of money spent at the federal level to control psychoactive substances, many would argue that Canada does not even have a funded national drug strategy.

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[34] While CDS deals with both licit and illicit substances, a separate strategy has been developed to identify specific approaches to tobacco.

[35] This does not include expenditures made by the First Nations and Inuit Health Branch, which total approximately $70 million.

[36] Health Canada, Presentation to the Special Committee on Illegal Drugs, 10 June 2002.

In 1997 the government implemented "Program Review", and severe financial cuts were applied to all departments, including Health Canada. The drug strategy did not escape these cuts and it sunset in 1997. In fact, there has been very little new money from the federal government for the field of addictions since.

Canada currently has no national strategy. We therefore simply do not have research data to guide us. In fact, no one knows the extent of drug consumption or prevalence in Canada because no national inquiry has been done since 1994. We therefore have to come up with hypotheses and resort to other tools to get a picture of the current situation in Canada. [37]

As mentioned, research, knowledge development and knowledge dissemination are severely lacking in Canada, despite the fact that these are intended to be key components of the CDS. A more complete analysis of these deficiencies in knowledge development and dissemination is set out in Chapter 6. To summarize, Canada has not given itself the means to conduct proper research and to acquire knowledge in this field. For example, only two general national drug surveys have been conducted - in 1989 and 1994. Much of the problem with respect to research and knowledge development can be attributed to the almost non-existent funding allocated to the CCSA. Considering the importance of the CCSA's role in knowledge development and the costs of substance abuse in Canada, it is clear that its funding has been totally inadequate over the years. The recent increase to its core funding may temporarily stop the bleeding but will not allow Canada to acquire the tools necessary to conduct vital and necessary research in this area.

The CDS has, since its implementation, stated that it reflects a balance between reducing the supply of drugs and reducing the demand for drugs. While such policy objectives are easy to pronounce, they have not been reflected in reality. The Auditor General has recently indicated that, of the approximately $500 million spent annually by 11 departments or agencies at the federal level to address illicit drug use in Canada, roughly 95% is spent on supply reduction. Notwithstanding the division of constitutional powers in Canada, one would be hard pressed to argue that this allocation of funds represents a balanced approach.

Another of the key objectives of the CDS is to ensure coordination and collaboration across all federal departments and with the provinces and municipalities. The Auditor General has recently criticized the leadership provided at the federal level and recommended a drug strategy with sound co-ordination and with clear objectives and results.

Canada requires stronger leadership and more consistent co-ordination to set a strategy, common objectives, and collective performance expectations. It must be able to respond quickly to emerging concerns about illicit drug use or the illicit drug trade. The present structure for leadership and for co-ordination of

[37] Michel Perron, *loc. cit.*, page71.

federal efforts needs to be reviewed and improved. The mechanisms for co-ordination with the provinces and municipalities also need review since they cross three levels of government. [38]

One of the obvious weaknesses of the CDS is the failure to provide comprehensive evaluations of its objectives. For example, we are unaware of any evaluations of the prevention and treatment programs that have been funded by the federal government. This lack of evaluation is an overall concern.

Although the federal government provides leadership and co-ordination for dealing with the illicit drug problem, it has not produced any comprehensive reports that demonstrate how well Canada is managing the problem. It would be logical for Health Canada, as the lead department, to report government-wide results of Canada's efforts to reduce the demand for and the supply of illicit drugs. [39]

In summary, it would be difficult to declare the CDS a success when we do not even have the tools needed to determine whether or not the objectives of the strategy have been satisfied. The current strategy has, at the very least, many fundamental weaknesses. As several critics have argued one must question whether we in fact even have a comprehensive drug strategy in Canada.

CONCLUSIONS

While we recognize that the federal government cannot act alone if it is to deal effectively with substance abuse problems, our conclusions with respect to a national strategy regarding psychoactive substances are generally limited to the role played at the federal level.

Conclusions of Chapter 11	
	➢ **Canada urgently needs a comprehensive and coordinated national drug strategy for which the federal government provides sound leadership.** ➢ **Any future national drug strategy should incorporate all psychoactive substances, including alcohol and tobacco.** ➢ **To be successful, a national drug strategy must involve a partnership with all levels of government and also with non-governmental organizations.**

[38] *Report of the Auditor General of Canada to the House of Commons* 2001, Chapter 11 – Illicit Drugs: The Federal Government's Role, page 1.
[39] *Ibid*., page 22.

	➢ **Over the years, the intermittency of funding has diminished the ability to co-ordinate and implement the strategy; adequate resources and a long-term commitment to funding are needed if the strategy is to be successful.** ➢ **Clear objectives for the strategy must be set out, and comprehensive evaluations of these objectives and the results are required.** ➢ **At the developmental stage, there is a need to identify clear and shared criteria for "success".** ➢ **The core funding for the CCSA has been insufficient for it to carry out its mandate; adequate funding for the CCSA is essential.** ➢ **There is a need for an independent organization – the CCSA – to conduct national surveys at least every second year; there is also a need to achieve some level of consistency, comparability and similar time frames for provincially based school surveys.** ➢ **Coordination at the federal level should be given to a body that is not an integral part of one of the partner departments.** ➢ **Canada's Drug Strategy's should adopt a balanced approach – 90% of federal expenditures are currently allocated to supply reduction.**

CHAPTER 12

THE NATIONAL LEGISLATIVE CONTEXT

Drugs have been prohibited for fewer than one hundred years; cannabis for slightly more than 75. It is tempting to think that the decisions made over the years to use criminal law to fight the production and use of certain drugs are in keeping with social progress and the advancement of scientific knowledge about drugs. Pre-twentieth century societies were less "advanced" and did not have the sophisticated tools that medicine, molecular biology and biochemistry, psychology and the cognitive sciences have provided over the course of this century of technological revolution. The prohibition measures adopted by parliaments, and on a wider scale, by the international community were therefore a more or less accurate reflection of the knowledge gradually acquired by scientists. The gradual conquest of territory occupied not so long ago by the irrational and its gang of charlatans and other shamans continued, for the greater good of humanity. As proof, phenomenal technical advances in medicine and pharmacology over the course of this century have resulted in increased longevity and decreased infant mortality in Western countries.

But is this really the case? Is civilization one long march towards progress, towards greater, and increasingly invincible, rationality? If we consider the state of the planet and the alarms sounded by more than one scientist today, we may have our doubts. From a social standpoint, the twentieth century has not brought fewer wars, less destruction, or more equality between people than previous centuries. With respect to drugs, is the legislation a more or less faithful translation of scientific knowledge for the greater good of all? Can we discern a rational structure in the national laws and international conventions that govern certain drugs and other substances? Are they based on knowledge of the effects of drugs on the psyche and human behaviour? Do they reflect the desire to ensure the well-being of the public?

The history of legislation governing illegal drugs in Canada, like the analysis in Chapter 19 of the structure of international conventions, suggests that this is highly doubtful. We do not deny that knowledge has advanced; the second part of our report testifies to this. But scientific knowledge itself is a structure that develops in a given historical context and responds to paradigms in the way problems are posed and research is conducted. The dominant scientific positivism is a temporary result in the long evolution of knowledge. It is not the "end of the story". Within the scientific process, a "selection" is made of pertinent questions and ways in which to ask them,

such that any question is not necessarily a good question and certain ways of answering are more acceptable to the community of researchers.

Moreover, legislation adopted by parliaments is influenced at least as much by prejudices and preconceptions resulting from "*pop science*" as by partisan, personal and international considerations. In this sense, the parliamentarian is no different from any other citizen, as we pointed out in the report's general introduction.

We were told several times that we could not compare the effects of cannabis to those of alcohol or tobacco. And yet, even at the risk of being unreadable if not unacceptable to the community, public policy on "drugs" must propose some rationale of the type: "this is prohibited, because…, and this is not, because…". Most of the time the "reason" – or the justification? – is presented as risks or dangers on the one hand and as medical usefulness on the other. Thus, under the current control regime, because of the risks or dangers they are believed to present, some drugs must be regulated, that is, they are not sold over the counter. When they present a danger **and** they have no known medical application, the regulatory controls prohibit their manufacture, production, growth, use, possession, etc., entirely. That is the case with the legislation and conventions governing opium and its derivatives (heroin), the coca plant and its derivatives (cocaine, crack) and the cannabis plant and its derivatives (marijuana, hashish). When the drug presents a danger but is medically useful, it is subject to more or less severe regulatory controls. That is the case with benzodiazepines and other powerful medications, which are sold by pharmacists and cannot be obtained without a medical prescription. Other drugs present a "health risk": nicotine, alcohol, as well as several other over-the-counter drugs. The packaging must indicate the risks (except for alcohol – which is very telling) so as to "warn" the user.

To what extent is such reasoning really rational?

> *Three researchers at the University of Toronto (Lazarou, Pomeranz, Corey, 1998) have estimated that* correctly prescribed *legal medications kill, on average, 100,000 people a year in North America. Although for methodological reasons that figure was cut back by one half or two thirds, it nonetheless illustrates the enormous losses of human life that go undetected by any monitoring system, including the legal system. No one thinks that this danger should be avoided by prohibiting medical prescriptions - the risky decisions made by physicians - or denying the "right to use" medications. Why? Because we do not see how that solution could be preferable to the solution of taking risks responsibly. Knowing that this problem exists, we will try to find other solutions, such as better quality control for the products, etc. Nor (fortunately) do we consider assigning criminal responsibility to physicians for taking the risk of writing a correct prescription, knowing that even correctly prescribed medications can cause death.* [1]

[1] Pires, A.P., (2002) *op. cit.*, page 43.

The 2001 report from the International Narcotics Control Board indicates a "worrisome" increase in the abuse of various prescription drugs in the United States and notes that several of these medications are found on the black market, in particular through the Internet.[2]

Tobacco use causes more than 400,000 deaths a year in the United States, and approximately 45,000 in Canada. As for alcohol, it is linked to physical aggression and violence, especially marital, and to road accidents, and its abuse causes thousands of deaths each year.

> *It is a mistake to see illegal drugs in a separate category from the legal drugs insofar as the history of criminalization is concerned. We have compounded that difficulty today because we do not tend to see the legal drugs in the same limelight as the illegal drugs. To demonstrate that, we use the phrase "alcohol and drugs" as if alcohol were not a drug, as if police officers who go to domestic disputes do not know already that the major drug problem they will likely find at that dispute is alcohol abuse, as if we do not already know that more than 70 per cent of all homicides involve alcohol abuse as a critical factor. For us to pretend that the consumption of alcohol is on a morally different plane from the consumption of illegal drugs seems to be a kind of cultural folly that speaks volumes about the cultural blinders we wear as we go about our business in everyday life.* [3]

Is the rationale of the system of controls acceptable in the eyes of civil society, users as well as abstainers? What criteria motivated the legislators' decisions? For that matter, were there any criteria? What motivated parliamentarians from Canada and elsewhere to prohibit certain substances, to control access to certain others, and to permit still others to be sold over the counter?

Knowing where you have been helps you to understand where you are going. That is the goal of this chapter, which retraces the evolution of Canadian drug laws from 1908 to the present day.[4] We have identified three legislative periods. The first, and longest, spans the years from 1908 to 1960. That is the period of hysteria. The second, which is much shorter, runs from 1961 to 1975 and is the period involving the search for lost reason. Lastly, the contemporary period, which really starts at the beginning of the 1980s, is the period of forging ahead regardless. As it would be too much to describe the different sections in the various bills adopted over the years, we have appended a table that explains and presents the clauses of the legislation adopted from 1908 to 1996 on the control of narcotics.

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[2] INCB (2002) pages 58-60 in particular.

[3] Testimony by Neil Boyd, Professor of Criminology, Simon Fraser University, before the Special Senate Committee on Illegal Drugs, Canadian Senate, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue 1, page 49.

[4] This chapter is based largely on the excellent report prepared at the Committee's request by François Dubois, research assistant to Senator Pierre Claude Nolin: *Le Parlement fédéral et l'évolution de la législation canadienne sur les drogues illicites,* Ottawa: Special Senate Committee on Illegal Drugs, June 2002. This report is available on line at www.parl.gc.ca/illegal-drugs.asp

1908-1960: HYSTERIA

At the time of the Shanghai Conference on opium in 1909[5], European societies had known for hundreds of years about opium, coca leaves, and cannabis, having discovered them through contact with other societies. These "drugs" were used in medical practice, as well as by a certain worldly or artistic elite, and especially as a commercial tool by colonial powers. In the midst of advances in chemistry, the 19th century saw the arrival of a large number of new drugs–primarily opiate-based–and their enthusiastic adoption by physicians, pharmacists, general store owners and traveling salesmen as miracle elixirs. What happened so that Canada in 1908, and the seven countries gathered in Shanghai in 1909, decided to prohibit this "drug"? At least four factors figured in the game of chance and necessity that led to prohibition.

First of all, geopolitical issues, commercial dealings with China in particular and the political stability of the Middle Kingdom in general, played a considerable role, as shown in Chapter 19. But from a domestic standpoint, these factors do not explain everything, especially since the concerns of the Dominion of Canada and its people about international politics were still relatively minor.

Initially, physicians noticed, sometimes from their own experience as a user, that use of opium derivatives resulted in a certain degree of dependence and health problems.[6] At first, these cases of drug addiction were limited to the leisured classes and to artists, who were rarely labeled as "delinquents". However, the increasing availability of these drugs[7] and the subsequent development of dependence problems within the working classes had a profound effect on public opinion about these drugs. There was no longer talk of "the ill" but rather of "delinquents" who [translation] *"could not face up to the demands of life as a good citizen and worker"*[8]. A few doctors, worried about protecting their monopoly, did not hesitate to demand laws from the government to restrict the use of drugs produced by pharmaceutical companies and thus avoid the propagation of this "scourge" that threatened the foundation of North American society.

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[5] See Chapter 19 for more details.

[6] We note in passing that in fact these were synthetic opium derivatives such as morphine. It was not discovered until much later that smoking heroin was much less harmful to the user than injecting it or using its synthetic derivatives. We can also draw a parallel with synthetic derivatives of cannabis, which cause more problems than smoking cannabis, as we saw in Chapter 9.

[7] Line Beauchesne talks about large pharmaceutical companies that flooded the market by manufacturing these products en masse and then trying to dispose of them in any way possible. Beauchesne, L., (1991) *La légalisation des drogues… Pour mieux en prévenir les abus.* Montreal: Méridien, pages 95-96.

[8] Beauchesne, L. *op. cit.*, page 98.

Even though the use of opium did not result in a social crisis before the beginning of the 1880s, whites who frequented Chinese opium dens were often seen as suspicious or dangerous. At the time, [translation] *"Frequenting the Chinese quarter and its opium dens is seen by several moral groups as a preference for the foreign, as willingly straying from white Anglo-Saxon values. This judgment is even more severe where women are concerned."* [9]

Associated with the problem of alcoholism in the working classes, the question of the use of drugs then became the metaphor par excellence for the decay of western Judeo-Christian civilization, and the favourite theme of temperance leagues in the United States as well as Canada. Born in the 19th century, these movements had a very strong religious basis, especially in the protestant ethic of responsibility for personal health through work and self control: [translation] *"work and sobriety were valued as a means to avoid loss of production and to maintain the economic superiority of the white Anglo-Saxon race."* [10] Waging "war" against alcohol that causes male violence and adultery, against drugs that kill young people, and also against prostitution, cigarettes and gambling suited these movements perfectly.[11] From community support groups designed to help those who wanted to break their bad habits, these leagues transformed themselves into powerful pressure groups demanding the complete prohibition of alcohol first, and then supporting the prohibition of opium and other drugs.

The third factor, closely related to the previous two, was population movement and especially Chinese immigration – it would be more accurate to talk about the importation of Chinese workers. The Chinese had immigrated to the United States in the middle of the 19th century to work in the mines and build the railroads in the American West. Once these large projects were completed, certain labour disputes broke out on the American West Coast, pitching the Chinese, who offered cheap labour to owners of agricultural enterprises, against powerful unions, largely composed of white workers. Following the appearance of the union-based anti-Chinese movement and legislation that prevented any further Chinese immigration, many Chinese had no choice but to develop the opium trade in the ghettos where they lived in large American cities. The temperance movement did not hesitate to adopt the racist feeling driving certain segments of American society in order to denounce the use of opium, seen as a scourge that promoted immorality, crime and the decline of the white Anglo-Saxon race. It was in this context of social unrest, although limited to the American West Coast, that the first American legislation governing the opium trade was adopted.

In Canada, in the middle of the 19th century, the Chinese became a major source of manpower for building the Canadian Pacific Railway. As the economy of British Columbia diversified, these immigrants found work in fish processing plants, coal mines and the forestry industry, although the jobs available to them remained limited.

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[9] *Ibid.*, page 126

[10] Beauchesne, L. (1999) "À propos du cannabis, que faire?" *L'écho-toxico*, page 14.

[11] Ati-Dion, G., (1999) *The Structure of Drug Prohibition in International Law and in Canadian Law (Doctoral Paper)*, Montreal, Université de Montréal, École de criminologie, page 24.

This worsened the competitiveness of the local labour market and increased their marginalization in society.[12] Beginning in the 1880s, the massive influx of Chinese juxtaposed with the economic slowdown brought on by the end of construction of the Canadian Pacific railway and the economic recession that marked the end of the 19th century and the early years of the 20th century caused several union and popular demonstrations demanding the end of Chinese immigration, the source of British Columbia's economic and moral problems.

According to Giffen, this fear was not justified since white immigration from other regions of Canada more than offset the increase in British Columbia's Chinese population. In fact, the proportion of Chinese in the province declined from 20% at the beginning of the 1880s to less than 6% in 1921[13], just before a clause in the *Opium and Narcotic Drug Act* was adopted authorizing the deportation of an immigrant found guilty of a drug-related offence.

But,

> *Tolerance for the habit of smoking opium lasted only as long as British Columbia's tolerance for the Chinese. In the early years of the twentieth century, both a labour surplus and anti-Asian resentment developed. The Asiatic Exclusion League was formed, supported by an amalgamation of the Vancouver Trades and Labour Council and federal Conservative politicians. Opposed to the Liberals' immigration policies [under Sir Wilfrid Laurier], the league demanded an end to immigration from Asia, claiming that the "yellow peril" was about to "swallow" a white British Columbia.*[14]

In fact, well before the development of this "social crisis", the British Columbia government had tried to halt Asian immigration by adopting the *Chinese Immigration Act* in 1884, which imposed an annual tax of $10 on the Chinese and other Asians living in British Columbia and prohibited them from buying land belonging to the province. The federal government disallowed this Act, but in 1885 it created a Royal Commission to investigate Chinese immigration and this commission recommended imposing a $10 entry tax on every Asian immigrant. In 1885, as a result of public pressure, the federal government adopted the *Chinese Immigration Act*, which imposed a $50 entry tax that was increased to $500 in 1904, as many had criticized the fact that despite the imposed tariff, 20,000 Asians had immigrated to the country between 1889 and 1900.

A major incident in 1907 led the federal government to intervene in matters of Chinese immigration and labour disputes in British Columbia. During the year, a demonstration organized by the *Asiatic Exclusion League* and attended by more than 10,000 people, most of whom were union workers and members of the middle class, turned into a riot when the angry crowd headed into Vancouver's Chinese district, attacking people and causing serious property damage. After convincing Prime Minister

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[12] Giffen, P.J. et al., (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws*, Ottawa: Canadian Centre on Substance Abuse, page 53.

[13] *Ibid*., page 53

[14] Boyd, N. (1991) *High society: Illegal and Legal Drugs in Canada*, Toronto, Key Porter Books, page 27

Laurier of the wisdom of compensating the Chinese, William L. Mackenzie King, then Deputy Minister of Labour, returned to Vancouver in the Spring of 1908, where he wrote a report[15] that would lead to the adoption of the *Opium Act.* Based primarily on moral, ethical, political, diplomatic and ethnic considerations, Mackenzie King's report, rather than attacking labour disputes between white and Chinese workers, shifted the problem to opium use by Asian foreigners.

> *[…] the amount [of opium] consumed in Canada, if know, would probably appall the ordinary citizen who is inclined to believe that the habit is confined to the Chinese, and by them indulged in only to a limited extent. The Chinese with whom I conversed on the subject, assured me that almost as much opium was sold to white people as to Chinese, and that the habit of smoking opium smoking was making headway, not only among white men and boys, but also among women and girls.* [16]

As in the United States, Chinese immigrants brought with them not only their labour but also their practice of smoking opium. They preferred this practice to the widespread habit of white workers of using alcohol and opiate-based drugs to cure illnesses and to momentarily forget their social and working conditions.[17] Thus the first opium den opened its doors in Vancouver in 1870. Some Chinese even opened factories to produce opium for smoking; the opium was then used in opium dens in Vancouver's Chinese district or was simply sold to white clientele. As Professor Boyd mentioned during his testimony before the Committee:

> *Over time, equal amounts of smoking opium were sold to whites as to Chinese. If you look back through the issues of Vancouver Province or the Victoria Times Colonist, you find advertisements. You do not find any expression of concern or anger about those smoking opium establishments, but you find advertisements.* [18]

In 1883, there were three factories producing smoking opium in Victoria and in 1891, there were more than 10 opium dens in the Chinese districts of large cities in the Canadian West.[19] The surge in this industry was beneficial to the British Columbia government since it imposed a customs tariff on crude opium of 10% to 25%.

> *If I could turn back the clock 100 years to Vancouver, Victoria and New Westminster, I could show you opium-smoking factories which were started in the late 1870s and persisted for 30 years without complaint. The labour surplus and the depression in the first decade of the 20th century led to concerns that led to the original legislation. It is noteworthy that the Opium and Narcotic Drug Act of 1908 was*

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[15] William L. Mackenzie King, *The Need for the Suppression of Opium Traffic in Canada.* Ottawa, Parliamentary Document 36b, 1908, 18 pages

[17] Beauchesne, L., (1991) *op. cit.,* page 125

[18] *Ibid.*

[19] Giffen, P.J. et al., (1991) *op. cit.* page 125

introduced by the Minister of Labour. When he introduced the act, he said, "We will get some good out of this riot yet," referring to the anti-Asiatic riot in Vancouver in September of 1907.
Imagine, today, the idea of illegal drug legislation coming forward from the Minister of Labour because he or she is seeking to get some good out of a labour crisis on Canada's West Coast. The situation in California was similar. [20]

Even though the Royal Commission of 1885 did not recommend specific measures governing the production or use of smoking opium, it did indicate that smoking such a substance was a pagan practice incompatible with the lifestyle of a Christian nation.[21] According to Line Beauchesne, the crusade against opium that followed this report gradually resulted in a decline in opium smoking.[22] The results of an investigation conducted by the *American Pharmaceutical Association* in 1903 into drug use claimed that drug consumption was widespread throughout American society, but involved two social groups more specifically: Chinese immigrants and Blacks. This study probably influenced some federal politicians and temperance movements that used similar arguments until the beginning of the 1930s to justify the prohibition of opium and other drugs.[23]

In short, while economic considerations were at the heart of anti-Asian feeling, temperance movements and religious groups took advantage of the situation to promote their views, not only in the immediate area of British Columbia but also across the rest of the country. These events drew the public's attention to the "dangers" of opium for Canadian society.

Opium Act, 1908

In the House of Commons on July 10, 1908, the Minister of Labour proposed the adoption of a motion prohibiting: *"the importation, manufacture and sale of opium for other than medicinal purposes."*[24] The motion was adopted without debate. The Minister introduced Bill 205, *An Act to prohibit the importation, manufacture and sale of opium for other than the medicinal purpose.* (*Opium Act, 1908*).[25] The first section of the Act prohibited the importation of opium without authorization from the Minister of Customs. Additionally the drug could be used for medical purposes only. The manufacture, sale and possession for the purpose of selling crude opium or opium prepared for use by smokers was also prohibited. Whoever violated these provisions could be found guilty of a criminal offence punishable by a maximum prison term of three years and/or a

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[20] Testimony by Neil Boyd, Professor of Criminology, Simon Fraser University, before the Special Senate Committee on Illegal Drugs, Canadian Senate, Second Session of the Thirty-Sixth Parliament, October 16, 2000, Issue 1, page 49.
[21] Beauchesne, L., *op. cit*. page 128
[22] *Ibid*., page 128
[23] Ati-Dion, G., (1999) *op. cit.* page 25
[24] Hansard, House of Commons, July 10, 1908, page 12550
[25] Statutes of Canada 1908, c. 50

minimum fine of $50 and not exceeding $1,000. Even though it prohibited the use of opium, the legislation was aimed at opium dealers, most of whom were Chinese, and not users. The bill was given Royal Assent on July 20, 1908.

The Opium and Narcotic Drug Act, 1911

The enactment of the *Opium Act* led to the introduction of 8 new bills intended to make it both more restrictive and effective on January 26, 1911, Mackenzie King, who had just become the Minister of Labour, introduced Bill 97, an *Act to prohibit the improper use of Opium and other Drugs* (the *Opium and Narcotic Drug Act, 1911*).[26] During the deliberations on second reading, Mackenzie King gave three reasons for introducing the bill: the Shanghai Commission, the panic in Montreal caused by cocaine use and the need to grant special powers to the police to ensure that the Act could be enforced effectively. The Shanghai Commission had adopted a number of non-binding resolutions, including: putting a gradual stop to the opium smoking habit, with due regard to the specific circumstances of each country; prohibiting the use of opium and its alkaloids and derivatives (morphine, heroin, etc.) and other drugs for non-medical purposes; and prohibiting the export of these substances to countries that prohibited their use.

No member raised any objections about the four drugs added to the Schedule to the Act, namely cocaine, opium, morphine or eucaine. Section 14 of the Act also provided that the Governor in Council had the power to order any alkaloid, by-product or drug preparation added to the Schedule when its addition was deemed necessary in the public interest–*a power which still exists today*. The justification given for this was that if the use of a new drug were to become widespread in society, it would be possible to add it more quickly to the Schedule than by having to enact new legislation.[27] Other provisions of the Act related to the use of opium, search powers granted to the police, orders for the confiscation or restitution of seized drugs and a reverse onus for cases of simple possession of drugs. The possibility of requesting that a higher Court issue a writ of *certiorari* with respect to prosecutions carried out under this Act was eliminated.

The post-war period led to a string of major amendments to the offences, penalties, police powers and criminal procedure provided in the *Opium and Narcotic Drug Act.* There are several factors to explain this legislative ferment: the concerns raised by Emily Murphy's writings about the extent of the "scourge" of drugs in Canada[28]; the renewed conflicts between Whites and Asians in British Columbia; the mobilization of doctors' and pharmacists' associations to prevent the Act from infringing on their activities; the establishment in 1919 of the Department of Health and the powerful Narcotics Division (the predecessor of the current (Office of Controlled Substances), which were responsible for enforcing international conventions on drugs in Canada; the

[26] Statutes of Canada 1911, c. 17
[27] Hansard, House of Commons, January 26, 1911, page 2549.
[28] This was discussed in Chapter 10.

establishment in 1919 of the Royal Canadian Mounted Police (RCMP), responsible for enforcing the *Opium and Narcotic Drug Act*; the enactment of the *Harrison Narcotic Act* in the United States in 1914; and the mobilization of the international community to enforce the *International Opium Convention* (The Hague - 1912) imposed on a number of countries by the 1919 Treaty of Versailles.

The establishment of the narcotics division

The enactment of the *Harrison Narcotic Act* in the United States and the mobilization of the international community to enforce The Hague Convention quickly brought to light three major shortcomings of the *Opium and Narcotic Drug Act*, 1911.[29]

The first problem appeared when the time came to control drug imports and exports. The Act had only vague instructions concerning trading in drugs for medical or scientific purposes. That being the case, customs officials were reluctant to seize cargo containing opium or other drugs.

The second problem stemmed from the enactment in the United States of the *Harrison Narcotic Act*, which was similar to the Act passed in Canada in 1911. However, it imposed a system of licences issued to businesses by the federal government authorizing them to import or export drugs. This led to a significant demand for illegal drugs in the United States. As the supply of these substances in Canada exceeded consumer demand, traffickers quickly took advantage of this business opportunity and exported their surpluses to the United States. This had become so profitable that in 1918, a committee of the US Senate filed an official complaint with the Canadian government concerning drug trafficking.

The third and final problem stemmed from the fact that traffickers quickly found ways to avoid the provisions of the 1911 Act because its enforcement was not centralized within a single government agency. On the one hand, Customs was attempting as best it could to control legal trade in drugs whereas on the other hand, municipal police departments handled illegal trafficking, which was becoming increasingly sophisticated every year, requiring that new powers be granted to the police.[30]

The many amendments to the Act to deal with these problems were orchestrated in part by F. W. Cowan the first Chief of the new Narcotics Division (1919-1927) of the Department of Health, and in particular by Colonel C. H. L. Sharman, the former RCMP officer who succeeded him (1927-1946). Cowan quickly understood after becoming Chief of the new division that he would have to centralize control over both legal and illegal trade in drugs to ensure that the Act could be enforced effectively, thereby assuring the long-term survival of his organization. During his tenure, an impressive communications network was created, and by the end of the 20s, it included the other divisions of the Department of Health, the Department of Justice and the

[29] Giffen, P.J., et al., *op. cit.*, page 105.
[30] *Ibid*., pages 105-121.

lawyers hired to prosecute drug offences, the RCMP, the media, municipal police departments, associations representing doctors and pharmacists, governments and agencies responsible for enforcing the laws of other countries, including the United States, and international narcotics control agencies established by the League of Nations.

Under Sharman's impetus, the administration of information from all of these participants was eventually conducted solely by the Division, and no longer by the Department of Justice or the RCMP. This made it possible for the director to have an overall picture of the narcotics situation, thereby making him an "expert" in the field. A former official of the Division described Colonel Sharman as "*a Czar running an empire of his own.*"[31] His influence grew when the Division was placed under the authority of the Deputy Minister of Health. The reorganization fostered a closer and more direct relationship with the Minister and Members of Parliament, making it possible for him to short-circuit proposals from other divisions within the Department. And when the time came to add further offences, penalties, criminal procedures or new police powers in the 20s, the Division never hesitated to take advantage of the "panic" generated by the media in Vancouver, or Emily Murphy's writings, to justify such amendments.[32]

From the standpoint of enforcing the Act, this structure was very useful. For example, up until the 50s, from the moment a police officer or a lawyer, anywhere in Canada, informed the Chief of the Division of a weakness in the Act, he would draft proposed amendments, pass them on to his network for rapid consultation, and if necessary, he would encourage the Minister of Health to introduce a bill to correct the problem situation. The federal drug bureaucracy as we know it today was born!

In such a context, the establishment of a network like this had a significant impact on the direction that would be taken by Canadian narcotics legislation:

> *In short, the establishment of an administrative organization to enforce narcotic law had the unintended consequence of creating a centralized pressure group which had the motivation and influence to play a major role in shaping the future course of the legislation. This centralization of power and expertise together with the fact that the resources were directed mainly at a socially powerless group helps to explain the virtual absence of an effective criticism and alternative proposals for control from 1920 to 1950.*[33]

Amendments to the Opium and Narcotic Drug Act (1920-1938)

Many amendments were made to the 1911 Act prior to an in-depth overhaul of the Act in 1938. It was during this period that cannabis was added to the schedule of the Act.

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31 *Ibid.*, page 144.
32 *Ibid.*, pages 138-146.
33 *Ibid.*, page 127.

Amendments to list of substances in schedule: Addition of cannabis

From 1911 to 1938, many drugs were added to the schedule of the *Opium and Narcotic Drug Act.* The 1911 Act was introduced to control only four drugs. In 1938, when the *Act to amend the Opium and Narcotic Drug Act*[34] was enacted, the schedule listed more than 15 drugs, including derivatives or salts, one of which was cannabis, added in 1923.

During a sitting of the Committee of the Whole in connection with a review of the 1923 Act, Minister of Health Henri-Séverin Béland simply said about the substance that, "*There is a new drug in the schedule*." [35] That is how cannabis ended up in the schedule to the Act. According to Giffen, the circumstances leading to the decision remain obscure because, until 1932, the issue of the effects of cannabis on people's physical, psychological or mental health had never been raised in Parliament. Giffen described the criminalization of the drug as a solution without a problem.

In the United States, beginning in 1890, some American doctors were worried that the potency of cannabis appeared to be variable and that individual reactions when cannabis was taken orally appeared to be unpredictable. Thus despite the continued use of much more dangerous drugs like barbiturates and opiates, cannabis was abandoned by doctors. At the beginning of the century, the discovery of the hallucinogenic nature of cannabis contributed considerably to its reputation as a dangerous drug. However, the people who wrote the *Harrison Narcotic Act* had not deemed it appropriate to subject it to the controls provided in the Act.[36] But in 1915, California became the first American state to prohibit the use of marijuana, and in the early 20s, marijuana had "become a major 'underground drug' traced to an influx of Mexican workers into Southern United States in the 1910s and 1920s."[37] As with opium, labour disputes, the economic interests of big business and morality served as catalysts to create a popular movement in favour of the prohibition of cannabis in the United States, which led to the passage of the *Marijuana Tax Act* in 1937, prohibiting the use and production of cannabis.

Unlike in the United States, there were no reliable accounts of the non-medical use of cannabis in Canada before the 1930s.[38] And unlike California, Canada was not faced with an influx of Mexican workers. Why then was cannabis added to the Opium Act schedule?

In 1922, Emily Murphy referred to the harmful effects of cannabis on human behaviour in her book *The Black Candle*, in which she worked over most of the articles she had published in *MacLean's* magazine. In the chapter entitled "*Marihuana – A New*

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[34] Statutes of Canada, 1938, c. 9.

[35] Hansard, House of Commons, April 23, 1923, page 2117.

[36] Beauchesne, L., (1991) *op. cit.*, page 117.

[37] Spicer, Leah, (2000) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*, Ottawa: Law and Government Division, Library of Parliament, Report prepared for the Senate Special Committee on Illegal Drugs, p. 20, available online at www.parl.gc.ca/illegal-drugs.asp

[38] *Ibid*., page 21.

Menace" she reported comments made by the Chief of the Los Angeles Police Department, who described the terrible effects of cannabis.

But Giffen's research in the archives of the Department of Health indicates that these scare tactics, which were steeped in morality, were not behind the placing of cannabis in the *Opium and Narcotic Drug Act* schedule, particularly given that at the time, it was virtually unknown in Canada and its use was not a problem.[39] This is confirmed in section 7 of the 1932 Act, which amended a provision of the 1920 Act by allowing the manufacture, sale or distribution, without a permit, of medicines if they contained only small quantities of certain drugs listed in the schedule. In 1932, the measure would henceforth apply to cannabis. During parliamentary debate on the introduction of this statute, the discovery of the existence of this drug appeared to elicit the interest of certain parliamentarians. During Committee of the Whole, MP Ernest Lapointe asked the Minister of Health, "*What is cannabis sativa?*", and the Minister replied "*Hitherto this was a drug which was not included in the list which might be used. It is one form of the drug used in India which, I believe, goes under the popular name of hashish. There is no objection to the use of it ….*"[40]

In short, it is remarkable that, over seventy-five years later, we should still not know why cannabis was placed on the list of prohibited drugs. On the other hand, no shortage of "reasons" were found in the years that followed.

Under the influence of American media campaigns, which were taken up by Canadian newspapers, and of horrifying accounts by police officers about young Canadians who were physically and mentally destroyed after using cannabis, the attitude of federal parliamentarians towards the drug would become less and less tolerant. The 1938 Act, enacted one year after the passage of the *Marijuana Tax Act* in the United States, was the end result of this "new panic". Section 3 of the Act prohibited anyone from growing cannabis or opium poppy without first having obtained a permit from the Department of Health. The penalties for this new offence were the same as those provided for trafficking in, and simple possession of, cannabis. This measure was unusual because Canada, for the first time, had climate conditions conducive to the growing and production of a drug, which it did not for the other drugs in the schedule. An analysis of parliamentary debates shows that the Department of Agriculture conducted scientific experiments on industrial hemp by growing cannabis at the Experimental Farm in Ottawa and at another research centre near Montreal. A number of entrepreneurs in Ontario were still growing hemp. The 1938 Act put an end to the practice.

Following the introduction of the Bill, Minister of Health Charles Power said in connection with section 3: *"The proposed amendments deal to a considerable extent with the attempt which is being made by the department to control what, though it cannot be called a new drug,*

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[39] Giffen, P.J. et al., *op. cit.* page 179.
[40] Hansard, House of Commons, 1932, page 1792.

is a new menace to the youth of the country".[41] Later, he said that it was very dangerous to smoke marijuana cigarettes. To demonstrate his comment, he cited a report prepared by Harry J. Anslinger, the first commissioner of the *Federal Bureau of Narcotics*, in which the drug was described as, *"the assassin of youth ... one of the greatest menaces which has ever struck that country."*[42] The Minister of Health nevertheless said that the situation in Canada was not as serious as in the United States. The statements by the Minister of Health about the harmfulness of cannabis were not disputed by any members, even though no research was put forward in defence of the statements made.

The most important amendments to the schedule were made in 1932, following the enactment of the *Act to amend the Opium and Narcotic Drug Act, 1932*.[43] In the amendments, over 10 psychoactive substances were added to the schedule, both natural drugs (like coca leaf) and synthetic drugs. The inclusion of these substances coincided with the adoption in 1931 of the *Geneva Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*, with Colonel Sharman making a major contribution to the negotiations leading to the signing of the convention. It was also at this time that Canada had begun to play an active role internationally with respect to drugs in support of the efforts of the United States and Harry J. Anslinger to better control international drug trafficking, particularly in the producing countries.[44]

During the debates on the enactment of the 1932 Act, which would implement the provisions of the 1931 Convention into Canadian law, no questions were asked of the Minister of Health, Murray McLaren, concerning the reasons leading the Minister to include the above-mentioned drugs in the schedule.

Amendment of penalties

The penalties for trafficking or illegal possession of narcotic drugs were amended several times during this period. Furthermore, other offences were created as trafficking techniques to get around the law became increasingly sophisticated. According to Giffen, there were several reasons why the authorities responsible for enforcing the Act wanted more flexibility:

> *"Latitude in regard to penalties helped to overcome the reluctance of the courts to convict in cases of lesser culpability and respectable social status; such cases were inevitable in the early years when the addict population was still relatively heterogeneous. Moreover, popular support for the law was more likely to be maintained if sentences that were regarded as unjust by local people could be avoided."* [45]

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[41] Hansard, House of Commons, February 24, 1938, page 772.
[42] Hansard, House of Commons, February 24, 1938, page 773.
[43] Statutes of Canada, 1932, c. 20
[44] Sinha, Jay (2001) *The History and Development of the Leading International Drug Control Conventions*, Ottawa: Library of Parliament, Law and Government Division, report prepared for the Senate Special Committee on Illegal Drugs, page 15. Available at www.parl.gc.ca/illegal-drugs.asp
[45] *Ibid*., page 199.

This flexibility gave more options to the police and Crown attorneys allowing them to negotiate guilty pleas more easily, to decide on the type of proceeding or to make use of people who had been charged as informers or undercover agents by promising them a reduced sentence or the withdrawal of the charges. In some instances, it also allowed for minimum sentence thereby reducing the Court's discretion during sentencing. The increase in the severity of penalties also sent a clear message to judges about the severity and level of social reprobation for drug offences. The possibility of proceeding by summary conviction also reduced the time period between the arrest and the sentencing. This made it possible to significantly increase the number of convictions. This was particularly important, because the higher the number of convictions, the more the people would be able to see the extent of the problem and the effectiveness of the act.[46]

The 1911 Act provided for a maximum sentence of imprisonment of one year and/or a maximum fine of $500. In 1920, after the *Act to amend the Opium and Narcotic Drug Act, 1920*, was passed[47], a minimum fine of $200 was assessed with the maximum increased to $1,000. In 1921, the *Act to amend the Opium and Narcotic Drug Act, 1921*,[48] significantly amended the penalty for this type of offence. Hybrid offences were created (summary conviction and indictment) for these two illegal activities. For an indictment, a maximum term of imprisonment of seven years could be imposed. For a proceeding by summary conviction, the maximum prison sentence was increased to 18 months, with the possibility of an additional 12 months for default of payment of any fine assessed by the Court. In 1922, the *Act to amend the Opium and Narcotic Drug Act, 1922*,[49] amended the sentence of imprisonment for a summary conviction by providing for the imposition of a minimum prison sentence of six months. In 1925, Parliament passed an amendment providing for the imposition, at the judge's discretion, of a sentence of forced labour for a summary conviction, for simple possession of a drug.

In 1921, an offence was created for the sale, gift or distribution of drugs by a trafficker to a minor. In such cases, one could only proceed by way of indictment and anyone convicted could receive a maximum prison sentence of seven years. Following a highly emotional debate, the sentence of whipping, which had been suggested by a Member, was withdrawn. However, the next year, while reviewing the 1922 Act in the Committee of the Whole, the same member once again suggested the imposition of a sentence of whipping for traffickers selling drugs to minors. At the end of the debate, the Minister of Health agreed to add the penalty of whipping to the Act. In 1929, federal parliamentarians stated their opinions about extending the punishment of whipping to trafficking and simple possession of drugs, as provided for in the *Act to amend and consolidate the Opium and Narcotic Drug Act, 1929*.[50]

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[46] *Ibid*., pages 199-200
[47] Statutes of Canada, 1920, c. 31
[48] Statutes of Canada, 1921, c. 42
[49] Statutes of Canada, 1922, c. 22
[50] Statutes of Canada, c. 49.

Another important penalty was introduced in the 1922 Act: the deportation of immigrants. Section 5 of this statute provided that, except as may otherwise be provided in the *Immigration Act*, any immigrant convicted of trafficking, simple possession or selling drugs to a minor could be deported from Canada. From 1922 to 1944, when the last immigrants were deported for drug offences, over 1,082 Chinese (82%) were deported, compared to 163 Americans (13%) and 68 other persons of various ethnic origins (5%), for a total of 1,313 deportations. In 1930, the "panic" in British Columbia was a thing of the past, but during the previous eight years, over 638 Chinese had been deported by the Canadian authorities.[51]

There were other offences as well in the legislation, for example possession of pipes, lamps or any other equipment for the preparation or use of opium; drug trafficking by mail; and obtaining drugs by consulting two doctors. Between 1922 and 1930, 7,096 persons were convicted for an offence under the *Opium and Narcotic Drug Act*. Of these, over 4,900 were Chinese, or 69%.[52]

Police powers

From 1920 to 1930, various amendments to the *Opium and Narcotic Drug Act* led to the police being granted new powers. These amendments specifically had to do with powers of search. Section 7 of the 1911 Act provided for the issuance of a search warrant authorizing police officers who had reasonable grounds to search the following kinds of premises: a dwelling-house, shop, boutique, warehouse, garden or ship, and to seize drugs found there as well as any containers in which the drugs had been found. Section 3 of the 1922 Act provided for the possibility of conducting a search for drugs without a warrant, either during the day or at night, in the above-mentioned premises. However, police officers were required to have a warrant to search a dwelling-house.

Section 8 of the 1911 Act provided that any drugs seized and the containers in which the drugs were found could be confiscated and delivered to the Court, and be destroyed after the accused's conviction. However, section 9 imposed a number of conditions on the procedure provided under section 8. Indeed, if the person charged was acquitted, there was a three-month period during which the Court could be asked to issue an order to give back the seized drugs. If they were not claimed during this period, they were to be destroyed. The 1921 Act slightly amended these two provisions by specifying that henceforth, drugs and the containers in which they were found were to be confiscated and turned over to the Department of Health, which would dispose of them as it saw fit. This amendment was deemed necessary by the Narcotics Division because several judges, rather than order the destruction of the goods, sent them to hospitals. The Division was afraid that the drugs so returned might fall into the hands of traffickers.

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[51] Giffen, P.J. et al., *op. cit.*, page 596.
[52] *Ibid.*, page 594.

In 1923, the powers to search and the orders of forfeiture were extended to vehicles in which drugs were found. In 1929, this procedure was extended to all traffickers' vehicles, whether or not any such substances were found in them. The purpose of this was to impede the activities of traffickers and to prevent their vehicles from being used by other criminals after they were convicted. The procedure was later extended to aircraft. In 1925, Parliament, by enacting the *Act to amend the Opium and Narcotic Drug Act, 1925*,[53] authorized police officers to search any person found on the premises searched, with or without a warrant.

The 1929 Act granted special search powers to police officers. Section 22 of this statute allowed a writ of assistance to be issued to a police officer. This was a general power, without any restrictions of time or place, to remain valid throughout the career of the peace officer. Such a writ authorized its recipient to enter a dwelling-house at any time of the day or night accompanied by whatever persons were deemed necessary to conduct searches and seize drugs. The writ of assistance thus made it possible to get around the prohibition on searches and seizures of drugs in a dwelling-house without a warrant. At the same time, the Act was amended to authorize police officers, during searches or seizures, with or without a warrant, to use force if required to conduct a search and to be assisted by persons other than peace officers.

Criminal procedure

In the 1920s, another major amendment was introduced to facilitate convictions in drug cases, a reverse onus provision. The onus was now on the accused, not on Crown prosecutors, to prove that he had not committed the crime with which he was charged. Under British criminal law, the task of proving an accused's guilt traditionally falls on the Crown, hence the expression "presumed innocent until proven guilty".

Section 10 of the Act of 1911 provided that, in a prosecution for drug possession or trafficking (with the exception of importing and exporting), in order to be acquitted, the accused had to prove that he had a legitimate excuse or that he had used such substances for therapeutic or scientific purposes. When Parliament amended the Opium and Narcotic Drug Act in 1920 to provide a better framework for dealing with importing and exporting, the manufacture, sale and prescription by physicians of scheduled drugs by means of a permit, the procedure established in 1911 was amended to specify that, in order to be acquitted, the accused had to prove that he had had a permit duly issued by the Department of Health.

Section 1 of the Act of 1921 expanded the application of the reverse onus to include any person who possessed or occupied a place (dwelling, store, boutique, warehouse, garden or ship) where drugs had been found. According to the wording of the section, that person was deemed to possess such a substance if he was unable to prove that it had been in that place without his consent or that he did not know that the drug was there.

[53] Statutes of Canada, 1925, c. 20

The article also provided that this procedure would apply when a person was charged with trafficking in raw or prepared opium for smoking purposes without having first obtained a permit issued by federal authorities. In 1923, the *Act to Prohibit the Improper Use of Opium and Other Drugs* (Act of 1923)[54] extended application of the reverse onus to offences involving the import or export of drugs without a permit. In cases involving the prescription or administration of a scheduled substance for non-therapeutic purposes, a physician or pharmacist had to prove that that substance had been used solely for medical purposes.

The Act of 1923 also cancelled another fundamental legal guarantee, the right of appeal. Section 25 eliminated the right of appeal in summary conviction cases involving possession, drug trafficking without a permit or for the sale, gift or distribution of a drug to a minor, the latter being an indictable offence. Section 26 of the Act of 1929 expanded this procedure to include possession of or trafficking in a substance similar to a drug. This new procedure rendered moot the provision enacted in 1911 prohibiting any application for a writ of *certiorari*, and the Narcotics Division sought its removal from the act, which was actually done in 1929.[55]

Two other important amendments were made to the *Opium and Narcotic Act* between 1920 and 1930 to provide for the admissibility of the certificate of a federal analyst and the application of the *Identification of Criminals Act* to summary conviction offences. Section 1 of the Act of 1921 had amended the legal procedure applicable in drug prosecutions by making the certificate of a federal analyst admissible in evidence with respect to one or more drugs seized by police officers. However, the courts were reluctant to accept the certificate because they could not authenticate the analyst's signature[56] or confirm his appointment. In 1929, an amendment was made to the *Opium and Narcotic Drug Act* (section 18) providing that the certificate would henceforth constitute *prima facie* evidence of the status of the person who gave or issued it. In this context, proof of that person's appointment or authentication of his signature was no longer necessary.

In 1923, the *Opium and Narcotic Drug Act* was amended to apply the provisions of the *Identification of Criminals Act* to persons convicted of an offence by way of summary conviction. Section 2 of that act permitted police officers to fingerprint, photograph and measure the accused solely in cases where they were indicted. That information constituted the accused's official "criminal record", which was kept in the national police records, with all the consequences that entailed for social, professional or family stigmatization. However, from the standpoint of the Narcotics Division, this amendment would prove beneficial since it would henceforth make it possible to establish files and more effectively monitor drug addicts convicted by way of summary conviction.

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[54] *Statutes of Canada*, c. 22.
[55] P.J. Giffen *et al.*, *op. cit.*, page 261.
[56] *Ibid.*, pp. 278-279.

Control measures

The *Act to Amend the Opium and Narcotic Drug Act* (Act of 1920)[57] established a control system for the legal trade in narcotics through a system of permits issued to businesses, pharmacists and physicians by the Department of Health in order to regulate Canada's supply of drugs for medical or scientific purposes. The Act provided for: a prohibition against importing or exporting drugs at a port not designated for that purpose by federal authorities; the issue of permits for the import, export, manufacture, sale and distribution of drugs; the imposition of criteria regarding packaging and labelling of packages containing such substances; an obligation for businesses to keep a record of their drug importing, exporting, manufacturing, sale and distribution activities duly authorized by federal authorities; an obligation for physicians to provide the information requested by federal authorities concerning the purchase, manufacture or prescription of medications containing drugs; an obligation for pharmacists to keep a record of their purchases and sales of drugs, the preparation of their own medications containing such substances and renewals of prescriptions signed by a physician;[58] and the authorization to sell medications (such as ointments and liniments) containing very small quantifies of scheduled drugs without a permit, provided they were not administered to children under two years of age and met certain labelling criteria.

Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954

In 1954, Parliament passed the *Act to Amend the Opium and Narcotic Drug Act* (Act of 1954),[59] repealing offences relating to opium use and the possession of equipment intended for that purpose, the sale of drugs to a minor and drug trafficking through the mail. It also made two other significant amendments to the act.

Under the impetus of R.E. Curran, Deputy Minister of Health, it now included a definition of the offence of drug trafficking in order to make the act more comprehensible and increased the maximum prison term for that offence from seven to 14 years. The minimum prison term of six months and the fine were repealed. Henceforth, this offence could only be prosecuted by way of indictment. However, a person convicted of the offence was still liable to whipping and deportation.[60]

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[57] *Statutes of Canada*, 1920, c. 31.

[58] This provision was added to the Act of 1911. In the years that followed, the criteria for renewing prescriptions issued by physicians were restricted so that the legal trade in narcotics could be monitored and drug addicts prevented from obtaining prescriptions and using the drugs thus obtained for trafficking purposes. For example, the Act of 1921 provided that a pharmacist could not fill or refill a prescription unless it had been signed by a physician. The Act of 1923 went further by prohibiting multiple refills of prescriptions of a drug based on the original prescription. The patient thus had to consult a doctor each time he wanted to renew.

[59] *Statutes of Canada*, 1954, c. 38.

[60] The provisions respecting the deportation of immigrants were transferred to the Immigration Act in 1952 but still applied to drug offences.

Subsection 4(3) of the Act of 1954 created the offence of possession for the purpose of trafficking, for which the new penalties provided for drug trafficking applied. This new offence would mean that those possessing large quantities of narcotic drugs would no longer be convicted for simple possession. As we have seen, a reverse onus was part of Canada's drug legislation from 1911 to 1929. In 1954, subsection 4(4) added a new criminal procedure to facilitate convictions for possession of drugs for the purpose of trafficking.

Thus, in every criminal prosecution for this offence, Crown prosecutors first had to prove that the accused was illegally in possession of the drug. The defendant then had to prove that he had not possessed the substance for the purpose of trafficking. If he succeeded, he was found guilty of possession; otherwise he was convicted of trafficking. In this specific case, Canadian courts established a distinction between the so-called secondary burden, which is to prove a specific fact (in this case the intention to traffic) and the primary burden (illegal possession), which consists in proving that fact where all the evidence is adduced. Thus the Crown prosecutor had the primary burden of establishing that an offence was indeed committed. In this particular case, however, the Crown did not have to prove that the accused intended to engage in trafficking. Proof of illegal possession was sufficient for the court to conclude that there was an intention to traffic.

This amendment was enacted in response to the recommendation by the RCMP and the Narcotics Office (former Narcotics Division) since, failing an admission by the accused, it was very difficult to prove the intention to traffic. However, this new procedure considerably undermined the rights of the accused, particularly since the act did not specify the quantity of drugs necessary to determine whether the accused had actually possessed it for the purpose of trafficking. The accused was thus guilty of trafficking in the absence of evidence to the contrary.[61]

Senate report of 1955

On February 24, 1955, the Senate passed a motion creating a Special Committee of the Senate on the Traffic in Narcotic Drugs in Canada following the motion made a few weeks earlier by Senator Thomas Reid. At that time, Senator Reid had asked the Senate government leader, W. Ross MacDonald, whether the federal government intended to create such a committee since, based on his information, the traffic in opium and other narcotics in the City of Vancouver was beyond the control of police authorities. In debate on the motion, Senator MacDonald accurately summed up the task before the members of the Senate Special Committee as follows:

> *The work of the committee will largely be to consider the causes of this unfortunate problem with which this country is faced, to hear expert witnesses and to determine in what way the Government can make*

[61] Giffen, P.J. *et al.*, *op. cit.*, pages 448-450.

its most valuable contribution in resolving this unfortunate condition. The reports of this committee, based upon an objective, cautious and factual assessment of the problem, may well become a document of the utmost importance and have far-reaching consequences in helping to found policy upon which the successful solution of this problem can rest. [62]

Upon adoption of the motion, Senator Reid was appointed chairman of the Committee. From March 25 to June 17, 1955, the committee organized public hearings in Ottawa and was the first to travel outside the capital, holding meetings in Montreal, Toronto and Vancouver. In addition to specialists, public servants and police officers, the senators also met a group of 150 people suffering from a drug dependency at Oakalla Prison in Vancouver to gain a better understanding of the reasons leading them to use drugs. The Committee heard 52 witnesses: 13 from law enforcement agencies, 10 from the various federal departments concerned by the fight against drug trafficking and 12 addiction treatment specialists. On June 23, 1955, Senator Reid tabled the Committee's report containing a series of recommendations for the treatment of people suffering from a drug dependency and the fight against the traffic in narcotic drugs.

According to the report, the figures provided by the Department of Health revealed that there were 515 “medical addicts” in Canada, that is to say individuals who had become dependent on a drug as a result of treatment for a disease, 333 “professional addicts” (doctors, pharmacists and so on) and 2,364 “criminal addicts”, for a total of 3,212. Of the persons belonging to the last category, 1,101 were located in Vancouver.[63] Only 26 of the 2,364 “criminal addicts” were under 20 years of age.

To establish a relationship between crime and drug dependency and to explain the difficulties in establishing treatment programs, the Committee cited a study conducted by the RCMP noting that, of 2,009 “criminal addicts”, 341 had first been convicted of an offence under the *Opium and Narcotic Drug Act*, 1,220 had first been convicted for other crimes and 478 had already had a criminal record. Thus, 1,668 of the total 2,009 “drug addicts” were criminals, which was sufficient in the Committee's view to confirm the thesis of the “criminal” or “contaminating” user.[64] It was therefore clear that drug addiction was not a disease. In the Committee's view, most “addicts” came from disadvantaged backgrounds in which crime and family problems were omnipresent.

The evidence of medical authorities was to the effect that drug addiction is not a disease in itself. It is a symptom or manifestation of character weaknesses or personality defects in the individual. The addict is usually an emotionally insecure and unstable person who derives support from narcotic drugs. The Committee was gravely concerned to learn that relatively few cases could be authenticated where drug addicts, while out of custody, had been successful in abstaining from the use of drugs for any lengthy

[62] *Hansard*, Senate, February 24, 1955, page 239.
[63] *Hansard*, Senate, June 23, 1955, page 739.
[64] *Hansard*, Senate, June 23, 1955, p. 739.

> *period of time. The complications and difficulties in the successful treatment of drug addiction, having regard to the pattern of development of the addict and his almost invariable criminal tendencies, cannot be too heavily stressed.* [65]

In the circumstances, the Committee unanimously rejected the idea of creating government clinics which, on certain conditions, would provide "criminal addicts" with ambulatory treatment. The Committee moreover emphasized that a resolution adopted at the time at the tenth annual session of the United Nations Narcotic Drug Commission, stated that this form of treatment was not advisable.[66] It also rejected the United Kingdom's model after confirming, with the aid of British specialists, that doctors should not encourage drug addicts to persist in their addiction if they could not, even after lengthy treatment involving gradual reduction of the prescribed doses abstain from drugs. On this point, the report states: "*[…] dangerous (narcotic) drugs in the United Kingdom are subject to a wide degree of control of the exacting standards demanded by the international agreements to which the United Kingdom, in common with Canada, is a party.*"[67]

Considering that "addicts" were "basically criminals who daily violate the *Opium and Narcotic Drug Act*", the Committee argued that municipal and police authorities, more particularly those of Vancouver, should more effectively invoke the provisions of the *Criminal Code* dealing with theft, vagrancy and prostitution. Citing the testimony of Harry J. Anslinger before a U.S. Congress committee, the Committee stated that such an initiative would solve much of the problem caused by drug addiction. Second, it noted that "*the evidence of many witnesses recommended the compulsory segregation and isolation of all addicts for long periods of time for the purpose of treatment and possible rehabilitation*."[68]

Thus, to prevent this "scourge" from spreading in the penitentiaries and to cure "criminal addicts" convicted of crimes, the Committee suggested that "*the penitentiary authorities might give further consideration to the particular problems presented by criminal addicts in terms of segregation, treatment including specialized training and rehabilitation and other measures necessary in view of the special problems which addiction superimposes.*"[69] In fact, as Minister of Health, Paul Martin had done a year earlier, the Committee instead emphasized the limits of federal jurisdiction and the efforts the provinces should devote to the treatment of "drug addicts" who had not been convicted of a crime. Still advocating the segregation of these individuals, the Committee indicated that the federal government wanted to make available to British Columbia the federal William Head quarantine station on Vancouver Island so that it could transform it into a treatment centre similar to that in Lexington, Kentucky. It further proposed the creation of a national health program to provide financial support for provincial drug addiction initiatives.

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[65] *Hansard*, Senate, June 23, 1955, p. 742.
[66] *Hansard*, Senate, June 23, 1955, p. 740.
[67] *Hansard*, Senate, June 23, 1955, p. 740.
[68] *Hansard*, Senate, June 23, 1955, p. 744.
[69] *Hansard*, Senate, June 23, 1955, p. 745.

The Committee also encouraged the creation of groups similar to Alcoholics Anonymous, but rejected the idea of national education campaigns for the general public and teenagers on the ground that "*such programs should not be used where they would arouse undue curiosity on the part of impressionable persons or those of tender years*".[70] The Committee supported the position of the UN Narcotic Drug Commission, recommending instead that a "mental health" program be established to detect behaviour in the schools that might lead to drug addiction.

Since treatment programs could not cure all "drug addicts", the Committee also proposed that certain measures be adopted to fight illegal trafficking in narcotics. It thus recommended:

- that a separate offence be created for the illegal importing/exporting of narcotic drugs in order to put an end to drug smuggling;
- that a maximum prison term be imposed of up to 25 years (life) for that new offence;
- that the maximum prison term be increased from 14 to 25 years for trafficking offences; and
- that it be possible to establish proof of a conspiracy in order to facilitate the conviction of the leaders of criminal organizations not directly involved in the sale of narcotics but which benefit therefrom.

In the Committee's view, the severity of these penalties would "*act as an effective deterrent to an individual in smuggling drugs into Canada for the profit of a 'higher up.'*"[71] Rather than waste police and court resources in trying to convict organized crime leaders who were the cause of the problem, an attempt had to be made to eliminate the "trafficker-distributors" in the neighbourhoods of the large cities and the problem would be solved.

Although the Committee's proposals were much more conservative than those advanced in the debates preceding its establishment, contrary to a number of other reports by parliamentary committees or royal commissions of inquiry, most of its recommendations would be followed by federal authorities. First, it contributed to a number of research projects in British Columbia and Ontario in 1956. And second, the Senate Committee's report was at the origin of most of the new provisions of the *Narcotic Control Act*, which was passed in 1961 to replace the *Opium and Narcotic Drug Act*.

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[70] *Hansard*, Senate, June 23, 1955, page 741.
[71] *Hansard*, Senate, June 23, 1955, page 746.

FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS

The period following World War II witnessed new attitudes toward narcotic drug control that would call into question the approach adopted by Canada since 1908 in fighting the abuse of and trafficking in narcotic drugs. The international human rights movement, the creation of organizations dedicated to the defence of civil liberties, the gradual democratization of access to universities, the appearance and development of new disciplines in the social sciences such as criminology, psychology, sociology, political science and the sociology of law, scientific progress and research into drug addiction were factors in the creation of new pressure groups consisting of more articulate individuals who disputed the use of criminal law as a "miracle" solution in responding to drug problems. However, it was not until the explosive increase in drug use in the 1960s, the hippie protest movement and the work of the Le Dain Commission that these demands materialized.

Narcotic Control Act (1961)

Passage of the *Narcotic Control Act* (Act of 1961)[72] coincided with the coming into force of the *Single Convention on Narcotic Drugs* of 1961, which played an important role in the creation of the modern international narcotic drug control system, an extension and expansion of the international legal infrastructure developed between 1909 and 1953. Work to group together the nine multilateral treaties signed during that period into a single international enactment began in 1948, and Canada played a significant role in the negotiations and drafting that led to its adoption.

While the Act retains most of the criminal procedures and offences established over the previous years, two amendments formed the subject of major parliamentary debate: the creation of an offence for illegal importing or exporting of narcotics and the increase in penalties for the offence of trafficking, and the treatment of drug addicts?. The minimum prison term of six months for simple possession was repealed, as was the procedure that provided that the *Identification of Criminals Act* would apply in the case of a summary conviction and the provision eliminating the right of appeal for certain offences.

The Act of 1961 was divided into two parts: the first, entitled "Offences and Enforcement", was placed under the authority of the Minister of Health, and the second, "Preventive Detention and Detention for Treatment", was to be administered by the Minister of Justice.

As the Senate Committee had recommended, section 5 of the Act of 1961 created the offence of importing and exporting narcotic drugs. Whoever was convicted of that offence (solely by way of indictment) was liable to a minimum prison term of seven years to a maximum of 25 years. That provision was designed to combat drug

[72] *Statutes of Canada*, 1961, c. 35.

smuggling between the United States and Canada and to comply with the international undertakings Canada had made in ratifying the Single Convention.[73]

In accordance with another recommendation from the Senate Committee report, section 4 of the Act of 1961 raised the maximum prison term for trafficking in narcotic drugs from 14 to 25 years. The provision for whipping was also repealed. These amendments also applied to the penalty provided for possession for the purposes of trafficking.

Part II of the Act, which comprised sections 15 to 19, defined the new federal policy regarding preventive detention and detention for treatment. First, the courts henceforth had the power to order that an individual convicted of trafficking, possession for the purpose of trafficking or importing/exporting drugs, and only if the accused had previously been convicted of similar offences, be placed in preventive detention for an indeterminate period of time. This measure replaced any other sentence which might have been imposed. Second, when a person was charged with simple possession, possession for the purpose of trafficking, trafficking or import/export, the court, at the request of Crown counsel or the accused, could order the accused detained for examination purposes to determine whether he was eligible for a drug addiction treatment program. If that was the case, the accused had to be sentenced to detention for treatment at a specialized federal institution for an indeterminate period of time in lieu of any other sentence provided for under the act. For a first offence, preventive detention could not exceed 10 years. The individual had a right of appeal, was subject to the *Parole Act* and could be referred to preventive detention at any time if he used drugs during his probation period.

Lastly, the Act of 1961 provided that, if a province adopted a preventive detention policy combined with a drug addiction treatment program (in cases not involving an offence under the act), the federal government could enter into an agreement with the competent authorities of that province to transfer drug addicts to the specialized federal institutions. These new provisions in fact enacted the Senate Committee's proposals.

Despite the intervention of two ministers, this treatment policy, based on a penal approach and, to a certain degree, oriented toward repression of the "contaminating user" or "criminal user", failed to stir up interest among parliamentarians. The measures were passed without opposition but, for reasons that remain unclear, were never proclaimed. The Le Dain Commission moreover questioned this decision by the federal government: *"Whether this is because of doubts about the constitutional validity of these provisions or the failure to develop suitable treatment methods and facilities or later reservations by the government as to the advisability of compulsory treatment in principle, or some combination of these, it's not clear."*[74]

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[73] *Hansard*, House of Commons, June 7, 1961, page 6794.

[74] G. Le Dain *et al.*, *Cannabis: Report of the Commission of Inquiry into the Non-Medical Use of Drugs*. Ottawa: Government of Canada, page 221.

Another provision of the Act of 1961, but not the least, was passed by Parliament without debate: the schedule. The Single Convention of 1961 contained a series of schedules prepared by the World Health Organization containing the list of drugs subject to rigorous control for the purpose of preventing them from being used for other than medical or scientific purposes. Most were on the schedule to the Act of 1961, which now comprised more than 92 drugs and their derivatives, spread over 14 major classes (opium, cannabis, coca, phenypipedridine, and so on). No member of Parliament questioned the Minister of Health to determine the criteria or reasons advanced by his department for subjecting such a large number of substances to the restrictive provisions of the act.

An Act respecting Food and Drugs* and Barbiturates *(1961)

In the early 1960s, the use of drugs not included in the schedule to the *Opium and Narcotic Drug Act*, or, later, in the *Narcotic Control Act*, began to concern medical and government authorities. These drugs were barbituric acids or "goof balls", amphetamines, methamphetamines and the salts and derivatives of those three substances. These so-called psychotropic drugs could be used to reduce stress, eliminate insomnia, stimulate muscle and brain activity and eliminate appetite.

When physicians and other health professionals began to notice the number of barbiturate dependence cases and the serious secondary effects of those drugs in the 1950s, they asked the government to regulate their distribution and use more effectively. In addition, in 1957, following a Health Department survey of 2,500 pharmacies, more than 300 pharmacists were convicted for failing to comply with regulations respecting the prescription of barbiturates and amphetamines. This time, it should be pointed out, the position of health professionals had more influence on government authorities than the positions of police officers or the Narcotic Control Office. These substances were included in the *Food and Drugs Act* as "controlled drugs" and not in the *Narcotic Control Act*, for two reasons. First, certain harsh provisions of the Act of 1961 were coming under increasing criticism. Second, the use of those substances in a number of prescription medications meant that their use was widespread among the general public, particularly among persons holding good jobs, which ultimately was quite different from the unflattering picture hitherto painted of "drug addicts". In the circumstances, having recourse to the provisions of the Act of 1961 was out of the question.[75]

In 1961, Parliament thus passed the *Act to Amend the Food and Drugs Act* (Food and Drugs Act of 1961)[76] to better regulate the trade in barbiturates and amphetamines. The new act created Part III concerning the "controlled drugs" listed in Schedule G. It also created the offence of trafficking or possession for the purpose of trafficking, for

[75] P.J. Giffen *et al., op. cit.,* pages 471-475.
[76] *Statutes of Canada*, 1961, c. 37.

which an accused was liable to a maximum prison term of 10 years, if convicted by way of indictment, or 18 months by summary conviction. However, simple possession of the substances was not illegal. Furthermore, unlike the *Narcotic Control Act*, the definition of trafficking excluded the distribution or giving of a controlled drug, but included the offences of importing and exporting.

In the case of criminal procedures applicable in a trial, a number of aspects were retained from the Act of 1961, such as the procedure concerning the reverse onus in a prosecution for possession for the purpose of trafficking, the use of a certificate from a federal analyst to confirm the nature of the drug, search and seizure writs of assistance, and the forfeiture and restitution of seized substances.

Lastly, Schedule G of the Act included three drugs: amphetamines, barbituric acids and methamphetamines, as well as the salts and derivatives of those drugs. During the debates, one member asked why other similar substances were not included in the schedule. The Minister of Health answered that, based on scientific research, only those three drugs were considered dangerous to human health.[77] Furthermore, as had been the case with the *Opium and Narcotic Drug* Act and the new *Narcotic Control Act*, the Governor in Council could make regulations upon recommendation by the Minister of Health, and where the public interest warranted it, to amend the schedule.[78]

Food and Drugs Act and hallucinogenics (1969)

In 1969, Parliament extended the application of legislative and bureaucratic controls to hallucinogenic drugs by passing the *Act to Amend the Food and Drugs Act* (Food and Drugs Act of 1969).[79] That enactment created Part IV, which was to govern the use of and trade in "restricted drugs" enumerated in the new Schedule J. Those drugs were lysergic acid diethylamide (LSD), N-Diethyltryptamine (DET) and Methyl-2,5-dimethoxyamphetamine (STP).

To better control the use of and trade in hallucinogenic drugs, the act provided for the same offences and procedures as those applying to barbiturates. It also created an offence of possession in order to deter anyone from using such drugs. In that instance, an accused was liable, on summary conviction, to a maximum prison term of three years and a fine of $5,000.[80] If found guilty of a first offence, on summary conviction, an accused was liable to a prison term of up to six months or a maximum fine of $1,000. For subsequent convictions, the act provided for a maximum prison term of one year or a fine of $2,000.

Narcotic Control Act and the offence of possession of cannabis

In the parliamentary debates on the Food and Drugs Act of 1969, the Minister of Health moved a very important amendment to the *Narcotic Control Act.* From 1921 until

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[77] *Hansard*, House of Commons, May 30, 1961, page 5799.
[78] Subsection 37(2) of the *Food and Drugs Act, 1961*.
[79] *Statutes of Canada*, c. 41.
[80] Section 9 of the *Food and Drugs Act, 1969*.

the *Narcotic Control Act* was passed, Canadian legislation had provided for a hybrid offence in the case of simple possession of a drug. Since 1961, however, that offence was solely an indictable offence punishable by a prison term of up to seven years. The amendment proposed in 1969 maintained the offence, but again offered the option of proceeding by way of summary conviction, thus recreating a hybrid offence. In the case of a first offence in which an accused was found guilty on summary conviction, the Act provided for a maximum prison term of six months or a fine of up to $1,000, and a term of up to one year and a fine of $2,000 for subsequent offences. The amendment was considered necessary by the Minister of Health since the number of prosecutions for cannabis possession had increased from 493 in 1966 to 1,727 in 1969.[81] In his view

> *[…] in spite of the enormous variety of individual situations involved in that number of cases, the relevant section of that act provides very little scope for flexibility, either on the part of the Crown prosecutors or presiding judges or magistrates. There is no provision for the Crown to choose to proceed summarily. […] This rigidity has been the subject of increasing criticism from a wide variety of sources such as the addiction research agencies of several provinces.* [82]

Lastly, the Food and Drugs Act of 1969 amended the procedure adopted in 1929 providing for the admissibility of a certificate from a federal analyst at trial for an offence involving a scheduled drug under the *Narcotic Control Act* or a Schedule G or J drug under the *Food and Drugs Act.* Crown prosecutors would henceforth be permitted to prove orally, under oath, by affidavit or solemn declaration, the status of the signatory of the certificate, who thus no longer had to appear in court. However, a judge could require the analyst to appear before him for examination or cross-examination to better assess the information contained in the affidavit or solemn declaration. The amendment was designed to ensure greater respect for the fundamental rights of the accused.

The Le Dain Commission (1969-1973)

When parliamentarians were examining the provisions of the *Food and Drugs Act* in 1969, they asked that a special committee be struck to look into the issue of drug use in Canada, particularly the use of cannabis. On May 29, 1969, the Liberal government headed by Pierre Elliott Trudeau passed Order-in-Council P.C. 1969-1112, establishing the Commission of Inquiry into the Non-Medical Use of Drugs, more commonly known as the Le Dain Commission. One of the reasons put forward to justify its creation was:

> *That notwithstanding these measures and the competent enforcement thereof by the R.C.M. Police and other enforcement bodies, the incidence of possession and use of these substances for non-medical purposes*

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[81] *Hansard*, House of Commons, March 27, 1969, page 7203.
[82] *Hansard*, House of Commons, March 27, 1969, page 7203.

has increased and the need for an investigation as to the cause of such increasing use has become imperative. [83]

The Commission's activities and reports

The Commission carried out its activities from mid-October 1969 until December 14, 1973, when its final report was tabled. During this period, it heard from 639 groups and individuals: 295 organizations presented briefs and 43 appeared before the members of the Commission; 212 individuals made submissions and 89 gave oral presentations. In total, the Commission held public hearings in 27 cities, including Ottawa and the ten provincial capitals, travelling some 50,000 miles around the country. During its term, the Commission published four reports: an interim report (1970), a special report on cannabis (1972), a report on treatment (1972) and a final report (1973). In addition to its Chairman, Gerald Le Dain, the Commission comprised four members: Ian L Campbell, Heinz Lehman, Peter Stein and Marie-Andrée Bertrand.

Before reviewing the Commission's recommendations in relation to cannabis, it is worthwhile to look into four aspects of the Commission's work that Dr. Marie-Andrée Bertrand brought up at a hearing of our Committee.

The first relates to the Commission's mandate, which was "extremely generous and broad." She presented it thus:

(a) to marshal from available sources, both in Canada and abroad, data and information comprising the present fund of knowledge concerning the non-medical use of sedative, stimulant, tranquillizing, hallucinogenic and other psycho tropic drugs and substances;

(b) to report on the current state of medical knowledge respecting the effect of the drugs...;

(c) to inquire into and report on the motivation underlying the non-medical use referred to in (a);

(d) to inquire into and report on the social, economic, educational and philosophical factors relating to the use for non-medical purposes... in particular, on the extent of the phenomenon, the social factors that have led to it, the age groups involved, and problems of communications; and

(e) to inquire into and recommend with respect to the ways or means by which the Federal Government can act, alone or in its relation with Government at other levels, in the reduction of the dimensions of the problems involved in such use.

Because the mandate was so broad, commissioners and the Commission's personnel got involved in a vast project which, in my opinion, had a great deal of impact on Canadian society. I am convinced that even though it had no influence at all on criminal legislation, the Le Dain Commission brought about a

[83] Le Dain, G., *et al*., (1973) *Canadian Government Commission of Inquiry into the Non-Medical Use of Drugs,* Ottawa: Government of Canada, page 4.

> *considerable change in the mentalities of Canadians, as it raised, for instance, awareness about the effects of traditional drugs.*[84]

Second, the method used by the Commission to seek the opinions of Canadians. After mentioning the Commission's travel, she recalled that the public hearings gave the public an opportunity to ask questions and to confront the experts.

> *Thus, we raised a wide national debate on the factors whereby Canadian society … can, frequently resort to psychotropic substances to alleviate some of its suffering. In my opinion, the generosity of the mandate, the method of consultation, the style and attitude of the commissioners - and more specifically those of the Commission's chairman - brought about an effervescence of ideas about democracy, about how the State functions, and about the feeling of alienation that many Canadians felt and still feel vis-à-vis their national, provincial or municipal government.* [85]

Third, the Commission's research mandate. Dr. Bertrand stated that the Le Dain Commission, at the height of its mandate, employed 100 persons, 30 of whom were full-time researchers. These researchers basically worked on four targets: (1) the effects of the drugs – and especially of cannabis, (2) drug use, (3) treatment problems, and (4) the influence of the media on the phenomenon.

Fourth, the Commission's impact. Dr. Bertrand believes that the democratic debate kicked off by the Commission had significant impact on knowledge about drugs. Many people came to understand that stereotypes of drug users as criminals were just that–stereotypes. The Commission also kicked off a deep debate about the factors pushing people to take drugs and increased awareness of these issues. What became apparent very quickly after the Commission started its work was Canadians' feeling of alienation from Canadian politicians and lawmakers, and the frustration that ordinary people are not listened to in this country.

The special report on cannabis

Before presenting their recommendations in connection with a new public policy on cannabis, the Commissioners made a number of observations about Canadian cannabis legislation.

- The decision to criminalize cannabis was made "*without any apparent scientific basis nor even any real sense of social urgency* […]".[86]
- The reversal of the evidentiary burden of proof for an offence of possession for the purpose of trafficking places a very heavy burden on the accused – significantly

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[84] Dr. Marie-Andrée Bertrand, Professor Emeritus of Criminology, Université de Montréal, Evidence presented to the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001, page 45.

[85] *Ibid*., page 46.

[86] Le Dain, G. *et al*., (1972) *Cannabis: A Report of the Commission of Inquiry into the Non-Medical Use of Drugs*, Ottawa: Government of Canada, page 230.

weakening the principle of the presumption of innocence – since he must prove that he did not intend to traffic by a preponderance of evidence, not just by raising a reasonable doubt in the mind of the judge or jury.

- Law enforcement is made very difficult by the very nature of the offences that take place secretly and often on a consensual basis, and extraordinary methods of law enforcement must be used. However, "*the combined effect of their use in connection with [drug] laws has been one of the chief causes of concern about the impact of the criminal law in this field*."[87]
- RCMP officers and officers in the provincial or municipal police services do not have the necessary financial, human or technical resources to curb narcotics trafficking as well as dealing with simple possession offences. All too often, possession cases are discovered accidentally in the course of other police investigations or surveillance activities over several months, resulting in a discriminatory application of the law.
- The decision as to whether to proceed by indictment or summary conviction varies considerably from one area to another of the country, and is influenced by the number of ongoing cases involving narcotics and the significant discretion exerted by crown attorneys. This inequitable application of the law can have extremely serious consequences on a defendant's future, particularly if a criminal record is the outcome.[88]
- Sentencing practices in drug cases are characterized by a wide disparity across Canada because of individual judges' perceptions about drug addiction, and their relative experience in criminal law and with cases involving simple possession or drug trafficking. According to the Commission's research, judges with greater experience in these types of cases handed down more lenient sentences. For example, sentences for simple possession involved fines or probation when a defendant did not have a criminal record, and, in trafficking cases, imprisonment of less than two years;[89] and
- From 1968 to 1971, the proportion of fines imposed for simple possession of cannabis increased from 1 % of all dispositions to more than 77 %.[90]

While the Commissioners agreed with these observations, their conclusions and recommendations were not unanimous.

The majority opinion – the recommendations of Gerald Le Dain, Heinz Lehman and Peter Stein

In order to explain the underlying reasons for their recommendations, the majority based their conclusions on the concept of harm, considering this the most

[87] *Ibid.*, page 239.
[88] *Ibid.*, page 245.
[89] *Ibid.*, pages 248-249.
[90] *Ibid.*, page 249.

useful criterion for laying down a new social policy for cannabis. This principle is associated both with the harm caused to an individual who uses a harmful substance, particularly his physical or mental health, and with the harm the individual causes to society, i.e. the impact on his family and colleagues. The concept of harm was of significance to the majority, since it made it possible to assess whether society should be concerned about the adverse effects of cannabis on human health and on society and, if such were the case, to what extent should criminal law apply in order to reduce those adverse effects. Should one criminalize simple possession of cannabis or only trafficking? Should measures such as decriminalisation or legalization be considered?

Initially, the majority wanted to eliminate some of the myths about the danger of cannabis:

> *The evidence of the potential for harm of cannabis is far from complete and far from conclusive. It is possible to find some fault with the methodology or the chain of reasoning in virtually all of the evidence. […] On the whole, the physical and mental effects of cannabis, at the levels of use presently attained in North America, would appear to be much less serious than those which may result from excessive use of alcohol. However, there has not been sufficient experience with long-term, excessive use of cannabis under North American conditions to justify firm and final conclusions.* [91]

Regarding the amotivational syndrome, the Commission said it did not have conclusive data about personality change.

> *Some observers have spoken of apathy and a loss of goals, an absorption in the present with little or no thought for the future. All of these symptoms might be equally associated with a profound change of values and outlook which many might regard as salutary.*[92] *In our opinion, these concerns justify a social policy designed to discourage the use of cannabis as much as possible, particularly among adolescents.* [93]

The Commission did not have specific and conclusive scientific data to identify the harmful or beneficial effects of cannabis. On the other hand, while it believed that the dangers of cannabis (particularly those involving operation of a motor vehicle, poly-drug use, long-term mental deterioration and disorder, and criminality) were exaggerated, the Commission recognized that cannabis, like all other drugs, can have particularly harmful effects when it is used along with other drugs and that its use by adolescents could have a harmful effect on their maturation. The majority of members explained that, even if the use of cannabis is not a threat to the foundations of Canadian society or to our system of values based, for example, on a productive life, this element could not be excluded from the formulation of a new policy on cannabis.

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[91] *Ibid.*, pages 266-267.
[92] *Ibid.*, page 270.
[93] *Ibid.*, page 274.

Secondly, since, in addition to health problems, cannabis use entails significant costs to the family, to society and to the economy, the majority justified the use of the criminal law, stating:

> *In our opinion, the state has a responsibility to restrict the availability of harmful substances-and in particular to prevent the exposure of the young to them-and that such restriction is a proper object of the criminal law […] where, in its opinion, the potential for harm appears to call for such a policy.* [94]

For this reason, the majority rejected a public policy model based on legalization of the use and distribution. Even if legalization would have had the benefit of better controlling supply and quality, without a considerable increase in the number of long-term users, it could have led to some users moving on to hashish, with its higher concentration of THC, or encouraged users to smoke more marijuana or other cannabis products in order to obtain the desired psychoactive effect, and this would have cancelled out the effectiveness of control measures and increased the likelihood of abuse. [95]

Therefore, the majority recommended maintaining the offences of cannabis trafficking, of possession of cannabis for the purpose of trafficking, and importing and exporting cannabis. However, it adopted a much more liberal position with regard to controlling the demand:

> *The criminal law should not be used for the enforcement of morality without regard to potential for harm. […] If we admit the right of society to use the criminal law to restrict the availability of harmful substances in order to protect individuals (particularly young people) and society from resultant harm, it does not necessarily follow that the criminal law should be applied against the user as well as the distributor of such substances.* [96]

In this context, the majority felt it was necessary to amend the Narcotic Control Act, because "we do not believe that a change in the law need have an adverse effect on a proper appreciation of the caution with which we believe cannabis should be treated."[97] It was necessary to restore Canadians' confidence in and respect for the cannabis policy by reclassifying the drugs listed in the appendix to the Act, particularly cannabis. The majority opinion was based on the fact that:

> *While the Single Convention groups cannabis with the opiate narcotics it does not insist that it be given identical treatment in the law of the member states. The Single Convention has certainly been responsible for reinforcing the erroneous impression that cannabis is to be assimilated to the opiate narcotics but it does not prevent domestic legislation from correcting this impression. Because the present classification and legislative treatment of cannabis is so generally recognized to be erroneous and indefensible, any change in*

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[94] *Ibid*., page 281.
[95] *Ibid.*, pages 283-286.
[96] *Ibid.*, page 282.
[97] *Ibid*., page 291.

it which corresponded more closely to the facts could be expected to command much more respect and careful attention [to the law]. [98]

Restoring Canadians' confidence in the *Narcotic Control Act* also involved a comprehensive review of criminal penalties relating to cannabis. To justify this view, the majority pointed out that the harm caused by the criminal law, particularly on mere users, was more serious than the harm to their health and their environment caused by using the drug. In its analysis, the majority focussed on the consequences of sentences on young people, since over 85% of those convicted for cannabis possession or trafficking in 1970 and 1971 were under the age of 25.

A criminal record could have serious consequences for the future of young people, limiting the right to travel, and because of the family, social or professional stigma it caused. The majority were of the view that the possibility of obtaining a pardon is not sufficient to resolve this situation, since: *"the knowledge which a lot of people invariably possess of a conviction and the knowledge which can be obtained by interested parties through careful investigation cannot be eliminated."* [99] In fact, the *Criminal Records Act* provides only for removing information about the criminal record stored in national police files following a pardon, but not information in police investigation reports, or in legal documents stored in the law courts about the trial and the sentence, let alone newspaper articles.

Moreover, the majority of members deplored the extreme severity of sentences for cannabis use, stating, *"they are out of all proportion to the harm which could possibly be caused by cannabis. Moreover, they are excessive by comparison with those of most other nations."* [100] It disapproved of the maximum penalty of seven years' imprisonment for cannabis cultivation for one's own use, the mandatory minimum penalty of seven years' imprisonment for cannabis importing or exporting, as well as the possibility of life imprisonment for cannabis trafficking. The majority's criticism also covered the definition of trafficking, which included giving or offering, so that people who are merely passing a joint among friends in an evening could be charged with trafficking. The majority also mentioned that these sentences were made even more severe because:

- in the cases relating to possession of cannabis for the purpose of trafficking, the Crown could only proceed by way of indictment, with the consequence of more severe sentences; and
- the enforcement of the Narcotic Control Act was discriminatory (police investigations, the Crown Attorneys' discretion in deciding how to proceed, reversal of the burden of proof to the detriment of the accused, and judges' past experience).

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[98] *Ibid.*, page 292.
[99] *Ibid.*, page 293.
[100] *Ibid.*, page 293.

The criminalization of cannabis had another negative effect: the illegal nature of simple possession and cultivation was conducive to the development of an illicit market, where some people must engage in crime or at least deal with criminals in order to obtain a supply. In some cases, people were exposed to other, more dangerous drugs. According to the majority:

> *Making cannabis legally available would not isolate people from contact with the illicit market in other drugs. From the point of view of influence, the important contacts are between drug users rather than between users and traffickers. Most users are initiated into new forms of drugs by other users. Interest in other drugs would not cease if cannabis were made legally available.* [101]

Finally, the use of extraordinary police powers, such as writs of assistance, often against users, only discredited the law further and adversely affected the morale of law enforcement authorities.[102]

For all these reasons, the majority recommended:

- that importing and exporting should be included in the definition of trafficking (as they are under the Food and Drugs Act), and they should not be subject to a mandatory minimum term of imprisonment;
- that it be possible to proceed by indictment or summary conviction in the case of trafficking and possession for the purpose of trafficking, and, on indictment, the penalty for this offence should be five years, and on summary conviction, eighteen months. It should be possible in either case to impose fine in lieu of imprisonment;
- that the prohibition against the simple possession of cannabis be repealed;
- that trafficking should not include the giving, without exchange of value, of a quantity of cannabis which could reasonably be consumed on a single occasion;
- that the prohibition against cultivating cannabis for personal use be repealed; and
- that the burden of proof on a person charged with possession for the purposes of trafficking be lightened, by stipulating in the Act that it is sufficient for the accused to raise a reasonable doubt as to his intention to traffic.

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[101] *Ibid.*, page 296.
[102] *Ibid.*, pages 295-299.

Minority Opinion–the recommendations of Marie-Andrée Bertrand

According to Marie-Andrée Bertrand, Canada's cannabis policy required an in-depth reform that went far beyond merely amending the *Narcotic Control Act.* Dr. Bertrand took a much more liberal approach than the majority, and particularly Ian L. Campbell, as we will see below. Dr. Bertrand wrote that the Commission's research findings "*establish that a large number of people have used cannabis-more than a million in Canada. Very few of them have ever required medical or psychological treatment as a consequence. Smoking marijuana or hashish generally produces no serious personal problems, nor does it result in criminality*."[103] Cases of habitual and excessive use were exceptional, as most users used cannabis recreationally. Any new public policy aiming at controlling cannabis use effectively without causing harm both to users and to society should consider these determinants. The use of the criminal law was out of the question. According to the Commissioner, there were several arguments in support of this conclusion.

Like the majority, she rejected a number of prejudices concerning harm caused by cannabis to human health, in particular its effects on brain activity and the ability to drive a vehicle, but recognized nevertheless that in large amounts cannabis could cause psychoses. While Marie-Andrée Bertrand commented that cannabis might have an effect on adolescent maturation, she said that very few facts supported the hypothesis put forward by the majority.[104] She also concluded that there was no relationship between cannabis use and criminality, aggression or the infamous amotivational syndrome.[105] Moreover, she rejected claims that cannabis use leads to poly-drug use in most users:

> *[…] a certain proportion of cannabis users take other drugs […]. We are not dealing with a phenomenon that is limited to cannabis, LSD and the amphetamines (which are used in combination by only a few), but with an almost indiscriminate use of mood-changing substances in our society. When we include alcohol, it can be said that Canadians consume great quantities of a variety of psychoactive drugs, even if cannabis is excluded.*[106]

Second, users could not be sure of the quality of cannabis they bought, with all the concomitant repercussions, given the illicit and clandestine nature of production and distribution activities. Dr. Bertrand responded to the argument made by the majority that quality control of cannabis in a legal market would encourage a number of users to move to hashish by saying that no evidence points to such a possibility.[107]

Third, the prohibition of cannabis trade and illicit use was expensive and ineffective. Attempts to curb trafficking, despite all the efforts made by RCMP officers and municipal police forces, along with severe penal sanctions, were ineffective. The

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[103] *Ibid.*, page 303.
[104] *Ibid.*, page 308.
[105] *Ibid.*, pages 307-309.
[106] *Ibid.*, page 308.
[107] *Ibid.*, page 309.

sentences provided for simple possession no longer had any dissuasive effect, since a million Canadians were using or had used cannabis.

Fourth, in its current form, the law had no educational or dissuasive impact, since Canadians' perception of the harm caused by cannabis was no longer the same as the government's. In this connection, Marie-Andrée Bertrand wrote:

> *A more important factor underlying problems in the application of the law is the gradual change in opinion taking place among Canadians regarding the harmfulness of this substance. The evidence has been taken into account - cannabis is not an opiate, its use does not induce physical dependence. The earlier opinions of society have been challenged and modified. […] However, the continued prohibition of cannabis has precipitated, among many users, a generalized disrespect for the law.* [108]

For all these reasons, Marie-Andrée Bertrand recommended a "controlled legalization" policy for cannabis. She concluded that the federal government should remove cannabis from the *Narcotic Control Act* and initiate discussions with the provinces to have the sale and use of cannabis placed under controls similar to those governing the sale and use of alcohol. Such a system would entail regulations prohibiting the sale or distribution of cannabis to minors, and governing the distribution of a quality product at a price that would make smuggling impractical. To guarantee the success of the new approach, the federal and provincial governments were to work together in developing all stages of the production and distribution of cannabis, while undertaking multidisciplinary epidemiological research to evaluate the repercussions of a controlled legalization policy on health and human behaviour and to monitor patterns of use.[109]

Lastly, Marie-Andrée Bertrand considered that this policy would prove beneficial, not only for users, but also for the federal and provincial governments because of the considerable revenue they might well derive from the sales taxes on such a popular product.[110]

Minority Opinion–the recommendations of Ian Campbell

In comparison with the very liberal recommendations made by Marie-Andrée Bertrand, the recommendations by Ian Campbell were much more conservative in tone. Although he was in almost full agreement with the conclusions of the majority, he firmly believed that decriminalizing simple possession of cannabis would be misinterpreted by the media and by Canadians. If cannabis were legalized, the signal that would be sent out to society, particularly to young people, would be that cannabis is harmless, and might eventually lead to the accepted use of other, much more dangerous drugs. In this regard, he stated that, in both cases:

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[108] *Ibid.*, p. 304
[109] *Ibid.*, pp. 310-311
[110] *Ibid.*, p. 304

> *I think there is also a risk that the repeal of the prohibition on the possession of cannabis, even by the young, would be misunderstood as indicating a willingness by the society to condone and accept the use of the drug. There is little evidence to suggest that such a willingness exists. […] The risk of such progression is probably not as great among those who have been deterred from use by the present law as among those who have already used cannabis. But the risk of progression is nonetheless real for some considerable number.*[111]

He also felt that maintaining the prohibition had a positive benefit–that of protecting young people from the harm caused by cannabis:

> *The potential for harm from adult use of cannabis is probably very much less than from use by the young. But, I find sufficient reasons to recommend the continuation of the general prohibition. Not the least of these reasons is the practical impossibility, at this time, of using the law to convey a perception of the dangers of cannabis without maintaining the prohibition for all, whether young or old.* [112]

Against this backdrop, the law was in the interest of prevention and morality, protecting as it did both individuals and society. Continuing in this vein, Mr. Campbell spoke about cannabis and young people's lack of maturity, saying:

> *We have properly been concerned about the damage done by placing too many duties and responsibilities on the individual too early. But it seems to me that recently we have been far too little concerned with the consequences of placing too many rights and freedoms on the shoulders of the young.* [113]

Despite it all, like other members of the Commission, Mr. Campbell recognized that some penal sanctions provided by the law could cause harm that was disproportionate in comparison with the real harm caused by cannabis on human health and society. He therefore recommended that the prohibition on the possession of cannabis be maintained, with possession of cannabis being punishable, upon summary conviction, by a fine of $25.00 for the first offence and a fine of $100.00 for any subsequent offence. Maintaining the prohibition would benefit not only users, but also police officers, since it:

> *Is entirely reasonable to assume that a high proportion of those currently arrested for possession as a result of systematic police investigation are in fact guilty of trafficking.* [114]

The work of the Le Dain Commission ended on December 14, 1973 when its final report was tabled. On July 31, 1972, John Munro, Minister of Health, revealed the policy that the federal government wanted to pursue following the tabling of the Commission's special report on cannabis. Even though he refused to legalize the use of

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[111] *Ibid.*, page 311
[112] *Ibid.*, page 313
[113] *Ibid.*, page 314
[114] *Ibid.*, page 316

cannabis, the Minister stated his intention to remove cannabis from the *Narcotics Control Act* and place it under the *Food and Drugs Act.* This measure would be accompanied by lighter sentences for certain cannabis-related offences, research and education programs about its non-medical use, and less severe legal consequences for users. This measure would have covered hashish since the government *"wanted to make a clear distinction between this drug [cannabis] and dangerous narcotics like heroin."*[115] Two years later, on November 26, 1974, the federal government met its commitments by tabling Bill S-19 in the Senate.

Bill S-19 and cannabis

Bill S-19 created Part V of the *Food and Drugs Act* entitled "Cannabis". Thus, as recommended in the majority opinion expressed in the Le Dain Commission's special report, cannabis and cannabis users were no longer subject to the harsh provisions of the *Narcotic Control Act.*

Clause 7 of Bill S-19 defined "cannabis" as hashish, marijuana, cannabidol and THC. It continued the offence of possession, which, however, could only be prosecuted summarily. Anyone convicted of a first offence would be liable to a maximum fine of $5000 or, failing payment, to a maximum prison term of six months. For repeat offences, the fine would be fixed at an amount not exceeding $1,000 or, failing payment, a prison term not exceeding six months could be imposed. As may be seen, fines were favoured over imprisonment for simple possession.

The Bill also maintained the offences of trafficking, possession for the purposes of trafficking and cultivation of cannabis without a permit provided for by the *Narcotic Control Act*, punishable on summary conviction by a maximum fine of $1,000 or a prison term of up to 18 months or, if prosecuted by way of indictment, by a prison term of up to 10 years. The penalties provided were thus less severe than those provided for by the Act of 1961, except for the cultivation of cannabis. Although Bill S-19 created a dual-procedure offence for this crime, the maximum prison term was more severe (10 years rather than seven if prosecuted by way of indictment).

Lastly, a person convicted of importing or exporting cannabis was liable, on summary conviction, to a maximum prison term of two years or, if prosecuted by way of indictment, to a prison term of three to 14 years. Parliament thus wanted to show that cannabis trafficking and smuggling were crimes which it still considered very serious.

Apart from these offences, Bill S-19 also contained the criminal procedures included in Parts III and IV of the *Food and Drugs Act* (evidence of possession for the purpose of trafficking, certificate of the analyst, police powers and so on). Lastly, the provisions respecting regulations that the governor in council may make concerning the

[115] VALOIS, Donat, "La marijuana et le haschisch ne seront pas légalisés", *Le Droit*, Ottawa, August 1, 1972.

issuing of cultivation permits and possession of cannabis were now contained in the new Part V.

The Bill was considered by the Senate Standing Committee on Legal and Constitutional Affairs, which, in its report, recommended three amendments. The first added a provision for an exception to the *Criminal Records Act* so that any person receiving an absolute or conditional discharge would be automatically pardoned. The purpose of this measure was to eliminate the possibility that a criminal record might remain with the Canadian Police Information Centre (CPIC) following discharge. The second amendment increased the maximum prison term for trafficking in a narcotic from 10 to 14 years less a day. The third repealed the minimum term of three years for smuggling.

Bill S-19 was passed on third reading on June 15, 1975 and referred to the House of Commons, where it never passed second reading. In the fall of 1976, Mitchell Sharp stated in an interview that the bill would not be reintroduced since more important legislation was under consideration.

AFTER LE DAIN: FORGING AHEAD REGARDLESS

Throughout the 1970s, a number of federal politicians promised major reforms to lessen, even eliminate, the criminal penalties imposed on cannabis users. In 1972, the Liberal Party of Canada stated in its election platform that it intended to amend Canada's policy on marijuana,[116] which likely gave birth to Bill S-19. In 1978, Joe Clark, Leader of the Progressive Conservative Party, declared that a government formed by his political party would decriminalize possession of that drug.[117] However, promises of reform ceased in the early 1980s.

In the mid-1980s, Canadians witnessed a significant change in the federal government's position on drugs. This new situation was perhaps not unrelated to the U.S. policy of "war on drugs" adopted in the early 1980s by President Ronald Reagan. The United States once again became very active within international drug control agencies to encourage the international community to take energetic measures to put an end to drug trafficking, which "threatened American youth".

In 1987, Canada became actively involved in the work of the International Conference on Drug Abuse and Illicit Trafficking.[118] Two important events occurred at that meeting organized under the aegis of the United Nations. First, delegates passed a full multidisciplinary plan for future activities to combat drug abuse encouraging the

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[116] Spicer, L. (2002) *Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"*. Ottawa: Parliamentary Research Branch, Library of Parliament.

[117] Giffen, P.J. *et al.*, (1991) *Panic and Indifference: The Politics of Canada's Drugs Laws.* Ottawa: Canadian Centre on Substance Abuse, page 571.

[118] Briefing notes, Research Office of the Progressive Conservative Party of Canada, June 1, 1987.

states to comply with their obligations under existing treaties. That initiative targeted four important areas: prevention and reduction of demand for illicit drugs, control of supply, suppression of illicit trafficking and treatment and rehabilitation. For the first time, international legal instruments made express provision for the reduction of supply. Second, delegates put the final touches on the treaty to suppress drug trafficking on a global scale. That treaty was passed in Vienna on December 20, 1988 as the *Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Convention of 1988).

In addition to taking part in the work leading to the adoption of that convention, starting in the mid-1980s, Canada stepped up its international efforts with regard to drugs. In June 1987, it ratified the Convention on Psychotropic Substances of 1971[119] and promised to increase its financial participation in the United Nations Fund for Drug Abuse Control to $1 million by 1991. The Canadian government justified its participation in the international drug effort as follows:

> *"The Government is acting to stem the flow of drugs in and out of Canada, not only because Canadians are among the victims of drug abuse, but also because we have a role to play as responsible citizens of the world."* [120]

Canada was influenced by this international effort when, on September 13, 1988, before it had even signed or ratified the Convention of 1988 – which was not done until 1990 – Parliament passed Bill C-61, designed to combat laundering of the proceeds of crime (money laundering, enterprise crime, etc.). The Bill was aimed at organized crime and the financing of its operations through drug trafficking. The *Criminal Code* and the *Narcotic Control Act* were thus amended to create two new offences: laundering of proceeds of crime and possession of property obtained through drug trafficking. These new provisions also applied to the illegal activities of drug cultivation, trafficking and importing and exporting in or outside Canada if they were committed by Canadian citizens. Parliament did not need to legislate to criminalize the other activities prohibited by the Convention of 1988 since, as noted above, many had already been covered since 1961.

Controlled Drugs and Substances Act

In accordance with the commitment the federal government made in 1987, Minister of Health Perrin Beatty tabled Bill C-85, *An Act respecting psychotropic substances*, on June 11, 1992. It merged Parts III and IV of the *Food and Drugs Act* as well as the

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[119] International Narcotics Control Board, *Report of the International Narcotics Control Board for 1987*, Vienna, United Nations Organization, 1988, p. 21.

[121] The tables of penalties in this section are reproduced from *Bill C-8: An Act to regulate certain drugs and other substances*, Legislative Summary 240, prepared by Allain, J., (1996; revised May 1997) Ottawa: Law and Government Division, Parliamentary Research Branch, Library of Parliament.

Narcotic Control Act into a single piece of legislation. Bill C-85 never passed report stage and died on the Order Paper in September 1993, when the 34th Parliament was dissolved.

On February 2, 1994, the new Minister of Health, Diane Marleau, retabled the legislation proposed by the former government under a different name, the *Controlled Drugs and Substances Act* (CDSA), which was passed by the House of Commons on October 30, 1995. After the first session of the 35th Parliament was prorogued, the bill was reintroduced in the Senate on March 6, 1996, and renumbered Bill C-8. The legislation went into effect on June 20, 1996.

This was the first major reform of Canada's drug legislation since the 1960s. Apart from the amendments made in 1988 under Bill C-61, the *Narcotic Control Act* had been amended in 1985 to abolish the writ of assistance and the procedure for establishing proof of possession of narcotics for the purpose of trafficking. In 1987, in *R. v. Smith*, the Supreme Court of Canada ruled that the minimum prison term of seven years for importing or exporting was unconstitutional under section 12 of the *Canadian Charter of Rights and Freedoms* (cruel or unusual punishment), as a result of which it was repealed.

One of the objects of the bill was to meet Canada's international obligations under the *Single Convention on Narcotic Drugs* (1961), the *Convention on Psychotropic Substances* (1971), and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Vienna Convention, 1988)*. It was further designed to introduce a legislative framework for regulating the import, production, export, distribution and use of scheduled substances under previous acts. The following sections describe the main provisions of this legislation.

Substances

The merger of the schedule of the *Narcotic Control Act* with those of the *Food and Drugs Acts* of 1961 and 1969, combined with the addition of new substances such as benzodiazepines and the precursors of this long list of substances, considerably increased the number of drugs subject to the restrictive provisions and procedures of the CDSA.

The expression "controlled substance" means a substance included in Schedule I, II, III, IV or V. In addition, the Act defines the term "analogue" as any substance that, in relation to a controlled substance, has a substantially similar chemical structure. Furthermore, anything that contains or has on it a controlled substance and that is used or intended or designed for use in producing or introducing the substance into the human body will be treated in the same way as that illegal substance.

- **Schedule I:** narcotic drugs such as opium, morphine and cocaine.
- **Schedule II:** cannabis, hashish, cannabinol, etc.

- **Schedule III**: stimulants such as amphetamines, hallucinogenics, such as mescaline, LSD and DET, and sedatives such as methaqualone, commonly called quaalude.
- **Schedule IV**: among others, anabolic steroids, hypnotics such as barbiturates and benzodiazepines (better known by their trademarks Seconal, Luminal, Valium and Librium).
- **Schedule V**: enumerates other substances that may be abused.
- **Schedule VI**: precursors, which produce no effects on the mind but can be converted or used to produce designer drugs, "simili-drugs" or substances contained in the schedules under Canada's international obligations under the *Single Convention on Narcotic* Drugs (1961) and the *Vienna Convention* of 1988.
- **Schedules VII and VIII:** concerning application of penalties for cannabis offences.

A total of more than 150 drugs, psychotropic substances and precursors now appear in the schedules of the act. It should be noted that section 60 of the CDSA continues the provision adopted in 1911 that the Governor in Council may, by order, amend any one of the schedules of the act by adding or deleting one or more substances where the Governor in Council deems the amendment to be necessary in the public interest.

Part I: Offences and Punishment

Participation in the aforementioned activities would not necessarily result in criminal penalties. As will be seen below, the act provides for regulations authorizing the possession, import and export and production for medical, scientific, industrial purposes or for the purposes of the act. Part I of the CDSA enumerates a number of types of offences:

(1) Possession of a Schedule I, II or III substance (subsection 4(1)); obtaining or seeking to obtain a Schedule I, II, III or IV substance, or the order necessary to obtain it from a practitioner (subsection 4(2)). The following table shows the maximum penalties for the offence of possession:[121]

Possession of a Schedule I Substance	
Indictable offence Summary conviction Reoffence	Seven years' imprisonment Fine of $1,000 or 6 months' imprisonment or both Fine of $2,000 or one year's imprisonment or both
Possession of a Schedule II Substance (cannabis in all its forms):	
Indictable offence Summary conviction Reoffence	Five years' imprisonment less a day Fine of $1,000 or 6 months' imprisonment or both Fine of $2,000 or one year's imprisonment or both
Possession of a Schedule VIII Offence (less than 1 g of cannabis resin (hashish) or less than 30 g of marijuana)	
Summary conviction only	Fine of $1,000 or 6 months' imprisonment or both
Possession of a Schedule III Substance	
Indictable offence Summary conviction Reoffence	3 years' imprisonment Fine of $1,000 or 6 months' imprisonment or both Fine of $2,000 or one year's imprisonment or both

The penalties imposed for the offence under subsection 4(2) are similar but slightly different from those provided for possession.

(2) Trafficking in a Schedule I, II, III or IV substance or any substance represented to be such a substance. Trafficking is defined as any transaction to sell, administer, give, transfer, transport, send or deliver a schedule substance, or to offer to do any one of those things. To "sell" means offering for sale, exposing for sale, having in one's possession for sale and distributing a substance, whether or not the distribution is made for consideration (subsection 5(1)); possessing any Schedule I, II, III or IV substance for the purpose of trafficking (subsection 5(2)). The following table shows the maximum penalties for these offences:

Trafficking in a Schedule I or Schedule II Substance (except in cases involving less than 3 kg of cannabis)	
Indictable offence No summary conviction offence	Life imprisonment
Trafficking in a Schedule III Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Trafficking in a Schedule IV Substance	
Indictable offence Summary conviction	Fine of $1,000 or 6 months' imprisonment or both One year's imprisonment

Trafficking in cannabis is not always punishable by the maximum penalty of life imprisonment. In cases of trafficking involving less than 3 kg of cannabis, a person is

guilty of an indictable offence and subject to a maximum term of five years' imprisonment less a day.

(3) Importing or exporting any Schedule I to VI substance (subsection 6(1)); having in one's possession any Schedule I to VI substance for the purpose of exporting it (subsection 6(2)). The following table shows the maximum penalties for these offences:

Importing or Exporting a Schedule I or II Substance	
Indictable offence No summary conviction	Life imprisonment
Importing or Exporting a Schedule III or IV Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Importing or Exporting a Schedule IV Substance	
Indictable offence Summary conviction	3 years' imprisonment One year's imprisonment

(4) Producing a Schedule I, II, III or IV substance. The expression "produce" is defined as meaning to obtain a substance by any method or process including manufacturing, synthesizing or using any means of altering the chemical or physical properties of the substance, or cultivating, propagating or harvesting the substance or any living thing from which the substance may be extracted or otherwise obtained. The following table shows the maximum penalties for this offence:

Producing a Schedule I or II Substance (other than cannabis / marijuana)	
Indictable offence No summary conviction	Life imprisonment
Producing cannabis (marijuana) (less than 1 g of cannabis resin (hashish) or less than 30 g of marijuana)	
Indictable offence No summary conviction	7 years' imprisonment
Producing a Schedule III Substance	
Indictable offence Summary conviction	10 years' imprisonment 18 months' imprisonment
Producing a Schedule IV Substance	
Indictable offence Summary conviction	3 years' imprisonment One year's imprisonment

(5) Possession of property obtained by crime (section 8) and offences relating to the laundering of proceeds of crime (section 9).

The penalties are obviously closely related to the schedule in which the substance in question appears. Furthermore, the penalties determined for cannabis offences also vary considerably depending on the quantity involved, a subject discussed in greater detail below.

Section 10 of the Act states the purpose of sentencing, which is to contribute to the respect for the law and the maintenance of a just, peaceful and safe society while encouraging rehabilitation, and treatment in appropriate circumstances, of offenders and acknowledging the harm done to victims and to the community. This section also provides a list of circumstances which the court is required to consider as "aggravating" factors in determining the sentence that shall be imposed on a person convicted of a designated substance offence. Those factors are: the use of a weapon or use of or threat to use violence, trafficking in a substance on or near school grounds or in or near any public place frequented by minors or by persons under the age of 18 years, and previous convictions of a designated substance offence. In addition, the use of the services of a minor in the commission of a designated substance offence is an aggravating factor. Any judge deciding not to sentence a person to imprisonment despite the presence of one or more aggravating factors is required to give reasons for that decision.

Part II: Enforcement

Sections 11 and 12 of the act concern search and seizure activities, which are discussed in greater detail in Chapter 14.

Section 13 incorporates certain *Criminal Code* provisions establishing a detailed plan for the return, reporting and detention of seized property. In the case of offence-related property, the *Criminal Code* provisions apply subject to sections 16 to 22 of the Act. Furthermore, a separate procedure is established under sections 24 to 29 to determine the disposal of controlled substances. It should be noted that section 14 provides for the issuing of a restraint order in respect of offence-related property.

Sections 16 and 17 concern the forfeiture of offence-related property. Offence-related property is defined as any property, within or outside Canada, by means of or in respect of which a designated substance offence is committed, that is used in any manner in connection with the commission of a designated substance offence, or that is intended for use for the purpose of committing a designated substance offence, but does not include a controlled substance or real property, other than real property built or significantly modified for the purpose of facilitating the commission of a designated substance offence. A court which convicts a person of a designated offence shall order the forfeiture of offence-related property where it is satisfied, on a balance of probabilities, that the property is offence-related property. Where the offence-related

property cannot be related to the offence with which the person is charged, the court may nevertheless order its forfeiture. The court may make such order where it is satisfied, beyond a reasonable doubt, that it is offence-related property. Furthermore, offence-related property may be forfeited even if legal proceedings were never instituted. The court shall render an order of forfeiture of property if it is satisfied (1) beyond a reasonable doubt that any property is offence-related property, and (2) that proceedings in respect of a designated substance offence in relation to the property were commenced, and (3) that the accused charged with the offence has died or absconded.

Sections 18 to 22 are essentially a restatement of sections 462.4 to 462.45 of the *Criminal Code*. The purpose of these provisions is to protect the interests of innocent third parties and good-faith buyers. As a general rule, if the court is satisfied that the claim is lawful, it may order the return of the property (or payment of its value if restitution is impossible) to the person who is its legitimate owner or who is entitled to own it.

Section 23 merely incorporates the *Criminal Code* provisions on forfeiture of proceeds of crime. The same terms and conditions are thus established in the case of the forfeiture of the proceeds of designated offences.

Part III – Disposal of Controlled Substances

Under subsection 13(4) of the Act, where a controlled substance has been seized, a report identifying the place searched, the substance seized and the location where it is being detained shall be filed with the justice of the peace of the territorial division concerned. Sections 24 to 29 of the Act govern the disposal of controlled substances.

Section 24 establishes the pre-trial procedure for the return of controlled substances. For example, any person may, within 60 days after the date of the seizure, finding or acquisition by a peace officer or inspector, apply to a justice of the peace for a restitution order. If the justice is satisfied that the application is valid, he shall order that the substance be returned to the applicant. In the opposite case, the justice orders forfeiture to the Crown. The substance is then disposed of in accordance with the applicable regulations or as the Minister directs. Where no application for return is made, the substance is delivered to the Minister and disposed of in accordance with the applicable regulations or, failing such regulations, in such manner as the Minister directs.

It should be noted that section 26 enables the Minister to ask the justice of the peace to order that a controlled substance be forfeited, at any time, if he has reasonable grounds to believe that it constitutes a potential security, public health or safety hazard. The application is essentially made *ex parte*. If the justice of the peace finds that the Minister has reasonable grounds to believe that the substance constitutes a potential security, public health or safety hazard, he orders its forfeiture. The substance is then disposed of in accordance with the applicable regulations or, if there are no applicable regulations, in such a manner as the Minister directs.

Section 27 regulates the post-trial procedure for returning controlled substances seized–the persons whose substances were seized is entitled to have them returned where the court rules his activities legitimate. Otherwise, the substance is returned to the true legitimate owner, provided that that person can be identified. If neither is possible, the substance is forfeited to the Crown, which disposes of it in accordance with the applicable regulations or, if there are no applicable regulations, in such manner as the Minister directs.

Section 28 enables the Minister to dispose of a controlled substance with the owner's consent.

Lastly, under section 29, the Minister may destroy any plants from which a Schedule I, II, III or IV substance may be extracted and that is being produced without a regulatory licence or in violation thereof.

Part IV – Administration and Compliance

This part concerns the powers assigned to inspectors to ensure that holders of a regulatory authorization or licence to deal in controlled substances or precursors are complying with the regulations.

The inspector may, at any reasonable time, enter any place he believes on reasonable grounds is used for the purpose of conducting that person's business or professional practice. The Act authorizes inspectors to conduct a series of inspection acts, including seizing and holding any controlled substance or precursor which he deems on reasonable grounds must be seized or held. The Act makes provision for the return of seized property. It should be noted that, in the case of dwelling-places, the inspector must first obtain the occupant's consent or hold a warrant.

Part V – Administrative Orders for Contraventions of Designated Regulations

This part makes provision for the administrative procedure that is to be followed where a regulation designated by the Governor in Council has been contravened. Under section 33 of the CSDA, the Governor in Council may proclaim certain regulations made under section 55 as "special regulations". Non-compliance with those regulations may result in administrative orders providing for severe penalties, including revocation of the permit or licence issued by the Minister of Health (subsection 40(4)).

Part VI – General

Sections 44 to 60 are general provisions. For example, sections 44, 45 and 51 concern the designation of analysts, the scope of their duties and the admissibility of their reports at trial.

Section 46 creates a general penalty applying to anyone who contravenes a provision of the Act for which no penalty is specifically provided or contravenes a regulation. An indictable offence is punishable by a maximum fine of $5,000 and/or three years' imprisonment. An offence punishable on summary conviction results in a $1,000 fine and/or six months' imprisonment.

Under section 47, summary convictions for certain offences under the act and regulations must be commenced within one year of the commission of the offence. All other summary procedures must be commenced within six months of the offence.

Other sections concern the following matters: that the prosecutor is not required, except by way of rebuttal, to prove that a certificate, licence, permit or other qualification does not operate in favour of the accused (section 48); that a copy of any document filed with a department is admissible in evidence without proof of the signature of the authority (section 49); that a certificate issued to a police officer exempting him from the act or its regulations is admissible in evidence at trial and, in the absence of evidence to the contrary, is proof that the certificate or other document was validly issued, without proof of the signature or official character of the person purporting to have certified it, although the defence may, with leave of the court, cross-examine the person who issued the certificate (section 50); that the giving of any document may be proved by oral evidence, affidavit or solemn declaration, even though the court may require the signatory to appear (section 52); that the continuity of possession of any exhibit tendered as evidence in a proceeding may be proved by the testimony, affidavit or solemn declaration of the person claiming to have had it in his possession (section 53); and that certified copies of records, books, electronic data or other documents seized may be presented as admissible evidence by the Minister's officer, the copied versions having the same probative force as the originals, unless the accused submits evidence to the contrary (section 54).

Subsection 55(1) establishes the power of the Governor in Council to make regulations. One of the objectives of Canada's drug policy was to monitor the legal trade in scheduled drugs for medical or scientific purposes. The CSDA significantly enhanced the Governor in Council's power to make regulations with respect to designated substances and precursors. The regulations made under the CSDA apply in particular to businesses, physicians and pharmacists. The Governor in Council may thus make regulations, with respect to the designated substances or precursors:

- Governing, controlling, limiting, authorizing the importation and exportation, production, packaging, sending, transportation, delivery, sale, administration, possession or obtaining of those substances or precursors;
- Issuing permits to businesses or persons permitting the aforementioned activities, defining the terms and conditions of payment and their revocation, and determining the qualifications required of permit holders;
- Controlling the methods of production, storing, packaging and restricting the advertising, if necessary, for the sale of those substances;
- Governing the books, records, electronic data or other documents that must be established by the businesses, physicians or pharmacists or any other permit holder engaged in the activities enumerated in the first point;
- Authorizing, if necessary, the communication of information obtained through investigations conducted by the inspectors of the Department of Health to provincial authorities in respect of a serious contravention of the regulations

concerning the activities defined in the first point so that they may take disciplinary measures;

- Exempting, on conditions set out in the regulations, any person or class of persons from the application of section 55.

Under subsection 55(2), the Governor in Council, on the recommendation of the Solicitor General of Canada, may make regulations that pertain to investigations and other law enforcement activities. This includes regulations exempting police officers, in certain circumstances, from the application of Part I of the Act (Offences and Penalties).

Under section 56, the Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of the act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Section 57 concerns the delegation of the powers of the Minister and the Solicitor General.

Section 58 provides that the provisions of the act and the regulations made under it prevail over any incompatible provisions of the *Food and Drugs Act* or its regulations.

Section 59 makes it an offence to make or assent to the making of a false or misleading statement in any book, record, return or other document that must be made under the act or regulations.

As mentioned, under section 60, the Governor in Council may amend any schedule to add or delete a controlled substance.

The specific case of cannabis

In the first version of the CSDA, cannabis was cited in the schedule containing the most dangerous drugs to which the most severe criminal penalties described above applied. To allay criticism, the government agreed to withdraw cannabis from Schedule I and created Schedules II, VII and VIII, which concern that drug exclusively. Schedule II defines cannabis as marijuana, cannabis resin (hashish) cannabinol, and so on. Schedule VII established at three kilograms of cannabis or hashish the maximum quantity for the imposition of a less severe penalty for trafficking or possession for the purpose of trafficking in that substance. Lastly, Schedule VIII provided that a person who had less than one gram of hashish or less than 30 grams of cannabis in his possession for his own personal use was liable to less severe criminal penalties than those provided for in Schedule II.

As a result, if a person is convicted of possession, possession for the purpose of trafficking or possession of a quantity greater than that defined in Schedules VII and VIII, the more severe penalties provided for in Part I for Schedule I or II substances apply. Otherwise, the CSDA defines new criminal penalties. As regards Schedule VIII, section 4 of the CSDA provides that a person charged with simple possession of cannabis may be prosecuted summarily and provides for a maximum term of

six months' imprisonment, a maximum fine of $1,000 or both. Contrary to the majority recommendation made in the 1972 special report of the Le Dain Commission respecting the reduction of the penalty imposed for importing and exporting cannabis, life imprisonment still applies. Lastly, the maximum prison term of seven years provided for by the *Narcotic Control Act* for the offence of cultivation (production) of that drug remains unchanged under the CSDA.

CONCLUSIONS

Conclusions of Chapter 12	
	➢ **Early drug legislation was largely based largely on a moral panic, racist sentiment and a notorious absence of debate.** ➢ **Drug legislation often contained particularly severe provisions, such as reverse onus and cruel and unusual sentences.** ➢ **The work of the Le Dain Commission laid the foundation for a more rational approach to illegal drug policy by attempting to rely on research data.** ➢ **The Le Dain Commission's work had no legislative outcome, except in 1996, in certain provisions of the Controlled Drugs and Substances Act, particularly with regard to cannabis.** ➢ **No action was taken on the reform proposals introduced in the 1970s, particularly for the decriminalization of cannabis.** ➢ **Thirty years after the Le Dain Commission, the legislation and its application have had no notable effect on the supply and demand of cannabis.** ➢ **The present act Act takes no account of data from research on the comparative effects of various substances, particularly the effects of cannabis.**

CHAPTER 13

REGULATING THERAPEUTIC USE OF CANNABIS

As discussed in Chapter 9, cannabis has an extremely long history of therapeutic use, going back several thousands of years. It was often used for the same medical conditions it is used for today. With the development of the pharmaceutical industry in the last century, the medical community has gradually discontinued its use. Various factors may explain this. Developments in the pharmaceutical industry provided the medical community with more stable and better tested medication. The practice of medicine itself has changed and so has our conception of health. Then, at the turn of the 20th century, the plants from which opium, cocaine and cannabis are derived were banned by the international community, except for medical and scientific purposes. In the case of cannabis, no rigorous study had been done, until recently.

Further to the social rediscovery of cannabis and the identification of its molecular composition and chemical elements in the 1960s, renewed interest in the therapeutic applications of cannabis grew in the early 1970s. More people began using the plant for its therapeutic benefits and many demanded a relaxation of the prohibitionist rules governing cannabis.

Because its safety and effectiveness have yet to be reviewed in clinical trials, cannabis has not been approved for sale in Canada as a medical product.[1] Despite this lack of approval, many use cannabis for its therapeutic purposes without legal authorization. In addition, because of the many claims regarding its therapeutic benefit, a growing number of people have called for a less restrictive approach and are demanding access to cannabis for people who could benefit from its use.

This chapter reviews the events that prompted the recent enactment of the *Marihuana Medical Access Regulations*. One of the objectives of the regulations is to provide a compassionate framework of access to marijuana for seriously ill Canadians while research regarding its therapeutic application continues. Also discussed is the implementation of these regulations, which came into force on 30 July 2001.

[1] Two commercially available drugs related to cannabis have been approved for sale in Canada: Marinol, which contains chemically synthesized THC; and Cesamet, a synthetic cannaboid. Both may be prescribed by physicians.

BACKGROUND TO THE RECENT REGULATIONS

Section 56 – Controlled Drugs and Substances Act

The *Controlled Drugs and Substances Act*[2] (CDSA) prohibits a series of activities relating to psychoactive substances, including: possession; cultivation; trafficking; possession for the purposes of trafficking; importation; and exportation. These activities are illegal unless authorized by regulations made under the CDSA. For example, the *Narcotic Control Regulations* regulate the legal distribution of narcotic drugs.[3] In addition, before a drug may be marketed in Canada, it must be approved for sale under the *Food and Drugs Act*[4] (FDA) and its regulations. The regulations under that Act set out controls dealing with, among others, the safety, efficacy and quality of therapeutic products. To market marijuana as a drug in Canada, a sponsor would have to file a "New Drug Submission" with the Therapeutic Products Programme of Health Canada. Submitted data would be evaluated to assess the potential benefits and risks of the drug before the drug would be approved for sale.

Other mechanisms authorize certain otherwise prohibited activities. Pursuant to section 56 of the CDSA, the Minister of Health is authorized to grant exemptions if, in his or her opinion, such an exemption is necessary for a medical or scientific purpose or is otherwise in the public interest. Thus, any person or class of persons may be exempted from the application of all or any of the provisions of the CDSA in these specified circumstances. These circumstances include both the cultivation and possession of marijuana, activities that are otherwise prohibited by the legislation.

In response to the growing demand for access to cannabis for therapeutic purposes and to Charter challenges in relation to therapeutic use, Health Canada published an Interim Guidance Document in May 1999. This document set out a process enabling Canadians to apply for an exemption to possess and cultivate marijuana for therapeutic purposes under the authority provided in section 56 of the CDSA. Applicants were required to demonstrate that the exemption was necessary for such purposes and required a statement from a physician in support of the application, along with details of their medical and drug therapy histories. Health Canada reviewed the applications on a case-by-case basis, taking into account the medical necessity of the applicant. The first exemption was issued in June 1999. As of 3 May 2002, 658 exemptions had been granted under the authority of section 56, and 501 were still active. With respect to the other 157 persons with exemptions, some are now authorized to possess the substance under the recently enacted *Marihuana Medical Access Regulations* and others may no longer need marijuana for therapeutic purposes. Under

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[2] S.C. 1996, Chapter 19.

[3] These drugs are set out in the schedule and include opium, codeine, morphine, heroin, cocaine, and cannabis.

[4] R.S.C. 1985, Chapter F-27.

this process, persons with exemptions were required to limit their cultivation to the quantity specified in their exemption letter.[5]

In February 2000, as part of a commitment to public consultation in relation to the section 56 exemption program, a multi-stakeholder consultation workshop was held. The participants[6] identified the following issues as priorities:

- Obtaining a legal source of marijuana for persons exempted under section 56;
- Exemptions for caregivers;
- Addressing the need for more information on the use of marijuana for medical purposes;
- Addressing concerns of law enforcement agencies;
- Improvement of the process and tools for section 56 applications; and
- Communications regarding the section 56 process and Health Canada's activities regarding marijuana for medical purposes.[7]

The information gathered at these consultations was later used for the development of the *Marihuana Medical Access Regulations*.

Charter challenges – therapeutic use of marijuana[8]

Charter challenges to prohibitions with respect to marijuana by those using the substance for therapeutic purposes have met with some success. In *Wakeford v. Canada* (1998),[9] a person suffering from AIDS and using marijuana to fight nausea and loss of appetite, which were side-effects of the drugs he was taking to fight AIDS, sought a constitutional exemption from the prohibitions with respect to marijuana in the CDSA. The Ontario Court, General Division, found that by denying the individual the autonomy to choose how to treat his illness, the law infringed his rights to liberty and security of the person under the Charter. The Court indicated that the prohibition on marijuana was not arbitrary inasmuch as there is some risk of harm associated with its use.[10] Thus, the Court found that in its general application, the law was consistent with

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[5] In June 1999, Health Canada released a report announcing a research plan for the use of marijuana for therapeutic purposes and stating that steps would be taken to establish a domestic source of research-grade marijuana. Both of these initiatives are discussed in more detail in subsequent sections of this chapter.

[6] Participants included representatives from law enforcement, practicing physicians, research clinicians, National Association of Pharmacy Regulatory Authorities, Health Canada and others of unknown affiliation.

[7] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, p. 17.

[8] This section is based largely on *Drug Prohibition and the Constitution*, a paper prepared for the Senate Special Committee on Illegal Drugs, by David Goetz, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 1 March 2001.

[9] [1998] O.J. No. 3522 (Ont. Gen. Div.).

[10] *Ibid*., at paras. 49-50.

the principles of fundamental justice as set out in section 7 of the Charter. However, the law's impact on medical users raised additional considerations. As applied to these users, the blanket prohibition is over-broad and does not support the state's rationale for prohibition.

The Court held that it would be contrary to the principles of fundamental justice to prohibit the use of marijuana where it can be shown to be a significant medical treatment for a debilitating and deadly disease and where there was no procedural process for obtaining an exemption from prosecution.[11] However, the Court noted that such a process was provided for in section 56 of the CDSA. Therefore, the Court found that the law was in accordance with fundamental justice – even in respect of medical users – and denied Mr. Wakeford a constitutional exemption. It emphasized that, without a ministerial exemption process for medical users, the case would have been decided differently.[12] Later, Mr. Wakeford was granted an interim constitutional exemption with respect to the offences of possession and production/cultivation of marijuana on the basis of "fresh evidence" indicating that no real process had been established to deal with applications for exemptions under section 56 of the CDSA. Because the statutory exemption turned out to be "illusory," the Court reopened the case and granted the exemption. It would remain in effect until the Minister of Health had made a decision on Mr. Wakeford's application for an exemption under section 56 of the CDSA.[13]

In *R. v. Parker* (2000),[14] the Ontario Court of Appeal reached a similar conclusion with respect to the impact of the blanket prohibition on marijuana use on the "liberty and security of the person" interests of medical users. In *Parker*, the accused–who had been charged with cultivation and possession of marijuana–grew and used marijuana to control his epileptic seizures. The Court held that the criminal prohibition on the use of marijuana, vis-à-vis *bona fide* medical users, engaged their section 7 right to liberty because of the possibility of imprisonment. In addition, by depriving such individuals of the ability to choose marijuana as medication to alleviate the effects of a serious illness, the prohibition also infringed their rights to liberty and security of the person, independent of the potential for imprisonment. The Court in *Parker* further concluded that the blanket prohibition on marijuana possession did not accord with the principles of fundamental justice. The Court of Appeal made reference to the findings of the trial judge with respect to the medical conditions and symptoms for which cannabis has a therapeutic effect:

> *Based on the evidence adduced at trial, the trial judge found that the defence had established that smoking marihuana has a therapeutic effect in the treatment of nausea and vomiting particularly related*

[11] *Ibid*., at para. 54.
[12] *Ibid*., at para. 66.
[13] [1999] O.J. No. 1574, at paras. 11, 31 and 32.
[14] 49 O.R. (3d) 481.

> *to chemotherapy, intraocular pressure from glaucoma, muscle spasticity from spinal cord injuries or multiple sclerosis, migraine headaches, epileptic seizures and chronic pain.* [15]

Of significance to this chapter, the Court in *Parker* concluded that the exceptions and exemptions contemplated by the legislation that could cover approved medical use were contrary to the principles of fundamental justice. Firstly, although the legislation theoretically contemplated that a person could obtain marijuana with a doctor's prescription, the evidence in the case established that no pharmacist would fill such a prescription; the government would not look favourably on any physician who prescribed marijuana; and it was practically impossible to find a legal source of marijuana in Canada.[16] Thus, this exception to the prohibition was held by the Court to be illusory.[17]

Secondly, with respect to ministerial exemptions under section 56 of the CDSA, the Court found this procedure to be inadequate and not in accordance with the principles of fundamental justice. The Court ruled that, under section 56, unfettered discretion was vested in the Minister of Health, an inappropriate basis for decisions relating to the security or liberty of the person in the context of access to medical treatment to alleviate the effects of serious illness.[18] Key issues relating to the section 56 exemption process included: the broad discretion given to the Minister under the CDSA; transparency of the process; and a clear definition of medical necessity.

In the end, the Court concluded that the broad prohibition on possession of marijuana was contrary to section 7 of the Charter and did not constitute a reasonable and justified limit under section 1 of the Charter.[19] The Court then declared the prohibition on the possession of marijuana to be unconstitutional and of no force and effect. However, the Court suspended the declaration of invalidity for one year in order to give Parliament the opportunity to amend the law to include adequate exemptions for medical use. In the interim, Mr. Parker was granted a personal exemption from the prohibition on possession of marijuana. The Court in *Parker* suggested its finding that the prohibition on possession of marijuana violated section 7 of the Charter would likely apply to the prohibition on cultivation as well.[20]

Government reaction

In September 2000, while an appeal was still under consideration, the government announced its intention to establish a new regulatory approach, which would define the circumstances and the manner in which the use of marijuana for therapeutic purposes

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[15] *Ibid.*
[16] *Ibid.*, at para. 155.
[17] *Ibid.*, at para. 163.
[18] *Ibid.*, at paras. 184-185 and 188.
[19] *Ibid.*, at paras. 191-194.
[20] *Ibid.*, at para. 190.

would be authorized.[21] A *Notice of Intent* was published on 6 January 2001 and meetings were held with key stakeholders as identified by Health Canada.[22]

In April 2001, the government unveiled proposed regulations governing the possession and production of marijuana for therapeutic purposes. The proposed regulations were designed to address the key issues raised by the Ontario Court of Appeal in relation to the section 56 exemption process. There were two parts to the draft regulations: (1) authorization to possess and (2) licence to produce.

The 30-day regulatory consultation period, during which Health Canada received comments from 139 individuals and groups, resulted in the following changes being made to the proposed regulations: the application process would be managed by the individual applicant instead of by a medical practitioner; restrictions on growing locations would be relaxed and would no longer include a one-kilometre restriction on cultivation outdoors near schools and other places frequented by children; the formula to calculate the number of plants permitted under a licence to produce would be adjusted to reflect estimated indoor and outdoor growing yields and margins of error; and transitional provisions would be included to extend all current exemptions by six months with the objective of ensuring patients would be afforded ample opportunity to comply with the new regulations.[23]

On 4 July 2001, the government announced that the regulations governing the possession and production of marijuana for therapeutic purposes would come into effect on 30 July 2001.

MARIHUANA MEDICAL ACCESS REGULATIONS

As stated above, there are two parts to the *Marihuana Medical Access Regulations* (MMAR): part 1, authorization to possess, and part 2, licence to produce. One of the objectives of the regulations is to provide a compassionate framework to allow access to marijuana for medical purposes.

> *The regulations establish a compassionate framework to allow the use of marijuana by people who are suffering from serious illnesses, where conventional treatments are inappropriate or are not providing*

[21] Health Canada, News Release, *Minister Rock announces intention to develop new approach for the use of marihuana for medical purposes*, 14 September 2000.

[22] Key stakeholders included representatives from the Canadian Medical Association, the Canadian Pharmacists Association, the Canadian AIDS Society, the RCMP, Solicitor General Canada, Department of Justice, Correctional Service Canada and the Canadian Association of Chiefs of Police.

[23] Health Canada, Information, *Marijuana Medical Access Regulations – Amendments Resulting from Public Consultations*, July 2001.

adequate relief of the symptoms related to the medical condition or its treatment, and where the use of marijuana is expected to have some medical benefit that outweighs the risk of its use.[24]

As will be reviewed in detail, the MMAR are intended to provide access to marijuana in special circumstances only: in the case of serious medical conditions where conventional treatment may not provide adequate symptomatic relief. Health Canada explains that this limitation is due to *"the health risks associated with the smoked form in particular, and due to the lack of evidence supporting the claimed health benefits."*[25]

Significantly, the application of the MMAR is limited to "Cannabis (marihuana)" as referred to in sub-item 1(2) of Schedule II of the CDSA. Thus, the regulations do not provide access to other cannabis-related products.

The key provisions of the MMAR are as follows.

Authorization to possess

Three distinct categories have been established in relation to authorization to possess dried marijuana, each with its own application requirements. In each case, the application is to be submitted by the patient, whose declaration must include information identifying the applicant and indicating 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 marijuana as a drug and that the applicant understands the significance of that fact; and
- The applicant has discussed the risks of using marijuana with a medical practitioner and consents to using it for the recommended medical purpose.

Category 1

- Eligibility: Applicants who suffer from a symptom associated with a medical condition for which the **prognosis is death within 12 months**.
- Conditions: A **medical practitioner** must provide a medical declaration indicating, among other things:
    - The applicant's medical condition and the symptom that is associated with that condition or its treatment;
    - The applicant suffers from a terminal illness;
    - All conventional treatments for the symptom have been tried or considered;
    - The recommended use of marijuana would mitigate the symptom;
    - The benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use;

[24] Health Canada, Information, *Medical Access to Marijuana – How the Regulations Work*, July 2001.
[25] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, page 8.

- The medical practitioner is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug;
- The applicant's recommended daily dosage and period of use.

Category 2

❖ Eligibility: Applicants who suffer from specific symptoms associated with some serious medical conditions, specially:

- **Multiple sclerosis**: severe pain and/or persistent muscle spasms;
- **Spinal cord injury**: severe pain and/or persistent muscle spasms;
- **Spinal cord disease**: severe pain and/or persistent muscle spasms;
- **Cancer**: severe pain, cachexia, anorexia, weight loss, and/or severe nausea;
- **AIDS/HIV infection**: severe pain, cachexia, anorexia, weight loss, and/or severe nausea;
- Severe forms of **arthritis**: severe pain; and
- **Epilepsy**: seizures.[26]

	Severe Pain	Persistent Muscle Spasms	Cachexia	Anorexia	Weight Loss	Severe Nausea	Seizures
Multiple Sclerosis	☐	☐					
Spinal Cord Injury	☐	☐					
Spinal Cord Disease	☐	☐					
Cancer	☐		☐	☐	☐	☐	
AIDS, HIV infection	☐		☐	☐	☐	☐	
Severe form of Arthritis	☐						
Epilepsy							☐

Source: Application for Authorization to Possess Dried Marihuana, Category 2 – Medical Specialist Form

❖ Conditions: Applicants must provide a declaration from a **medical specialist** to support their application, indicating, among other things:

- The applicant's medical condition and the symptom that is associated with that condition or its treatment;
- The specialist practises in an area of medicine that is relevant to the treatment of the applicant's medical condition;

[26] These symptoms are listed in a Schedule to the MMAR and were selected based on the outcome or conclusions of scientific and medical reports, although seizures associated with epilepsy were added in view of the findings in the *Parker* decision. This list is intended to be reviewed on a regular basis and is to be amended as new information becomes available.

- All conventional treatments for the symptoms have been tried or considered and were found to be medically inappropriate for reasons outlined in the Regulations;
- The recommended use of marijuana would mitigate the symptom;
- The benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use, including risks associated with long-term use of marijuana;
- The medical specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug; and
- The applicant's recommended daily dosage and period of use.

Category 3

❖ Eligibility: Applicants who have symptoms associated with a medical condition, **other than those described in Categories 1 and 2.**

❖ Conditions: Declarations from **two medical specialists** must accompany the application. The first declaration must indicate all information required under Category 2; all conventional treatments that have been tried or considered for the symptom; and the reasons, from those outlined in the Regulations, why the medical specialist considers that those treatments are medically inappropriate.

SYMPTOM(S)	TREATMENTS	REASONS – For each conventional treatment listed in the "Treatments" column, please provide the reasons why you consider that the treatment is medically inappropriate. (CHECK OFF THE APPROPRIATE BOX BELOW).							
In the column below, please list the name of symptom(s) associated with the medical condition or its treatment and that is (are) the basis for the application.	In the column below, for each symptom, please list the name of conventional treatments tried or considered.	The treatment was ineffective.	The applicant has experienced an allergic reaction to the drug used as a treatment.	There is a risk that the applicant would experience cross-sensitivity to a drug of that class.	The applicant has experienced an adverse drug reaction to the drug used as a treatment.	There is a risk that the applicant would experience an adverse drug reaction based on a previous adverse drug reaction to a drug of the same class.	The drug used as a treatment has resulted in an undesirable interaction with another medication being used by the applicant, or there is a risk that this would occur.	The drug used as a treatment is contra-indicated.	The drug under consideration as a treatment has a similar chemical structure and pharmacological activity to a drug that has been ineffective for the applicant.
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐	☐

Source: Application for Authorization to Possess Dried Marihuana, Category 3 – First Medical Specialist Form

❖ The second declaration must indicate that, among other thingss: the specialist has reviewed the applicant's medical file and the reasons why the conventional

treatments are considered to be medically inappropriate; the specialist has discussed the applicant's case with the first specialist and agrees that the recommended use of marijuana would mitigate the symptom, and the benefits of the applicant's recommended use of marijuana would outweigh any risks associated with that use, including the risks associated with long-term use of marijuana; and the second specialist is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marijuana as a drug.

Dosage

The medical practitioner or specialist sets the daily dosage. If the recommended daily dosage is more than 5 grams per day, the medical practitioner or specialist must indicate that he or she has considered the risks associated with an elevated daily dosage of marijuana, including risks with respect to the effect on the applicant's cardio-vascular, pulmonary and immune systems and psychomotor performance, as well as the potential for drug dependency; and that in his or her medical opinion, the benefits of the applicant's use of marijuana according to the recommended daily dosage would outweigh the risks associated with that dosage, including risks associated with the long-term use of marijuana.

Maximum quantity possessed

The authorization to possess specifies the amount that may be possessed at any given time is a 30-day treatment supply. As explained above, the medical practitioner or specialist sets the daily dosage used to determine the 30-day treatment supply.

Duration

Generally, authorizations to possess are valid for one year and may be renewed.

Licence to produce

There are currently two possible legal sources for holders of an authorization to possess: they can grow their own supply or they can designate someone else to grow it for them. Health Canada has stated that, in the future, they should also be able to obtain it from a licensed supplier.

Only holders of an authorization to possess (personal-use production licence) or someone who has been designated as their representative (designated-person production licence) are eligible to hold a licence to produce. A designated person cannot be remunerated for their activities.

Conditions for obtaining a licence to produce include the following:

- A person cannot be the holder of more than one licence to produce;
- One site may be used for the production of marijuana under a maximum of three separate licences;
- The holder of a licence to produce must maintain measures necessary to ensure the security of the product;
- The production of marijuana outdoors is not permitted if the production site is adjacent to a school, public playground, day care facility or other public place frequented mainly by persons under 18 years of age;
- A person is ineligible for a designated-person production licence, who has been found guilty of a designated drug offence in the previous 10 years.

The licence specifies the maximum number of plants that may be cultivated. The licence also deals with the maximum quantity of dried marijuana that may be kept in storage and, in the case of a designated representative, the transportation of marijuana. The maximum amount of marijuana that may be cultivated and stored at any time depends on the daily dosage that has been set by the medical practitioner or specialist, and whether plants are grown indoors or outside. The regulations also deal with inspection powers and record-keeping requirements.

Other provisions

There are also provisions dealing with matters such as: measures to ensure the security of the marijuana in the possession of an authorized person; the revocation of licences; the showing of documents to police officers; the referral to police of complaints received by inspectors; and the disclosure of information about a medical practitioner to provincial licensing authorities of medicine. Of note is a transitional provision extending section 56 exemptions for an extra six months after the date of their expiry.

Health Canada has established an ongoing review process to monitor the effectiveness and application of the MMAR and provide advice on future measures related to the manufacture, distribution and sale of marijuana for medical purposes. This process involves a series of activities intended to collect information and seek input on various aspects of the MMAR. A 15-member committee representing a number of different stakeholder groups is currently being established, with a its first meeting planned in October 2002.

COMPASSIONATE ACCESS?

One of the objectives of the MMAR was to provide a compassionate framework for medical access to marijuana. In addition, one of the criteria used in choosing the current regulatory approach was that it *"must not unduly restrict the availability of marihuana to patients who may receive health benefits from its use."*[27]

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.

The following was stated in the Regulatory Impact Analysis Statement that accompanied the publication of the MMAR.

> *Due to anticipated increased visibility and efficiency of the new regulatory scheme and increased awareness of the potential uses or medical benefits of marihuana, it can reasonably be expected that the numbers of applicants will* ***increase significantly****. (emphasis added)*

As reported to us by Health Canada, as of 3 May 2002, 658 exemptions had been granted under the authority of section 56, and 501 were still active. In terms of the MMAR, 498 applications were received and 255 had been authorized as of the same date. In addition, 164 personal production licences and 11 designated personal licences have been issued. The rest of the files are open and are incomplete, awaiting more information or undergoing review.[28]

Thus, almost one year after the MMAR came into force, only 255 people have been authorized to possess marijuana for therapeutic purposes and only 498 applications have been received. These numbers are significantly lower than the number of exemptions that were granted under section 56 of the CDSA. Although 501 exemptions under section 56 are still active, it is clear that the number of applicants has not increased significantly as could "reasonably be expected" under the MMAR. In fact, the stated efficiency of the new regulatory scheme should be viewed with much scepticism. The low participation rate, in itself, should raise serious concerns among those sincerely aiming to provide compassionate access to cannabis for therapeutic purposes. In addition, the following sections will set out some of the specific problems

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[27] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, page 13.
[28] Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, page 32.

that must be addressed if the regulatory scheme is to be truly efficient and compassionate.

Eligibility

The current framework requires an applicant to obtain a declaration from a medical practitioner (or one or two specialists) indicating that the recommended use of marijuana would mitigate the applicant's symptom and that the benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use. The medical practitioner must also determine the applicant's recommended daily dosage and period of use. A medical practitioner is defined as someone who is authorized under the laws of a province to practise medicine.

It is clear to everyone that requiring medical practitioners to act as "gatekeepers" in the use of marijuana for therapeutic purposes has created a major impediment to access, or, as Health Canada states, *"there is a conundrum"*. The Canadian Medical Association and many other professional medical organizations have refused to support the new federal application process because of issues of patient safety, dosages, and the legal liability of physicians prescribing cannabis.

This reluctance should not have come as a surprise to Health Canada. During the consultation process with regard to the proposed regulations, two medical associations and two provincial licensing authorities opposed the use of smoked marijuana for medical purposes. Their reasons included:

- The lack of scientific evidence supporting its use;
- The fact that marijuana is not an approved drug product;
- The view that the use of smoked marijuana is not an acceptable form of drug administration; and
- The view that the responsibility placed on doctors to support the use of marijuana for medical purposes may place them in conflict with professional conduct rules relating to the use of unapproved or "alternative" medicines.[29]

The position taken by the Canadian Medical Protective Association (CMPA) is fairly reflective of the positions taken by other individuals and organizations in the medical community. The CMPA is a medical mutual defence organization with 60,000 members–about 95 per cent of the physicians practising in Canada. It has warned its members that they could expose themselves to liability or professional misconduct complaints if they prescribe marijuana without "detailed knowledge" of the drug's risks and benefits and the appropriate dosage. The following was stated in an information sheet sent to members:

> *Section 69 of the regulations allows a medical licensing authority to request from the federal health minister information regarding a specific medical practitioner, which may be provided if the minister has*

[29] Regulatory Impact Analysis Statement accompanying the *Marihuana Medical Access Regulations*, p. 19.

> *reasonable grounds to believe the medical practitioner has made a false statement under the regulations. This is a significant concern, as physicians may unknowingly make a false statement because they are being asked to attest to matters that may go beyond the scope of their expertise. As a result, the risk that physicians could be reported to their College is increased.*
>
> *The fact that marijuana is not an approved drug product may lead some to conclude marijuana is an alternative medicine. This raises the important point as to whether the Colleges would consider physicians' involvement in the application for a licence to possess marijuana as requiring them to comply with the policy of that College concerning alternative or complementary medicines. The CMPA advises physicians to ascertain from their regulatory authority what their position is in this regard.*
>
> *Given the consequences that may befall physicians with respect to their licensing body, or potential medico-legal liability, physicians will want to be very careful when determining whether to assist a patient in making an application under these regulations.* [30]

The CMPA has also stated that the information about the effectiveness of medical marijuana in each patient's case, the relative risks and benefits of the drug and what dosage would be appropriate is "simply is not available," making it nearly impossible for the vast majority of doctors to comply with requirements of the MMAR. It views the MMAR as placing "an unacceptable burden on member physicians" and states that, since "many physicians would not have the necessary knowledge about the effectiveness, risks or benefits of marijuana, we believe it is unreasonable to make physicians gatekeepers in this process."[31] The CMPA advised its members as follows:

> *As you will see from the attached Information Sheet, now in the hands of our members, we have advised those physicians who are not or do not feel qualified to make those assessments to refrain from signing a declaration for a patient. We also advised our members to explain to their patients why they do not have the knowledge about marijuana, and to refer the patient to another physician, if known, with more experience in the medical use of marijuana.*
>
> *Finally, recognizing that some physicians, out of compassion for their patients, may believe in good faith that their medical condition would benefit from marijuana, we have advised them to complete only Parts 1 and 2 of the form and to* NOT *complete Parts 3, 4 and 5, leaving Health Canada to decide whether to process an incomplete application.* [32]

Clearly, under these circumstances, patients will have difficulty finding a medical practitioner willing to complete the required declaration forms, and even more difficulty accessing the appropriate specialists. This situation has created an unacceptable barrier to access and one must conclude that physicians should not be the

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[30] Canadian Medical Protective Association, *What To Do When Your Patients Apply For A Licence To Possess Marijuana For Medical Purposes*, October 2001.

[31] Canadian Medical Protective Association, letter to the Honourable Allan Rock, Q.C., 8 November 2001.

[32] *Ibid.*

"gatekeepers" under the MMAR, a responsibility that they themselves do not desire. Even Health Canada recognizes that there is a problem.

> *Without that scientific evidence, the doctors are in a legitimate quandary. For other therapeutic products, doctors rely on information that Health Canada either develops or analyzes through the drug review process. That is the basis for doctors' understanding of the particular products. They do not have that analysis in this particular situation.*
>
> *Through the marijuana medical access regulations, we have eliminated the criminality of possessing and growing for your own purposes. That is the regulatory regime that is in place. We are working with Prairie Plant Systems, as Ms Lynch has said, to develop a research source for this product that will be made available through legitimate clinical trials for patients.*
>
> *Until such time as we can begin to get the results of the research and until the medical community can determine whether it will prescribe this in legitimate circumstances, there is a conundrum.* [33]

The involvement of physicians in the process is not questioned–what must be determined is their proper role with respect to use of cannabis for therapeutic purposes. Physicians are trained to provide a diagnosis of a person's medical conditions and symptoms and to determine how to treat these conditions and symptoms medically. Most do not have, however, adequate knowledge of the therapeutic benefits of cannabis and are reluctant to associate themselves with this product for a variety of reasons, including its illegality. In our view, and as we have explained in detail in Chapter 9, a distinction must be made between an approved medicine per se and a substance that has, at the very least, potential therapeutic applications–although these may not have been "scientifically" confirmed to date. Chapter 9 enumerates the conditions and symptoms for which cannabis has potential therapeutic applications. Let us be clear: we do not view cannabis as a "miracle" substance that will treat or cure numerous medical conditions or symptoms. It is a substance, however, that is known to provide effective relief of certain medical conditions and symptoms, thus improving the quality of life of many individuals.

In these circumstances, the proper role of the physician should be to make a diagnosis of the patient's medical conditions or symptoms. If the condition or symptom is one where cannabis has potential therapeutic applications, the patient would be authorized to use the therapeutic product of his or her choice, including cannabis. This would also mean eliminating the current requirement that all other "conventional treatments" have been tried or considered before the use of cannabis is authorized. There is no justification for making cannabis an option of "last resort."

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[33] Dann Nichols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, pages 37-38.

The requirement for specialist involvement in the current scheme clearly can lead to long delays. To make matters worse, the stated positions of medical organizations would make it very difficult to get two specialists to make the required declarations. This creates another unwarranted barrier.

> *The requirement to involve a medical specialist in the authorization of possession of medicinal cannabis is unjustified, unfounded, unrealistic and punitive. It negates timely access, and places au unjustified burden on both the patient and the Health Care system. Many patients already wait from nine months to a year to see a specialist. This means that those waiting for authorization to access medicinal cannabis may be on hold for upwards of a year. This is an inhumane wait to force upon those in dire medical need. In addition, it will unnecessarily exacerbate already extensive waiting lists for specialists, meaning those in genuine need of the specialists will unduly suffer.* [34]

The conditions and symptoms for which cannabis use would be authorized are set out in Chapter 9. New conditions or symptoms would be added based on ongoing research.

We are aware that the *1961 Single Convention on Narcotic Drugs* would seem to require medical prescriptions for the supply or dispensation of drugs to individuals.[35] We make two comments:

- International conventions are generally subject to a country's constitutional provisions. As previously discussed, courts in Canada have found that depriving an individual of the ability to choose marijuana as medication to alleviate the effects of a serious illness does violate the rights protected under the *Canadian Charter of Rights and Freedoms* unless there is a statutory exemption scheme authorizing such use. The courts have indicated that, where a statutory exemption scheme turns out to be "illusory," a constitutional exemption will be granted. The stated positions of Canadian medical organizations may make the current MMAR exemption scheme turn out to be "illusory."
- It is better to look to the spirit rather than the letter of the Convention. While cannabis may not be an approved medicine per se, there is no doubting its potential therapeutic applications. Thus, the Government of Canada should advise the international community that we will not strictly adhere to this requirement and that we will be requesting appropriate amendments to the international conventions.

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[34] B.C. Compassion Club Society, *BCCCS Response to Health Canada's Proposed Medical Marijuana Access Regulations*, 4 May 2001, page 4.

[35] *Single Convention on Narcotic Drugs, 1961*, Article 30.2.b.i.

Access to cannabis

Concerns regarding patients' ability to grow marijuana on their own or to find a person willing and able to do it for them were often raised. This problem is compounded by the condition in the MMAR that a person cannot be the holder of more than one licence to produce. Problems associated with the present scheme include a lack of experience in cultivation; products of unknown potency and quality; security risks related to cultivation of marijuana; etc.

Undoubtedly, patients must have access to safe and high-quality cannabis products. The current option of self-cultivation should remain open for those who prefer this avenue. In such cases, the patient would register directly with Health Canada. In cases where self-cultivation is not appropriate or feasible, access should be permitted through properly regulated **Dedicated Cannabis Distribution Centres**. These centres would be staffed by personnel with knowledge of the therapeutic use of cannabis, who could advise patients on the dosage, strain and potency best suited for their particular conditions. The failure to obtain a domestic source of research-grade marijuana, as had been planned, provides further justification for allowing distribution centres to dispense high-quality cannabis to eligible patients. In addition, we are convinced that the government should not be the only distributor of cannabis intended for therapeutic purposes. Currently, Compassion Clubs play a very important role in distributing cannabis to those who need it for therapeutic purposes. For example, the B.C. Compassion Club Society is a registered non-profit society that has been distributing cannabis for medical use since 1997. It employs a staff of 28 and serves a membership of approximately 1,600 people. Before registering a member, the club requires a confirmation of diagnosis and a recommendation for cannabis from a physician, naturopathic doctor or a psychiatrist. If a doctor will not sign a recommendation solely because he or she is uncomfortable with the legal status of cannabis, or has concerns about professional retribution, the club may register the patient without a doctor's recommendation, depending on the severity of the diagnosis. Similar Compassion Clubs exist elsewhere in Canada.[36]

Access to a variety of strains of cannabis with varying levels of potency is crucial. For example, the B.C. Compassion Club Society currently stocks many varieties of cannabis products.

> *Our daily menu usually has seven to ten varieties of cannabis, one or two varieties of hashish, cannabis tincture and baked goods. It is important that medicinal users have access to a variety of strains, as the effect of cannabis varies depending on which strain is being used and the method of ingestion. Our members are made aware of the differences and can then select the best strain of cannabis to most effectively treat their symptoms.* [37]

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[36] For example, the Vancouver Island Compassion Society currently has 235 members and the Club de compassion de Montréal has 130 members.

[37] Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 36

High-quality products would be ensured through proper testing. The importance of testing was raised as a key issue.

> *It is absolutely crucial in the developments on which we are working – and that we would like to continue – to have strict guidelines in terms of moulds and mildews, pesticides, fungicides, heavy metals and the kinds of things – which can be very dangerous – that you find in non-organic cannabis. Even in organic cannabis, some of those elements of microbiology can be very harmful to people, especially for people with depleted immune systems. We can only develop such standards when the medical marijuana community has access to laboratories. I think that there are all kinds of standards that can be developed in terms of safety and cleanliness in growing and distribution.* [38]

Despite what most would view as laudable motives–distributing cannabis to patients in order to alleviate their suffering–most of the existing clubs have faced or are facing difficulties with the justice system. Because they are operating in a grey area, those involved in these clubs are subject to prosecution and have in fact been prosecuted. For example, we heard from Philippe Lucas, director of the Vancouver Island Compassion Society (VICS), who indicated that he had been arrested and charged with possession for the purposes of trafficking because of his work with VICS. Mr. Lucas pleaded guilty to the charge but was recently granted an absolute discharge. Some of the comments made by the judge at sentencing are certainly relevant to this chapter. On the question of eligibility, the judge stated the following:

> *This case must be viewed in a broad context, in which to date, the combination of federal regulations and College of Physicians trepidation has made it extremely difficult for applicants to obtain approval to use marijuana.* [39]

He added the following with respect to access to marijuana:

> *Further, the federal government has so far been unable to ensure any legal supply of marijuana to those whom Health Canada thinks need it as a therapy. This is a particular hardship for those who cannot grow it.*
>
> *…the Crown cannot rely upon the argument that there is a lawful option for those in need of the drug when the evidence establishes that the drug is only theoretically available through legitimate sources.* [40]

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[38] *Ibid*., page 44.
[39] *R.* v. *Lucas*, Provincial Court of British Columbia, Victoria, File No: 113701C, para. 47 (Honourable Judge Higinbotham).
[40] *Ibid*., para. 47-48.

In conclusion the judge stated the following.

> *I find that while there is no doubt that Mr. Lucas offended against the law by providing marijuana to others, his actions were intended to ameliorate the suffering of others. His conduct did ameliorate the suffering of others. By this Court's analysis, Mr. Lucas enhanced other peoples' lives at minimal or no risk to society, although he did it outside any legal framework. He provided that which the Government was unable to provide a safe and high quality supply of marijuana to those needing it for medicinal purposes. He did this openly, and with reasonable safeguards. The fact that he has stated he will continue this activity points to the sincerity of his principles, and points to our need as a society to get this thorny issue resolved quickly by either Parliament or the Supreme Court of Canada. If he re-offends, he will have to argue his case again, and may find a discharge difficult to obtain in the future. This court hopes that cooler heads will prevail pending the final resolution of issues regarding the medical and non-medical use of marijuana.* [41]

In Montreal, we heard how two volunteers of the *Club Compassion de Montréal* had been arrested only three months after they started operations. A decision is expected by the end of August 2002. Encouragingly, Hilary Black, founder and director of the B.C. Compassion Club Society, stated that the local police had generally been *"wonderfully supportive of their work."* However, her next statement reveals readily apparent contradictions.

> *Police who have come to the Compassion Club Society have told me what great work we are doing, and have, on one occasion, protected a safe full of cannabis on our behalf. However, I have had a police gun held to my head for being at a growing facility. While I met with the federal health minister, Alan Rock, to give recommendations and information Health Canada had requested from us, the RCMP raided a greenhouse that was growing low cost, organic cannabis for the Compassion Club Society. While I am here before you, sharing our information as experts in the distribution of medicinal cannabis, my colleagues risk arrest, imprisonment, their ability to travel, to be employed, and their freedom to distribute cannabis to those in need. Prohibition is not protecting Canadians from the evils of cannabis; prohibition is destroying Canadians' lives.* [42]

Because these organizations are presently operating in a grey area we would hope that those in charge of enforcement would use their discretion powers liberally and that cooler heads will prevail. Some of the statements made by Hilary Black led us to be optimistic in this area. Clearly, in other areas of the country, the political climate will have to change.

In order to create a transparent therapeutic distribution system, these centres should be licensed and properly regulated. The conditions of their operation should include a requirement that they be authorized only to distribute cannabis for therapeutic purposes to those who have been diagnosed as having an enumerated

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[41] *Ibid*., para. 49

[42] Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 41.

condition or symptom. In addition, the distribution centres would be required to keep suitable records and make periodic reports. The purpose of such information would be to keep Health Canada informed of the centres' members for registration purposes and also to provide valuable information for scientific research. Thus, the records would include information on a patient's medical condition and its evolution, the amounts consumed and the observed effects on the patient. The centres would also be required to ensure that security measures are in place and would be subject to inspections to ensure compliance with the regulations.

While added regulation will increase the costs of these distribution centres, this is essential to ensure proper controls over therapeutic use of medicinal cannabis. We insist that the costs of this regulatory scheme be kept to a minimum so as not to impede access to cannabis through inflated prices.

With respect to obtaining products, centres would agree to be supplied only by licensed producers. Such producers would be able to cultivate cannabis only for therapeutic purposes–since the separation of the therapeutic system from the recreational system is crucial. Licensed producers would be properly regulated–in particular, to ensure adequate safety measures are in place–and would be required to produce safe, high-quality products.

Products

Currently, the MMAR authorize possession of only dried marijuana, and not other cannabis products. We do not feel that this is justified and would recommend that the scheme be expanded to cover other cannabis derivatives .

Costs

We heard on several occasions that patients using cannabis for therapeutic purposes were often suffering from serious debilitating diseases, which negatively affected their financial situations. We recognize that drug coverage by insurance plans is generally a provincial responsibility. However, we believe that the purchase of marijuana for therapeutic purposes, and the purchase of equipment necessary for its cultivation, should be considered a medical expense for the purposes of the *Income Tax Act.*

Marihuana Medical Access Regulations	**Committee Proposals**
Eligibility • The medical practitioner must not only confirm the applicant's medical condition and the symptom that is associated with that condition or its treatment, but also confirm that the recommended use of marijuana would mitigate the symptom and that the benefits from the applicant's recommended use of marijuana would outweigh any risks associated with that use • Requirement to consult one (category 2) or two (category 3) specialists for symptoms associated with medical conditions set out in category 2 and category 3 • Generally requires that all conventional treatments have been tried or considered • Three categories of eligibility	**Eligibility** • The diagnosis of a medical doctor or other medical practitioner regulated by a provincial colleges of physicians and surgeons would suffice for the purpose of authorizing therapeutic use • Eliminate the requirement to consult one or two specialists • Eliminate the requirement that all conventional treatments have been tried or at least considered before cannabis may be used • Eliminate the three categories and enumerate the medical conditions or symptoms for which cannabis use would be permitted – updating the list on a continual basis based on commissioned research
Access • Patients are limited to growing their own supply or designating someone to grow it for them	**Access** • Patients would be allowed to grow cannabis themselves or obtain it from dedicated distribution centres supplied by licensed producers
Products • Limited to cannabis (marijuana)	**Products** • Include all cannabis-derived related products
Dosage • Set by medical practitioner	**Dosage** • Would be determined by patient in association with the dedicated distribution centre

RESEARCH PLAN

Health Canada's Office of Cannabis Medical Access is responsible for the administration of the MMAR. It also co-ordinates other initiatives related to cannabis, including research on the safety and effectiveness of marijuana used for therapeutic purposes and the establishment of a reliable Canadian source of research-grade marijuana.

As stated previously, Health Canada released a report in June 1999 announcing a research plan for the therapeutic use of marijuana. The document[43] laid out a five-year research plan for evaluating the risks and benefits of the use of marijuana for medical purposes. The plan included the following elements:

- a research agenda composed of projects to address the issues of safety and efficacy of smoked marijuana and cannabinoids;
- mechanisms for medical access to marijuana outside the projects (for example section 56 exemptions discussed previously in this chapter); and
- the development of a Canadian source of research-grade marijuana.

Scientific research

As part of the government's strategy to address the issue of medical marijuana, Health Canada decided to sponsor research activities to evaluate the safety and efficacy of smoked marijuana and of cannabinoids. Health Canada was concerned that the evidence of the therapeutic value of smoked marijuana was heavily anecdotal and that the scientific studies supporting the safety and efficacy of marijuana for therapeutic claims were inconclusive. Health Canada was also concerned about the health risks associated with the use of marijuana, especially in smoked form.

The strategy has been developed with advice from the Therapeutic Products Programme's (TPP) Expert Advisory Committee on New Active Substances, an external body of scientific and medical experts who provided advice to the TPP.

Currently, there is a partnership program between Health Canada and the Canadian Institutes of Health Research (CIHR), a granting agency. This is to ensure scientific validity of the studies. The Health Canada/CIHR Medical Marijuana Research Program (MMRP) has been established as a five-year research plan with estimated funding of up to $7.5 million. The initial focus is on the smoked form of marijuana, although future initiatives are also to focus on non-smoked marijuana and cannabinoids.

We are aware of at least two studies that have been planned:

- In July 2001, Health Canada and the CIHR announced a contribution of $235,000 to fund a pilot study at McGill, with about 32 patients, aimed at evaluating the effects of smoked marijuana for chronic neuropathic pain.
- In June 2001, Health Canada announced funding of $840,000 to support a research project by the Community Research Initiative of Toronto (CRIT) on the efficacy of smoked marijuana in the treatment of wasting syndrome in those living with HIV/AIDS. At the time, it was entering the second phase of a three-part research project on smoked marijuana – The acute effects of smoked cannabis on appetite in persons living with HIV/AIDs (PHAs): A randomized, double-blind, placebo-controlled, crossover pilot study.

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[43] Health Canada, Therapeutics Products Programme, *Research Plan for Marijuana for Medicinal Purposes : A Status Report*, 9 June 1999.

It should be noted, however, that neither of these projects is currently under way because they do not have access to marijuana.

In addition to pilot projects, Health Canada has announced that research-grade marijuana will be provided to eligible individuals who agree to provide health information for monitoring and research purposes. Health Canada will collect and analyse this information for research purposes. Once again, Health Canada has yet to provide marijuana to authorized users.

Health Canada has indicated that the knowledge gained from the overall research program will be used, in part, to amend the MMAR if necessary. For example, category 2 symptoms may need to be adjusted or the daily dosage may need to be more precisely determined. Health Canada also indicated that if no benefits were shown, the continued need of the MMAR would be in doubt.

Clearly, research on the therapeutic aspects of marijuana is essential. While Health Canada should be applauded for establishing a research plan, what is less commendable is the pace at which the research is progressing. As stated, the authorized pilot projects have yet to commence their research because Canada must rely on an American source for research-grade marijuana. This means that American institutions, in particular the National Institute on Drug Abuse, are entitled to review Canadian research protocols to determine whether or not they will deliver their marijuana products to Canadian researchers.

> *Our first source or our first attempt at sourcing the marijuana for research purposes was through NIDA, the National Institute on Drug Abuse in the States. They have seed and dried product. We are still negotiating with them to get some dry product.*
>
> *In order to use their product, we have to have the protocols that the product will be used for approved by both the health department there and NIDA themselves. Once they have approved the actual scientific protocol, then it has to go to the DEA to see if they will allow the export.* [44]

While further research is essential, it does not suggest that therapeutic use is not justified in specified circumstances. The ongoing research should focus on confirming its justification and on identifying new medical conditions or symptoms for which cannabis has therapeutic value. Research to determine the value of cannabis as a medicine per se should also be a priority, as should finding alternative delivery systems that are as effective as smoked cannabis.

Before leaving the issue of research, mention should be made of the considerable expertise and knowledge currently residing in the Compassion Clubs, which have become established outside of the legal system. This source of valuable

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44 Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, pp. 47-48.

information and expertise has not been acknowledged under Health Canada's current research plan. We feel strongly that the information they have must be gathered and analysed for research purposes. The validity of ongoing research using what some consider to be low-quality, low-potency cannabis imported from the National Institute on Drug Abuse or similar type of product that may be produced in Canada must also be called into question. Hilary Black, founder and co-director of the B.C. Compassion Club Society, stated the following.

> *We created a research proposal with a team of research scientists from Vancouver. However, we were turned down because we refuse to facilitate a study using a placebo or low-quality, low-potency cannabis imported from the US National Institute on Drug Abuse. Any study attempting to prove the efficacy of cannabis as a medicine using such a low-potency herb, or unknown strains such as those currently being grown in Canada by Plant Prairie Systems, is destined to fail. There is no need to import cannabis for research, considering the high quality and huge quantity of cannabis being produced in Canada. The information we could gather is being requested by doctors, patients, pharmaceutical companies, Plant Prairie Systems and Health Canada, yet we are not financially empowered to facilitate this research.* [45]

Research-grade marijuana

As was previously stated, another priority in Health Canada's research plan was the development of a Canadian source of research-grade marijuana. A request for proposal (RFP) was released on 5 May 2000 through Public Works and Government Services Canada. The purpose of the RFP was to establish a Canadian source of quality, standardized, affordable, research-grade marijuana for scientific research. Originally, the marijuana was to be made available only to qualified, approved scientists for research. A number of proposals were received by the closing date of 28 June 2000. The evaluation criteria included: financial status, qualifications of personnel, security requirements respecting personnel, etc. No experience in growing marijuana was required, although there was a requirement for experience in growing plant material for human consumption.

In December 2000, a contract was awarded to Prairie Plant Systems Inc. of Saskatoon (PPS) to provide Health Canada with a reliable source of affordable, quality, standardized marijuana for medical and research purposes. Health Canada also announced that until the domestic supply was established, it would submit requests to the U.S. National Institute of Drug Abuse to obtain research-grade marijuana for clinical trials being conducted in Canada on behalf of researchers.

PPS met the contract requirements for security and was given authorization to begin growing marijuana. The site chosen for the cultivation of research-grade marijuana in Canada was an abandoned mine in Flin Flon, Manitoba. While to some this appears comical, Health Canada justifies this decision because of the security this

45 Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, p. 10 :38-10 :39.

location provides and the opportunity to control the temperature, the humidity and the growing conditions.

The first product was expected to be delivered to Health Canada by early 2002. Under the terms of the five-year, $5.7 million contract that Prairie Plant Systems Inc. signed with Health Canada, the company would

- Set up and operate a marijuana growing, processing, fabrication and storage establishment;
- Conduct laboratory testing and quality control of marijuana throughout the product life cycle;
- Fabricate, package, label and store marijuana material;
- Distribute marijuana product to recipients authorized by Health Canada; and
- Conform to the requirements of the CDSA including stringent security and physical measures.

Health Canada also announced that this product would, in addition to use for research purposes, be made available to authorized Canadians using it for medical purposes who agree to provide information to Health Canada for monitoring and research purposes.

This spring, Health Canada revealed that the first crop could not be used for research purposes because of the varying quality. While they had hoped to obtain seeds from the National Institute on Drug Abuse, the seeds that were used were obtained from police seizures in Canada. This led to a collection of marijuana with different strains and characteristics. Health Canada states the importance of research-grade marijuana as follows:

> *Going back to the comments we made earlier on why Health Canada is involved in the study of medical marijuana, it is to determine whether to develop the scientific evidence that is required to determine whether there is a benefit. In order to develop that scientific evidence, one must have a base product that meets research standards. It was not a question of whether Prairie Plant Systems did in fact grow marijuana; it was a question of whether the product they developed was consistent, research-grade standard such that it could be used in legitimate scientific research.* [46]

While we are sympathetic to this argument, there would appear to be no justification for not supplying this product to those who have been authorized to do so under the CDSA, particularly since the safety of the product, in regard to pesticides, moulds, etc., should not be in question.

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[46] Dann Nichols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch, Health Canada, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-Seventh Parliament, 2001-2002, Issue No. 22, page 46.

CONCLUSIONS

We would like to emphasize that the changes we propose to the MMAR still ensure that therapeutic use is limited to cases of legitimate medical need and that distribution and production is done under governmental licence.

Conclusions of Chapter 13	
	➢ **The MMAR are not providing a compassionate framework for access to marijuana for therapeutic purposes and are unduly restricting the availability of marijuana to patients who may receive health benefits from its use.** ➢ **The refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an "illusory" legislative exemption and raises serious Charter implications.** ➢ **In almost one year, only 255 people have been authorized to possess marijuana for therapeutic purposes under the MMAR and only 498 applications have been received – this low participation rate is of concern.** ➢ **Changes are urgently needed with regard to who is eligible to use cannabis for therapeutic purposes and how such people gain access to cannabis.** ➢ **Research on the safety and efficacy of cannabis has not commenced in Canada because researchers are unable to obtain the product needed to conduct their trials.** ➢ **No attempt has been made in Health Canada's current research plan to acknowledge the considerable expertise currently residing in the compassion clubs.** ➢ **The development of a Canadian source of research-grade marijuana has been a failure.**

CHAPTER 14

POLICE PRACTICES

Views on police priorities regarding enforcement of laws on illicit drugs are, at the very least, inconsistent, if not completely contradictory. Some believe that too much police time, effort and resources are spent in investigating illicit drug offences and, more specifically, possession offences – even more specifically, cannabis possession offences. Others–including the police themselves – claim that police priorities are already focused on traffickers and producers, and that possession charges are laid as a result of police presence to deal with other criminal activity. Thus, they maintain that the vast majority of cannabis possession charges are incidental to other police responsibilities.

This chapter will review the key organizations that are responsible for enforcing Canada's current illicit drugs legislation, the *Controlled Drugs and Substances Act* (CDSA). It will include a discussion of the powers they have been granted, and the investigative techniques used, in relation to illicit drug investigations. Finally, key police-related statistics will be explored. This information should help clarify some of the misconceptions related to enforcement of laws on illicit drugs.

ENFORCEMENT AGENCIES

Several organizations play a role in enforcing Canada's illicit drug legislation. This section will review three: the RCMP, the Canada Customs and Revenue Agency (CCRA), and provincial and municipal police forces. These key players co-operate with many other organizations when required, such as National Defence, Fisheries and Oceans, and the Canadian Coast Guard.

The RCMP

The RCMP's role and mandate is to enforce laws, prevent crime, and maintain peace, order and security. The RCMP is involved mainly in four components of Canada's Drug Strategy: enforcement and control; national co-ordination; international co-operation; and prevention programming.

At the national level, the RCMP's drug enforcement responsibilities are primarily carried out by two groups:

- The Drug Enforcement Branch: with approximately 900 employees, this branch is responsible for drug enforcement in Canada through its head office in Ottawa and its divisional drug enforcement units located throughout the country. The Branch also provides rapid communication to members of the international drug enforcement community.
- Integrated Proceeds of Crime Initiative: with about 415 employees, this group is responsible for investigating persons for proceeds of crime and seizing assets obtained through criminal activities. With an estimated 90 per cent of seizures related to drugs, it is primarily a drug-related initiative. The 13 units are staffed with a mix of: federal, provincial, and municipal police; Justice counsel; customs officers; tax investigators; asset managers; and forensic accountants. Cases tend to be complex and lengthy.

These two services also receive assistance from other RCMP sections such as intelligence and other specialized investigation services, including electronic and physical surveillance. Their current priorities lie in the investigation and arrest of upper echelon criminal organizations, involved in the drug trade, and in the seizing of proceeds of crime. The RCMP has adopted an intelligence-driven approach and conducts project-oriented investigations–for example, focusing on organized crime. It gathers information that is fed through its intelligence process to identify the main threats across the country. National priorities are based on these threat assessments so that resources will be focussed on the areas of greatest risk to Canadians. National priorities are reassessed, modified and retargeted based on gathered intelligence. Within those national priorities – for example, outlaw motorcycle gangs – particular groups will be specifically targeted. This approach has resulted in cases that are complex and lengthy and consume significant resources. Many of these investigations can take many years to come to fruition.

When it appeared before the Committee in October 2001, the RCMP set out the following national priorities:

> *Our current strategic national priorities are outlaw motorcycle gangs, Asian-based organized crime, Italian-based organized crime, and Eastern European-based organized crime. These are national targets; they are not drug targets. These are the RCMP national targets. These groups are involved in all commodity areas. However, you will notice that all four groups are involved in illicit drugs* [1]

The RCMP works closely with other national and international enforcement agencies in its efforts to reduce the supply of drugs in Canada. In this function, it will

[1] R..G. Lesser, Chief Superintendent, RCMP, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 8, page 11.

regularly participate in joint forces operations–which can be permanent working groups or temporary operations aimed at a specific target–to co-operatively investigate criminal activity and exchange intelligence. Liaison is maintained with provincial and municipal police departments, Interpol, the United Nations, the Organization of American States, National Defence, Fisheries and Oceans, Correctional Service of Canada, the Canadian Coast Guard, as well as Customs authorities and drug enforcement agencies worldwide, such as the Drug Enforcement Administration, FBI and U.S. Customs.

The RCMP is also involved in drug prevention and has established a Drug Awareness Service. With a budget of $4 million and 31 employees, this Service is responsible for going into the community to educate students, parents, athletes, coaches, employees, employers and community groups. The RCMP–including all personnel and not only the 31 full-time employees–makes over 10,000 presentations per year. Programs include Drug Abuse Resistance Education (DARE)[2], the Aboriginal Shields Program, the Two-way Street: Parents, Kids and Drugs, and the Drugs and Sport Program.

In addition to its federal responsibilities, the RCMP is involved in local enforcement as part of the provincial and municipal policing responsibilities it performs under contract. Sgt. MacEachern, Drug Enforcement Coordinator in New Brunswick, provided the following explanation:

> *The RCMP has a contractual obligation to the Province of New Brunswick and, as such, we provide policing services to all rural areas of the province, a large number of the smaller service districts and small municipalities, and as well a significant number of larger municipalities. In addition, we have federal law enforcement units throughout the province, and for drug enforcement we have offices and suboffices in Bathurst, Moncton, Saint-Leonard, Saint John and Fredericton.*
>
> *Simply put, our federal enforcement personnel dedicate themselves to larger scale investigations involving organized criminal groups at the provincial, interprovincial, national and international levels. Our provincial or contract detachments are tasked with targeting local or street level drug traffickers, but often, in the interests of addressing a significant local trafficking situation, our federal units combine resources with our detachments to pursue a specific goal.* [3]

While enforcement statistics are discussed in greater detail in following sections of this chapter, it is interesting to note that, according to the following chart from the Auditor General's 2001 Report,[4] the RCMP was responsible for approximately 24% of all charges under the *Controlled Drugs and Substances Act* in 1999, with only 4% of the charges relating to its federal policing services. In this chart, the number of persons

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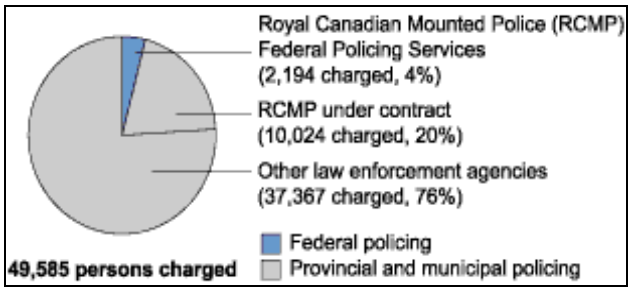
[2] DARE is discussed in greater detail in Chapter 17.

[3] Presentation submitted to the Committee on 5 June 2002.

[4] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," p. 11.

charged is according to the most serious offence in a given incident and means persons charged by police or persons against whom the police recommended charges be laid.

Charges under the Controlled Drugs and Substances Act in 1999



The Canada Customs and Revenue Agency [5]

The CCRA–currently with over 8000 employees–has always played a key role in drug enforcement in Canada and is responsible for intercepting drugs at the point of entry. This is a significant task because many of the illicit drugs found in Canada are smuggled across our borders – although this statement may be less accurate with respect to cannabis, because of local production.

The *Customs Act* grants customs officers certain powers. Section 98 authorizes an officer to search a person arriving in Canada if the officer suspects on reasonable grounds that the person has secreted on or about his person: anything in respect of which the Act has been or might be contravened; anything that would afford evidence with respect to a contravention of this Act; or any goods the importation or exportation of which is prohibited, controlled or regulated under the Act or any other Act of Parliament. In addition, section 99 authorizes examination of goods that have been imported into Canada.

The CCRA deals with several types of contraband, including firearms, alcohol, tobacco and drugs. Like that of the RCMP, its work is intelligence-based, using information gathered through its own extensive intelligence network and through other enforcement agencies (both nationally and internationally). Thus, its contraband and intelligence program works with national and international enforcement agencies to develop information, indicators and trends to help identify suspicious shipments and/or persons before they arrive at the border.

The enforcement programs are based on strategic planning, risk management, information gathering and dissemination, partnerships, and effective training of

[5] This section relies to a great extent on the testimony of Mark Connolly, Director General, Contraband and Intelligence Services Directorate, Customs Branch, Canada Customs and Revenue Agency, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 8, pages 33-39.

personnel. The Contraband and Intelligence Services Directorate–with illegal drugs as its first priority–is responsible for the design, development, and implementation of strategies with regard to anti-smuggling and intelligence programs. Due to increasing volume, the CCRA implemented the Customs Action Plan–modernizing customs processes and introducing programs based on risk management.

The CCRA contraband and intelligence program is made up of intelligence officers, analysts, and databases to support front-line customs inspectors in identifying high-risk persons and goods at our borders. These units are responsible for collecting and developing intelligence and disseminating it to the line officers across the country.

The CCRA maintains alliances with other customs administrations, national and international law enforcement agencies, and external stakeholders in connection with contraband, intelligence, strategic export and counter-terrorism programs. It has also built important partnerships with other law enforcement agencies in Canada, such as the RCMP and provincial and municipal police, and around the world with other customs administrations and law enforcement agencies such as the United States Customs Service, the Drug Enforcement Agency, the World Customs Organization, the Caribbean Customs Law Enforcement Council, and Interpol. The CCRA regularly participates in joint-force operations of both short- and long-term duration. For example, the Integrated Border Enforcement Teams (IBETS) is a multi-agency law enforcement initiative between Canada and the United States to address cross-border crimes. In addition, the CCRA and police pool resources on a daily basis with local, state and provincial enforcement agencies to combine expertise and intelligence. The CCRA is also part the Integrated Proceeds of Crime initiative discussed above.

Specific activities in relation to drug enforcement include:

- Use of highly sophisticated contraband detection equipment to conduct non-intrusive examinations to assist in the identification of narcotics – X-ray systems, including baggage, mobile truck and rolling cargo systems; ion scans used to detect trace amounts of narcotics on almost any surface; detector dog teams deployed across the country; contraband detection kits that include a number of useful tools such as probes and fibrescopes; and one submersible remote-operated vehicle used to detect narcotics and other contraband attached to the hull of ships, below the water level.
- Emphasis on training its customs inspectors in the area of contraband enforcement.
- Use of several enforcement systems and databases, both internal and external, which allow customs officers and inspectors to identify the level of risk of travellers, carriers and/or drivers.
- Deployment of dedicated enforcement personnel to enhance intelligence and interdiction in the regions. Regional Intelligence Officers work with local police authorities, targeters, investigators and customs officers to identify high-risk movement across the border. Flexible Response Teams consist of highly trained customs officers who have been placed across Canada to perform monitoring and

compliance verification activities, as well as sampling stints on travellers chosen on a random basis. Regional Intelligence Analysts analyze large seizures to identify links to organized crime; they also conduct threat assessments based on trends, and help identify future risk.

The CCRA estimates that it is responsible for approximately 50% of all drug seizures in Canada.

Provincial and municipal police

Provincial and municipal police forces handle the majority of drug cases in Canada. They are involved primarily in enforcing illicit drug legislation at the street level. In addition, members of these forces are often involved in joint operations with the RCMP and/or the CCRA and other enforcement agencies. For example, the Committee was informed of joint operations currently being run with the RCMP–and in certain cases other enforcement agencies–and the Toronto Police Service, the Vancouver Police Department and the Regina Police Service.

COSTS [6]

The Committee had requested certain details from police forces such as the proportion of time officers spend on drug-related cases, the number of officers assigned to drug enforcement, etc. In most cases, we either received no response to these questions or very general broad statements. Either the police forces were not willing to share this information or police work does not lend itself to these types of calculations and no one knows how much is spent on drug enforcement. In either case, the lack of data makes it extremely difficult to estimate how much of police budgets is allocated to drug-related matters and to analyze whether or not public funds are efficiently allocated.

Estimating the cost of drug enforcement is a fairly complex exercise. Questions raised include: Which items should be included? Which items should be left out because of a lack of data? How should each cost element be measured? Are such costs truly avoidable? How are items to be costed? Finally, what is the effect of these factors on the quality of the results?

[6] This section relies to some extent on *The Costs of Drug Abuse and Drug Policy*, a paper prepared for the Special Senate Committee on Illegal Drugs by Antony G. Jackson, Economics Division, Parliamentary Research Branch, Library of Parliament, 22 April 2002.

The Canadian Centre on Substance Abuse (CCSA) undertook the latest major study of the costs of drug abuse in Canada.[7] This study was published in 1996 and relates to 1992 data. Law enforcement costs were estimated as:

Police	**$208.3M**
Courts	$59.2M
Corrections (including probation)	$123.8M
Customs and Excise	**$9.0M**
Total law enforcement costs	$400.3M

Police costs consisted of the costs for specialized law agencies such as the (then) RCMP Narcotics Division, plus that fraction of the general costs of operations that could be attributed to dealing with illicit drug crimes. Such crimes included both direct violations of the drug laws and also that proportion of general crimes that could reasonably be attributed to illicit drugs.

Data existed on the proportion of homicide and assault cases in which the perpetrator was under the influence of illicit drugs. The CCSA study estimated the proportion of those cases where the assault or homicide could be causally attributed to the drug intoxication of the perpetrator. Putting these two together, it estimated that 8% of violent crimes were attributable to illicit drugs in Canada. No such figure was estimated for property crimes.

The measure of police output was the offence. To estimate policing costs, total policing expenditures as reported by Statistics Canada were multiplied by the percentage of offences that were estimated to be drug-related. The CCSA study concluded that in 1992, 2.4% of all offences were attributable to illicit drug use.

Policing costs of enforcing federal drug laws	$168.4M
Policing costs of 8% of violent crimes	$39.9M
Total policing costs	$208.3M

The Customs and Excise figure excluded programs financed under the Drug Strategy.

While we are unable to conduct an in-depth study of enforcement of laws on illicit drugs costs in relation to the RCMP, the CCRA and provincial and municipal police, we can assert with certainty that the current costs of enforcement of laws on illicit drugs are significantly higher than the approximately $210 million estimated in 1992.

The Auditor General's 2001 report estimated that the RCMP alone spent approximately $164 million in 1999 on enforcement of laws on illicit drugs.[8] This

[7] Single, E., et al., (1996) *The Costs of Substance Abuse in Canada: A Cost Estimation Study*, Ottawa: Canadian Centre on Substance Abuse.

estimate was based on detailed expenditure data gathered by the federal drug enforcement program. The amount included costs directly related to drug enforcement as well as costs in related areas such as proceeds of crime and customs and excise initiatives.

The $164 million applies **only** to RCMP federal policing services, however, and not to the policing services rendered by the RCMP under contract to a province or municipality, which account for the largest share of the force's budget. We were told that, at present, it was not possible to ascertain the costs related to the enforcement of laws on illicit drugs for the latter functions.

> *In the case of contract policing, enforcement of drug laws is rendered in conjunction with a number of other services as, typically, the officers under contract are performing uniform duty, that is, general policing duties in communities. It is therefore difficult to determine what portion of their time is spent doing which activity. This difficulty is enhanced when the drug offence is incidental to another crime, which is often the case.*
>
> *One must consider that a large portion of the cost of any police service is the pay and benefits extended to its members. In order to accurately determine the cost of drug enforcement in contract policing, the amount of time devoted to the effort must be measured.*
>
> *While this is done for members of the RCMP employed in the federal services, the present system applied to contract policing is incapable of collecting this information. An effort is being made to develop a new system that could possibly capture this information. However, given the breadth of day-to-day contract policing duties, it is a clear challenge to separate out, in a meaningful way, drug-related activity.*
>
> *…I should like to speak now to the cost borne by provincial and municipal police forces. We have recently begun a process to determine what information exists on enforcement costs and where the gaps lie. Last month, at the most recent meeting of the National Coordinating Committee on Organized Crime, which I chair, our department distributed a questionnaire to collect existing information on the cost of enforcement in the provinces and territories. The questionnaire has since been distributed to police forces across the country through the Canadian Association of Police Boards. We are very interested in analyzing the results once we have received them.* [9]

This Committee is obviously also very interested in these results, since they would provide the most accurate information available to date. As previously explained, we found it extremely difficult, if not impossible, to obtain any specific details on cost breakdowns for drug-related activities for provincial and municipal police forces. While Chief Fantino of the Toronto Police Service indicated that "probably one-third of our

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[8] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," page 17.

[9] Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch, Department of the Solicitor General, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, pages 9-10.

resources are sucked right up in some form or another relating to drug work,"[10] this type of statement is insufficient to permit concrete conclusions with respect to policing costs. What we did hear was that drug investigations–in particular those targeting trafficking networks–can be very resource-intensive for police forces.

> *It is a large pull on resources, due to the nature of the work. The work is complex and, as you point out, it involves surveillance. It will sometimes involve wiretap surveillance as well. It requires a network of people who work in a clandestine fashion. It takes the police a long time to assemble credible evidence to reveal the network, make the connections, and then to correlate all of that for the court. It is a very resource-intensive aspect of policing, therefore, it is very expensive to the police department.* [11]

It is not clear, however, whether the same rationale with respect to costs applies in the case of cannabis possession.

> *Cannabis use is, except as it is incidental to an encounter with a police officer, not a target of police investigation at this time, at least not in this community. We do not go out and seek people who are simply using cannabis. We do encounter them, however, as we go about our business in many other circumstances. We encounter them as one part of the drug investigation into trafficking, so we see the users there and some charges arise. We see them in domestic disputes. We see users in drinking establishment investigations and sometimes in traffic-infraction situations. Their presence is incidental to the investigation.*
>
> *As far as targeting cannabis trafficking and cannabis cultivation, that is a mainstream of the drug investigations. The money from cannabis cultivation and cannabis trafficking does flow into other aspects of crime. In some communities it is most definitely formal, organized crime; in other communities it is groups of affiliated criminals who are involved for profit only. We direct our activity to those areas.* [12]

With respect to customs-related costs, the CCRA indicated that of its $410 million budget for 2001-2002, it can be estimated that $75 million is dedicated to the interdiction of illegal drugs, in areas such as: Flexible Response Teams; district-targeting units; the container examination program; the marine centre of expertise; regional intelligence analysts; and regional intelligence officers. In addition, costs were associated with contraband detection technology that includes: X-rays; ion-mobility spectrometers; and the Detector Dog service. The CCRA did indicate that the officers involved in contraband detection are not dedicated solely to drug enforcement but to contraband enforcement in general–although illicit drug interdiction was their first priority. The

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[10] Chief Julian Fantino, Toronto Police Service, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 5, page 11.
[11] Chief Cal Johnston, Regina Police Service, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 16, page 31.
[12] *Ibid.*, page 33.

Auditor General's 2001 report had estimated the CCRA's enforcement expenditures at between $14 and $36 million for illicit drug interdiction.[13]

The numbers indicated below have been selected from the following sources:

- RCMP (federal policing services) – Auditor General's 2001 report and testimony before the Committee;
- Provincial and municipal forces and RCMP (under contract) – by multiplying the estimated total policing expenditures for municipal and provincial policing of $5.0 billion (in 1997-1998, expenditures totalled $4.8 billion – excluding RCMP federal policing services expenditures)[14] by 3.5% (the percentage that illicit drug offences represented of all CDSA and *Criminal Code* offences in 2001: 91,920 CDSA offences and 2,534,319 *Criminal Code* offences = 2,626,239 total CDSA and *Criminal Code* offences)[15]; and
- CCRA – based on an estimate between figures provided in the Auditor General's 2001 report ($14 to $36 million) and the CCRA's testimony before the committee ($75 million).

While this is a crude and unscientific method of calculation and does not take into account a series of factors that would certainly lead to adjustments, it does provide some basis for comparison.

RCMP (Federal Services)	$164 million
Provincial and municipal policing	$175 million
CCRA	$50 million
Total	**$389 million**

As indicated above, given the fact that drug investigations are extremely resource-intensive, drug enforcement may be assumed to represent much more than 3.5% of policing budgets. Chief Fantino of the Toronto Police Service indicated that it was probably closer to 33% of his budget. Even if a conservative number such as 15% were used, the figure for provincial and municipal policing costs would increase to $750 million. **This would mean that almost $1 billion is being spent on drug enforcement in Canada every year.** Clearly, not all costs would be recoverable, even under a legalized system. For example, already overburdened police forces would surely

[13] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role," page 16.

[14] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Justice Spending in Canada, Catalogue no. 85-002-XIE, Vol. 19, No. 12, pages 4-6.

[15] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, page 14.

redirect resources to other priorities. However, significant savings could reasonably be expected, if the cannabis laws were relaxed.

> *…the actual savings in law enforcement costs attributable to changing prohibition of possession are hard to estimate. The difficulty occurs in part because cannabis arrests have decreased in recent years in Vancouver reflecting the overall tendency to relax enforcement for simple possession. Nevertheless,* ***reduced law enforcement activities would have substantial savings if the law was repealed or changed****.*[16]*(emphasis added)*

POLICE POWERS [17]

There are those who argue that police have been granted powers that are far too extensive in relation to drug enforcement and that in this fight against drugs, society has come to tolerate a battery of investigative techniques–wiretapping, strip-searches, the use of paid informants, entrapment, etc–which are offensive to our basic notions of civil liberty. As will be discussed in more detail, the nature of drug offences renders them difficult to enforce. This results in police agencies requesting and using a variety of unusual methods of enforcement. While there is a long history of special police powers in relation to drug enforcement, this chapter will focus primarily on modern police powers.

No one questions the fact that police require powers for the maintenance of law and order in our society. In investigating criminal offences, the police may use less intrusive investigative techniques such as observation and interrogation. In other cases, they may be required to use more intrusive methods such as electronic surveillance and reverse sting operations. While such methods are not limited to drug enforcement and may be used in other criminal matters, they are certainly used much more extensively in drug investigations.

These powers must be constrained, however, so as to protect individuals from excessive police activity. As stated by La Forest J.: *"The restraints imposed on government to pry into the lives of the citizen go to the essence of a democratic state."*[18] In determining whether police conduct is acceptable, conflicting interests generally have to be weighed. First, there are the individual's interests, including the interest of being free from state intrusion. Second, there are the state's interests, including that of protecting society

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[16] Kash Heed, Vice Drugs Section, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 10, page 62.

[17] This section is in essence a summary of *Police Powers and Drug-Related Offences*, a paper prepared for the Special Senate Committee on Illegal Drugs by Gérald Lafrenière, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 6 March 2001.

[18] *R.* v. *Dyment*, (1988) 45 C.C.C. (3d) 244 at p. 254 (S.C.C.).

from crime. Because these interests generally conflict, it can sometimes be difficult to agree on where the line should be drawn in relation to police conduct.

The courts have recognized that, as crimes become more sophisticated, police must be able to use more sophisticated investigative techniques to detect their commission. In addition, with respect to drug-related offences and other consensual types of offences,[19] it is acknowledged that routine investigative techniques are often insufficient because of the difficulty in detecting these activities. Generally, because there is no "victim," no one is there to complain or report the offence to police. Both Parliament and the courts appear to agree that additional police powers may be warranted in these circumstances. It is believed that police need to be proactive, rather than reactive, as is generally the case for other non-consensual offences. An example of this viewpoint is expressed in the following statement by former Chief Justice Laskin of the Supreme Court of Canada:

> *Methods of detection of offences and of suspected offences and offenders necessarily differ according to the class of crime. Where, for example, violence or breaking, entering and theft are concerned, there will generally be external evidence of an offence upon which the police can act in tracking down the offenders; the victim or his family or the property owner, as the case may be, may be expected to call in the police and provide some clues for the police to pursue. When "consensual" crimes are committed, involving willing persons, as is the case in prostitution, illegal gambling and drug offences, ordinary methods of detection will not generally do. The participants, be they deemed victims or not, do not usually complain or seek police aid; this is what they wish to avoid. The police, if they are to respond to the public disapprobation of such offences as reflected in existing law, must take some initiatives.* [20]

The Le Dain Commission had also recognized the special nature of drug offences.

> *The peculiar nature of drug crimes–the fact that the people involved in them are consenting and co-operative parties, and there is rarely, if ever, a victim who has reason to complain, as in crimes against persons and property – makes enforcement of the drug laws very difficult. The police are rarely assisted by complainants. For the most part they have to make their own cases. Moreover, the activity involved in non-medical drug use is relatively easy to conceal. It can be carried on, by agreement of the parties involved, in places which are not easily observed by the police. Further, the substances and equipment involved are relatively easy to conceal or dispose of.*
>
> *All of these difficulties have given rise to the development of unusual methods of enforcement.* [21]

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[19] Other consensual offences include gambling and prostitution.

[20] *R.* v. *Kirzner* (1977) 38 C.C.C. (2d) 131 (S.C.C.) at page 135.

[21] Commission of Inquiry into the Non-medical Use of Drugs (1972) *Cannabis*, A Report, Ottawa, page 239.

Searches and seizures

Special powers of search and seizure have long been part of drug law enforcement practices. For example, before they were eliminated in 1985, writs of assistance generally gave peace officers the power to search without first having to obtain a warrant. Such powers were found in previous versions of the *Customs Act*, the *Excise Act*, the *Food and Drugs Act* and the *Narcotic Control Act.* Before its repeal in 1985, section 10(1) of the *Narcotic Control Act* allowed peace officers acting under *"the authority of a writ of assistance or a warrant"* to enter and search a dwelling-house "at any time," so long as the peace officer had a reasonable belief that there was a narcotic in the house *"by means of or in respect of which"* an offence under the Act had been committed. Section 8 of the Charter eventually put an end to writs of assistance.

Today, the CDSA establishes a comprehensive search and seizure scheme for drug-related offences. Although these provisions are similar to the search and seizure provisions of the *Criminal Code*, police have some additional powers under the illicit drug legislation. Section 11(1) allows a justice to issue a search warrant if he or she is satisfied by information on oath that there are reasonable grounds to believe that specific items are in a place. These items are:

- A controlled substance or precursor in respect of which the CDSA has been contravened;
- Anything in which a controlled substance or precursor referred to in the previous paragraph is contained or concealed;
- Offence-related property; or
- Anything that will afford evidence in respect of an offence under the CDSA.

A warrant may be obtained even though there is no reason to believe that there are illicit drugs in the place being searched, so long as there are grounds respecting the presence of one of the other three types of items.

The CDSA authorizes a search **"at any time."** Thus, there is no requirement to obtain authorization to search at night, as in the case of a search under the *Criminal Code*.

Another special power is found in subsection 11(5), which allows the police to **conduct searches of the person** in certain circumstances. This power is not found in the *Criminal Code*, although the police do have power of search incidental to arrest under common law. The CDSA gives the police, in the process of executing a search warrant, the power to search a person for a controlled substance or other specified items. This can be done only if the officer has reasonable grounds to believe that the person found in the place set out in the warrant has in his or her possession a controlled substance or other specified items set out in the warrant. Thus, this provision authorizes the police to conduct a search of the person even if no arrest is made, but only for specified items and only if the police have reasonable belief of certain facts.

Subsection (7) allows the police to conduct a search described in subsections (1), (5) or (6) without a warrant *"if the conditions for obtaining a warrant exist but by reason of exigent circumstances it would be impractical to obtain a warrant."* As will be discussed later, warrantless searches are presumed to be unreasonable, but the courts have allowed for exceptions. The rules have been summarized as follows:

> *A warrantless search has been justified where, based on the circumstances of the search, it was not feasible to obtain the warrant; for example, where a vehicle, airplane or other conveyance having the ability to change location is the subject of the search. The onus in such cases is on the Crown to establish that the obtaining of a warrant in the circumstances of the specific case would impede the effectiveness of the enforcement of the law.*
>
> *Where there is no common law search power regarding searches in "exigent circumstances", the courts have held that it is necessary for the enabling legislation to specifically refer to a warrantless search power in certain circumstances, for example, exigent circumstances. Such legislative provisions should narrowly define the type of investigation which would permit the use of a warrantless search.* [22]

Although exigent circumstances may be created by the presence of drugs in a vehicle, whether a warrantless search of a person's home in exigent circumstances will be found to be constitutional is still in doubt.[23] The courts will require some public interest sufficiently compelling to override the privacy interests attaching to the home. One example of such a compelling interest is the preservation of human life or safety.[24]

The legislation also allows: a police officer to seize things not specified in the warrant if the officer believes on reasonable grounds that they are items mentioned in subsection (1);[25] and the power to seize anything that the officer believes on reasonable grounds has been obtained by or used in the commission of an offence (not limited to drug offences) or will afford evidence in respect of an offence.[26]

The CDSA also deals with the use of force. Section 12 allows a police officer who is executing a warrant to "enlist such assistance as the officer deems necessary" and "*use as much force as is necessary in the circumstances.*" It should be noted that the search provisions in the *Criminal Code* do not specify that force may be used, although this is set out in other sections of the *Criminal Code*.

Things seized under the CDSA can be classified as either offence-related property (for example, money and automobiles) or controlled substances ("drugs"), with specific rules regarding detention and forfeiture for each category. The legislation also provides for the search, seizure, detention and forfeiture of proceeds of crime in relation to

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[22] Brucker, T. (2002) *The Practical Guide to the Controlled Drugs and Substances Act*, Third Edition, Carswell, page 101.

[23] In *R.* v. *Feeney*, the Supreme Court of Canada refused to deal with the issue because, according to the Court, exigent circumstances did not exist when the arrest was made.

[24] *R.* v. *Godoy*, (1999) 131 C.C.C. (3d) 129 (S.C.C.).

[25] See *Controlled Drugs and Substances Act*, section 11(6).

[26] See *Controlled Drugs and Substances Act*, section 11(8).

drug-related offences by incorporating the proceeds of crime provisions of the *Criminal Code*.

Section 8 of the Charter–warrantless searches

Section 8 of the Charter provides that everyone has the right to be secure against unreasonable search and seizure. Court decisions have dealt with the question of whether searches are reasonable in various situations and with the ancillary question of whether evidence obtained during the searches can be adduced at trial. A search will generally be reasonable if it is authorized by law, the law itself is reasonable, and the search is carried out in a reasonable manner.

Section 8 protects the public's reasonable expectation of privacy from state intrusions. Thus, where there is no reasonable expectation of privacy, section 8 does not apply. In addition, a diminished expectation of privacy (for example, in prisons or at border crossings) will lower the standard of reasonableness (for example, excusing the absence of a warrant or reducing the standard required for justifying the search). A person's home is where there would be the greatest expectation of privacy and thus a greater degree of constitutional protection.

Although the Charter does not specifically require that police obtain a search warrant to conduct a search, the Supreme Court of Canada in *Hunter* v. *Southam Inc*. has established a presumption that a warrantless search is unreasonable.[27] The general rule for a valid search is that the police will require prior authorization to conduct the search (for example, by obtaining a search warrant) and reasonable and probable grounds to justify it. This is to provide a safeguard against unjustified state intrusion.

This is the general rule; however, there are exceptions. It is recognized that a prior authorization is not always feasible. With respect to these exceptions, the courts require some authority, in statute or at common law, to conduct warrantless searches. The existence of such authority is not enough, however, because the courts will also review this authority to ensure that it is reasonable. In defining what is reasonable, the courts have established that warrantless searches should generally be limited *"to situations in which exigent circumstances render obtaining a warrant impracticable."*[28] In *R. v. Grant*, the Court stated:

> *To sum up on this point, s. 10 may validly authorize a search or seizure without warrant in exigent circumstances which render it impracticable to obtain a warrant. Exigent circumstances will generally be held to exist if there is an imminent danger of the loss, removal, destruction or disappearance of the evidence if the search or seizure is delayed. While the fact that the evidence sought is believed to be present on a motor vehicle, water vessel, aircraft or other fast moving vehicle will often create exigent circumstances, no blanket exception exists for such conveyances.* [29]

[27] *Hunter (Director of Investigation & Research)* v. *Southam Inc*. (1984) 14 C.C.C. (3d) 97 (S.C.C.).
[28] *R.* v. *Grant* (1993) 84 C.C.C. (3d) 173 (S.C.C.) at p. 188.
[29] *Ibid.*, page 189.

While every case will be reviewed on its merits, the greater the degree of urgency the police can demonstrate in the circumstances, the more inclined a court will be to find the warrantless search reasonable.

Searches of the person

Apart from a few specific provisions, such as the one found in the CDSA, federal criminal law does not provide authorization for a search of the person. The common law does, however, allow a search of the person incidental to a lawful arrest. This common law power is an exception to the general rule that a search requires prior authorization to be reasonable. This is a very important exception, because most searches of the person are done pursuant to this power. As explained earlier, the CDSA does allow a police officer who is executing a search warrant under that Act to search people who are present, under certain conditions.

A person may be searched under the common law power only for the purpose of locating further evidence relating to the charge upon which he or she has been arrested or to locate a weapon or some article that may assist him or her to escape or commit violence. Although the power to search incidental to an arrest is fairly broad, there is no automatic unrestricted right to search incidental to an arrest.

Manner in which search conducted

Courts have shown a willingness to scrutinize the manner in which a search of the person is conducted. For example, in *Collins*, a British Columbia case, the accused was sitting in a bar that was said to be frequented by heroin users and traffickers. The accused was seized by two police officers; while one of them used a choke-hold that rendered her semi-conscious, the other forced open her mouth. While this was happening, three caps of heroin dropped out of the accused's right hand. The Court held that the officers in this case had not had reasonable and probable grounds to believe that narcotics were in the accused's mouth and that therefore the search was unlawful. The Court went further and determined that to admit the evidence would bring the administration of justice into disrepute, for it would condone and allow the continuation of unacceptable conduct by the police. This decision was affirmed on appeal by the Supreme Court of Canada. This does not mean that a choke-hold will always be considered unreasonable. The following was stated in *R. v. Garcia-Guiterrez.*[30] *"a choke-hold was used to prevent the evidence from being swallowed and a punch to the solar plexus to force the suspect to cough it up. Subject to a strongly worded dissenting opinion, the majority of the B.C. Court of Appeal held that the choke-hold to preserve evidence was acceptable in the circumstances."*[31]

Searches of the person authorized by statute and the common law generally provide no indication as to the scope of the search that can be carried out. As discussed above, one of the requirements of a reasonable search is that it be executed in a

[30] (1991) 65 C.C.C. (3d) 15 (B.C.C.A).
[31] Fontana, J.A. (1997) *The Law of Search and Seizure in Canada*, Fourth Edition, Butterworths, page 396.

reasonable manner. With respect to searches of the person, the level of intrusion may render the search unreasonable.

When discussing body searches in border areas, the Supreme Court of Canada distinguished between three categories of searches:

> *It is, I think, of importance that the cases and the literature seem to recognize three distinct types of border search. First is the routine of questioning which every traveller undergoes at a port of entry, accompanied in some cases by a search of baggage and perhaps a pat or frisk of outer clothing. No stigma is attached to being one of the thousands of travellers who are daily routinely checked in that manner upon entry to Canada and no constitutional issues are raised. It would be absurd to suggest that a person in such circumstances is detained in a constitutional sense and therefore entitled to be advised of his or her right to counsel. The second type of border search is the strip or skin search of the nature of that to which the present appellant was subjected, conducted in a private room, after a secondary examination and with the permission of a customs officer in authority. The third and most highly intrusive type of search is that sometimes referred to as the body cavity search, in which customs officers have recourse to medical doctors, to X-rays, to emetics, and to other highly invasive means.* [32]

In the *Simmons* case, Dickson C.J.C. went on to add that the different types of searches raise different issues and entirely different constitutional issues *"for it is obvious that the greater the intrusion, the greater must be the justification and the greater the degree of constitutional protection."*[33] This approach was confirmed in the 1999 Supreme Court of Canada decision in *Monney* (discussed below). In both cases, the constitutionality of the third category of searches was left open, while the first two categories were held to be reasonable under section 8 even if based only on suspicion. It should be noted that these cases were decided in the context of border searches.

The Supreme Court of Canada indicated the following with respect to frisk searches in the context of a search incidental to arrest:

> *A "frisk" search incidental to a lawful arrest reconciles the public's interest in the effective and safe enforcement of the law on the one hand, and on the other its interest in ensuring the freedom and dignity of individuals. The minimal intrusion involved in the search is necessary to ensure that criminal justice is properly administered.* [34]

Thus, when a search of the person is justified, a frisk search will generally be held to be reasonable because it is the least intrusive means available to conduct one.

Strip searches were considered in *R.* v. *Flintoff*.[35] A police officer arrested the accused at the scene of an accident for impaired driving. The accused was strip-searched before the breath tests, pursuant to a general police policy requiring all police

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[32] *R.* v. *Simmons,* (1988) 45 C.C.C. (3d) 296 (S.C.C.).
[33] *Ibid.*
[34] *Cloutier* (1990) 53 C.C.C. (3d) 257 (SCC) at pages 277-278.
[35] (1998) 126 C.C.C. (3d) 321 (Ont. C.A.).

officers to strip-search every person brought into the station in custody, regardless of the circumstances of the case or the individual. The Court held that the search was unreasonable and in violation of section 8 of the Charter. The Court stated that the strip search was not justified in law and was not incidental to an arrest. It found the breach was *"outrageous"* and *"flagrant"* and that it would shock the public. According to the Court, strip-searching *"is one of the most intrusive manners of searching" and "one of the most extreme exercises of police power."* Although the police can search incidental to an arrest, *"the degree of intrusion must be reasonable and in pursuit of a valid objective such as safety."*

The recent Supreme Court of Canada decision in *R. v. Golden*[36] reviews issues surrounding searches incidental to arrest and the manner in which such a search may be conducted. Mr. Golden was arrested following what police believed were drug transactions in a restaurant. He was taken to a stairwell where the police pulled down his pants and underwear and noticed a clear plastic wrap containing a white substance in the anal area. The police tried to retrieve it but the accused resisted. He was escorted back into the restaurant and patrons were told to leave. The accused was forced to lean over a table and his pants and underwear were lowered. He continued to resist police attempts to retrieve the plastic wrap and accidentally defecated–which did not dislodge the plastic wrap. The police retrieved a pair of rubber dishwashing gloves and removed the package while the accused was face-down on the floor. The accused was strip-searched again at the police station. The Supreme Court made the following statement regarding strip searches:

> *While the respondent and the interveners for the Crown sought to downplay the intrusiveness of strip searches, in our view it is unquestionable that they represent a significant invasion of privacy and are often a humiliating, degrading and traumatic experience for individuals subject to them. Clearly, the negative effects of a strip search can be minimized by the way in which they are carried out, but even the most sensitively conducted strip search is highly intrusive. Furthermore, we believe it is important to note the submissions of the ACLC and the ALST that African Canadians and Aboriginal people are overrepresented in the criminal justice system and are therefore likely to represent a disproportionate number of those who are arrested by police and subjected to personal searches, including strip searches... As a result, it is necessary to develop an appropriate framework governing strip searches in order to prevent unnecessary and unjustified strip searches before they occur.* [37]

In *Golden*, the Supreme Court of Canada found that the Crown had failed to prove that the strip search of the appellant was carried out in a reasonable manner. It was of the view that the evidence fell far short of establishing that a situation of exigency existed so as to warrant a strip search outside of the police station, particularly with the station two minutes away. Thus, the Court concluded that this was not a case involving an urgent and necessary need to conduct a strip search "in the field" for the purpose of preserving evidence.

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[36] 2001 SCC 83.
[37] Ibid., para. 83.

The Supreme Court also cautioned against the use of force in conducting a search:

> *We particularly disagree with the suggestion that an arrested person's non-cooperation and resistance necessarily entitles police to engage in behaviour that disregards or compromises his or her physical and psychological integrity and safety. If the general approach articulated in this case is not followed, such that the search is unreasonable, there is no requirement that anyone cooperate with the violation of his or her Charter rights. Any application of force or violence must be both necessary and proportional in the specific circumstances. In this case, the appellant's refusal to relinquish the evidence does not justify or mitigate the fact that he was strip searched in a public place, and in a manner that showed considerable disregard for his dignity and his physical integrity, despite the absence of reasonable and probable grounds or exigent circumstances.* [38]

The importance of *Golden* is that the Supreme Court adopted a *"framework for the police in deciding how best to conduct a strip search incident to arrest in compliance with the Charter:"* It set out the following questions:

1. *Can the strip search be conducted at the police station and, if not, why not?*
2. *Will the strip search be conducted in a manner that ensures the health and safety of all involved?*
3. *Will the strip search be authorized by a police officer acting in a supervisory capacity?*
4. *Has it been ensured that the police officer(s) carrying out the strip search are of the same gender as the individual being searched?*
5. *Will the number of police officers involved in the search be no more than is reasonably necessary in the circumstances?*
6. *What is the minimum of force necessary to conduct the strip search?*
7. *Will the strip search be carried out in a private area such that no one other than the individuals engaged in the search can observe the search?*
8. *Will the strip search be conducted as quickly as possible and in a way that ensures that the person is not completely undressed at any one time?*
9. *Will the strip search involve only a visual inspection of the arrestee's genital and anal areas without any physical contact?*
10. *If the visual inspection reveals the presence of a weapon or evidence in a body cavity (not including the mouth), will the detainee be given the option of removing the object himself or of having the object removed by a trained medical professional?*
11. *Will a proper record be kept of the reasons for and the manner in which the strip search was conducted?*

Because of the nature of drug-related offences and the fact that the substance is more easily concealed, it would appear that more intrusive searches may be allowed. The courts are certainly aware of the tactics used by offenders to conceal drugs and may be more willing to allow police conduct that would otherwise be unreasonable. It is clear from the decisions, however, that the more intrusive the search, the greater must be the justification and greater the constitutional protection.

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[38] *Ibid*., para. 116.

Schools

In *R. v. M. (M.R.)*,[39] in a majority decision, the Supreme Court of Canada has held that a student's reasonable expectation of privacy in the school environment is *"significantly diminished"* because school authorities are responsible for *"providing a safe environment and maintaining order and discipline in the school."* In the case of searches by school authorities (not the police), there is no requirement for a warrant, and the standard is reasonable belief. The school authority must not, however, be an agent of the police. The Court added that students must know *"that this may sometimes require searches of students and their personal effects and the seizure of prohibited items."* In the result, the Court held that the seizure of marijuana from a student searched during a school dance did not infringe his rights under section 8 of the Charter. While setting out the parameters for a reasonable warrantless search in such circumstances, it must be noted that the majority decision expressly limited its findings to the elementary or secondary school milieu, with "no consideration" having been given to a college or university setting.

Borders

Searches conducted by customs officers at the border are an example of reduced constitutional protections where the courts find that there is a lower expectation of privacy based on the context. In such cases, the standards established in *Hunter* may not apply.

Section 98 of the *Customs Act*[40] allows an officer to search a person who has just arrived in Canada within a reasonable time of the person's arrival, or a person who is about to leave, if the officer suspects on reasonable grounds that the person has hidden illegal items on his or her person. The Supreme Court of Canada has interpreted this standard as one of reasonable suspicion and not the higher standard of reasonable grounds.[41] A person about to be searched can request to be taken before a senior officer who will make a determination as to whether the search shall proceed.[42]

In *R.* v. *Simmons*,[43] the accused was required to submit to a strip search as the result of a customs officer's belief that she was carrying contraband. The Supreme Court's decision acknowledged Canada's right as a sovereign state to control both who and what crosses its boundaries. Even though the search power did not meet the standards that it had set out in *Hunter* (for example, prior authorization and reasonable grounds), the Court stated:

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[39] [1998] 3 S.C.R. 393.
[40] S.C. 1986 c. 1.
[41] *R.* v. *Monney*, (1999) 133 C.C.C. 129 (S.C.C.).
[42] The *Customs Act* also contains many other provisions dealing with powers of customs officers. These are not discussed.
[43] (1988) 45 C.C.C. 296 (S.C.C.).

I accept the proposition advanced by the Crown that the degree of personal privacy reasonably expected at customs is lower than in most other situations. People do not expect to be able to cross international borders free from scrutiny. It is commonly accepted that sovereign states have the right to control both who and what enters their boundaries. For the general welfare of the nation the state is expected to perform this role. Without the ability to establish that all persons who seek to cross its borders and their goods are legally entitled to enter the country, the state would be precluded from performing this crucially important function. Consequently, travellers seeking to cross national boundaries fully expect to be subject to a screening process. This process will typically require the production of proper identification and travel documentation and involve a search process beginning with completion of a declaration of all goods being brought into the country. Physical searches of luggage and of the person are accepted aspects of the search process where there are grounds for suspecting that a person has made a false declaration and is transporting prohibited goods.

In my view, routine questioning by customs officers, searches of luggage, frisk or pat searches, and the requirement to remove in private such articles of clothing as will permit investigation of suspicious bodily bulges permitted by the framers of ss. 143 and 144 of the Customs Act*, are not unreasonable within the meaning of s. 8. Under the* Customs Act *searches of the person are not routine but are performed only after customs officers have formed reasonable grounds for supposing that a person has contraband secreted about his or her body. The decision to search is subject to review at the request of the person to be searched. Though in some senses personal searches may be embarrassing, they are conducted in private search rooms by officers of the same sex. In these conditions, requiring a person to remove pieces of clothing until such time as the presence or absence of concealed goods can be ascertained is not so highly invasive of an individual's bodily integrity to be considered unreasonable under s. 8 of the Charter.*

I also emphasize that, according to the sections in question: (i) before any person can be searched the officer or person so searching must have reasonable cause to suppose that the person searched has goods subject to entry at the customs, or prohibited goods, secreted about his or her person, and (ii) before any person can be searched, the person may require the officer to take him or her before a police magistrate or justice of the peace or before the collector or chief officer at the port or place who shall, if he or she sees no reasonable cause for search, discharge the person.

In light of the existing problems in controlling illicit narcotics trafficking and the important government interest in enforcing our customs laws, and in light of the lower expectation of privacy one has at any border crossing, I am of the opinion that ss. 143 and 144 of the Customs Act *are not inconsistent with s. 8 of the Charter.* [44]

It is noteworthy for our purposes that the Court mentioned the problems of controlling illicit narcotics trafficking as a factor in determining that the search was reasonable under section 8 of the Charter.

The fact that those travelling through customs have a lower reasonable expectation of privacy does not, however, diminish the obligation on state authorities to adhere to the Charter, even if the grounds prompting the search are reasonable and drugs are found as a result. Before any search, the inspectors must clearly explain to the subject his/her rights under the Charter – especially the prior right to consult a lawyer –

[44] *Ibid.*, at pages 320-321.

and the right to have the search request reviewed before complying with it, as provided in the *Customs Act.* In *Simmons*, the subject remained ignorant of her legal position because she had not properly been informed of her rights. As a result, the Supreme Court of Canada found that the search was unreasonable; even so, the evidence was not excluded because the customs officers had acted in good faith.

The Supreme Court of Canada has determined that section 98 of the *Customs Act*, authorizing searches for contraband "secreted on or about" the person, applies to contraband that a traveller has ingested. In *R.* v. *Monney*,[45] the Court concluded that a customs officer who has reasonable grounds to suspect that contraband has been ingested is authorized by the Act to detain the traveller in a "drug loo facility" until that suspicion can be confirmed or dispelled. Although such action amounts to a search for the purposes of section 8 of the Charter, the Court confirmed that *"the degree of personal privacy reasonably expected at customs is lower than in most other situations" and that the search in question was "reasonable for the purposes."*

The Court did indicate that the different levels of intrusion raise different constitutional issues (for example, by potentially requiring a higher standard than reasonable suspicion). The Court stated: *"the potential degree of state interference with an individual's bodily integrity for searches in the third category requires a high threshold of constitutional justification."*[46]

It is clear that the courts apply a lower standard of constitutional protection for searches at the border than elsewhere. As stated in *Monney*, *"decisions of this Court relating to the reasonableness of a search for the purposes of s. 8 in general are not necessarily relevant in assessing the constitutionality of a search conducted by customs officers at Canada's border."*[47]

Electronic surveillance

Because of the consensual nature of drug offences, police often resort to special investigative techniques to detect these crimes, including the use of electronic surveillance. The Supreme Court of Canada has stated that electronic surveillance constitutes a search for the purposes of section 8 of the Charter, and its decisions in this area have had a significant impact on the *Criminal Code* provisions dealing with such techniques. Because electronic surveillance is more invasive of privacy than actions under regular search warrants, more procedural safeguards are provided in the legislation. Although surreptitious interception is often used for drug offences, it can also be used for many other serious offences under the *Code* and other federal legislation.[48] The Solicitor General's 1998 report entitled *Annual Report on the Use of Electronic Surveillance* states the following with respect to the importance of electronic surveillance as an investigative tool:

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[45] (1999) 133 C.C.C. 129 (S.C.C.).
[46] *Ibid.*, at page 152.
[47] *Ibid.*, at page 151.
[48] See *Criminal Code* section 183.

Electronic surveillance plays a crucial role in the battle against organized crime, especially with respect to the offence of drug trafficking. In curtailing the importation and distribution of illicit drugs in Canada, law enforcement agencies rely heavily upon the interception of private communications. Section III of this report demonstrates that the majority of authorizations granted by the courts allow for the use of electronic surveillance in relation to trafficking in a controlled substance. As in previous years, many of these authorizations were related to criminal conspiracies, crimes which are difficult for the police to detect, investigate and solve.

…The use of electronic surveillance has led to a number of seizures of large quantities of drugs in Canada. These seizures reduce the amount of drugs available in streets and neighbourhoods, and assist in the prevention of crimes associated with drug abuse. Without this crucial tool, the ability of the law enforcement community to prevent crimes and ensuing social harm would be seriously hindered.

Although it is clear that electronic surveillance is an effective investigative tool, it is also clear that it constitutes a dramatic infringement of the right to privacy. The Supreme Court of Canada stated the following:

The very efficacy of electronic surveillance is such that it has the potential, if left unregulated, to annihilate any expectation that our communications will remain private. A society which exposes us, at the whim of the state, to the risk of having a permanent electronic recording made of our words every time we opened our mouths might be superbly equipped to fight crime, but would be one in which privacy no longer had any meaning. As Douglas J., dissenting in United States v. White, supra, put it, at p. 756: "Electronic surveillance is the greatest leveller of human privacy ever known." If the state may arbitrarily record and transmit our private communications, it is no longer possible to strike an appropriate balance between the right of the individual to be left alone and the right of the state to intrude on privacy in the furtherance of its goals, notably the need to investigate and combat crime.

This is not to deny that it is of vital importance that law enforcement agencies be able to employ electronic surveillance in their investigation of crime. Electronic surveillance plays an indispensable role in the detection of sophisticated criminal enterprises. Its utility in the investigation of drug related crimes, for example, has been proven time and again. But, for the reasons I have touched on, it is unacceptable in a free society that the agencies of the state be free to use this technology at their sole discretion. The threat this would pose to privacy is wholly unacceptable. [49]

Because electronic surveillance is more invasive of privacy than are actions permitted under regular search warrants, more procedural safeguards are provided in the legislation. Similar rules apply to video surveillance.

The Supreme Court of Canada decisions rendered on 25 January 1990 in the *Duarte* and *Wiggins* cases had a significant impact on policing methods, particularly undercover investigations involving drug and morality offences. In *Duarte*,[50] the Court affirmed that electronic surveillance constitutes a search and seizure within the meaning of section 8. This only occurs, however, where a reasonable expectation of privacy

[49] *R.* v. *Duarte*, (1990) 53 C.C.C (3d) 1 (S.C.C.) at page 11.
[50] (1990) 53 C.C.C. (3d) 1 (S.C.C.).

exists. The Court said that unauthorized electronic surveillance and interception *"of private communications by an instrumentality of the state with the consent of the originator or intended recipient thereof, without prior judicial authorization, does infringe the rights and freedoms guaranteed by section 8."* Until then, it had been legal for the police to intercept such communications, as long as one of the parties to the conversation consented. It is now necessary for a judge to authorize such interception in the same way as interception of an entirely private conversation ("wiretapping") where neither party has given prior consent. The Court also required that there be reasonable and probable grounds, established on oath, to believe that there is evidence of an offence in the place to be searched. Suspicion would not satisfy this requirement.

In *Duarte*, the Supreme Court of Canada said that "the primary value served by section 8 is privacy," which it defined as *"the right of the individual to determine when, how, and to what extent he or she will release personal information."* Accordingly, *"one can scarcely imagine a state activity more dangerous to individual privacy than electronic surveillance and to which, in consequence, the protection accorded by s. 8 should be more directly aimed."* The Court took the position that it could no longer allow the police an "unfettered discretion ... to record and transmit our words" without prior judicial authorization because this widespread police practice represented an *"insidious danger"* to the *"very hallmark of a free society,"* namely, the *"freedom not to be compelled to share our confidences with others."* In *Wiggins*,[51] the use of "body pack" microphones by police was also found to be unconstitutional, for the reasons expressed in *Duarte*. The Duarte decision demonstrates that even if conduct is authorized by legislation, this does not mean that it is reasonable under section 8. The *Code* has since been amended to provide for prior authorization of consent interceptions.

With respect to surreptitious interceptions, a judge must ensure that: (1) the best interests of the administration of justice would be served; and (2) other investigative procedures (a) have been tried and have failed; or (b) are unlikely to succeed; or (c) the situation is urgent. In 2000, the Supreme Court of Canada in *R.* v. *Araujo*[52] interpreted the second requirement set out in the legislation. The Court indicated that the standard for branch (b) was not one of "efficiency" but rather "necessity." The test is: There must be, practically speaking, no other reasonable alternative method of investigation, in the circumstances of the particular criminal inquiry.

Section 24

Section 24(1) of the Charter provides a course of action for accused persons whose Charter rights have been infringed or denied. Under it, they can apply to a "court of competent jurisdiction" for the "appropriate and just" remedy. Section 24(2) allows a court to exclude evidence obtained in a manner that infringed or denied Charter rights, if admitting it into evidence *"would bring the administration of justice into*

[51] [1990] 1 S.C.R. 30.
[52] (2000) S.C.C. 65.

disrepute." The three primary factors to be considered are: (a) does the admission of the evidence affect the fairness of the trial; (b) how serious was the Charter breach; and (c) what would be the effect on the system's repute of excluding the evidence.

Some have criticized the way these factors are applied to drug-related offences. For example, Don Stuart stated the following:

> *The impression left by these recent Supreme Court and Ontario Court of Appeal rulings, especially in drug cases, is that these Courts seem generally determined not to exclude real evidence found in violation of section 8. These Courts tend to ratchet up the rhetoric respecting the third Collins factor about the seriousness of the offence and the effect on the repute of the system if the exclusion of reliable evidence were to result in acquittals. If this is the major reason for admitting the evidence, it points to an irony and inconsistency with the Stillman approach, in that the seriousness of the offence and reliability are* not *relevant factors when evidence is characterized as going to trial fairness. Canadian criminal trials under the Charter are no longer exclusively concerned with determining guilt or innocence and it betrays respect for the Charter to argue a return to the pre-Charter days where police conduct was not a material consideration. Particular abhorrence of drug offences may well have coloured consideration of the second Collins factor so that seriousness of the violation is unduly de-emphasised. The Courts, as guardians of the Charter, should be above the war against drugs. This one category of offences does not require special and reduced Charter standards.* [53]

The decision of whether the evidence should be excluded can be important; if courts are reluctant to exclude evidence, they may be sending conflicting messages to the police. Although their conduct will have been found to breach a person's Charter rights, there may be little incentive for the police to adhere to the limits imposed by the courts if the evidence is not excluded.

Entrapment and illegal activity

Entrapment and illegal police activity are both based on the doctrine of abuse of process.

Entrapment

In some cases, police forces use informers (including paid informers) or undercover police agents to obtain information about criminal offences. With consensual offences such as those related to drugs, infiltrating a group and acting as a consensual participant is often the only way for the police to obtain evidence of an offence. They are generally there to observe the suspect and, in some instances, may afford the suspect an opportunity to commit an offence The police must ensure that the actions of the informer or the undercover agent do not go too far. When police actions are excessive, the accused may attempt to rely on the doctrine of entrapment. Although police tactics intended to provide a person with the opportunity to commit

[53] Stuart, D. (1999) "The Unfortunate Dilution of Section 8 Protection," *Queens Law Journal*, Volume 25, Number 1, page 68.

an offence and illegal police activities are not limited to drug offences, it is fair to state that these tactics are probably much more prevalent in investigations of these types of offences.

The leading case in Canada on entrapment is the Supreme Court of Canada's decision in *R*. v. *Mack*.[54] Lamer J., as he then was, delivered the unanimous judgement of the Supreme Court of Canada. He explained that entrapment is not a substantive defence (such as necessity or duress) and indicated that the rationale for this defence is not a lack of culpability in the accused (because the essential elements of the offence will generally be present). Rather, the rationale is based on the need for the Court "to preserve the purity of the administration of justice" and to prevent an abuse of the judicial process. Thus, entrapment is based on the common law doctrine of abuse of process. According to Lamer J., entrapment occurs when the conduct of the police exceeds acceptable limits. This is the case in the following circumstances:

- The authorities provide a person with an opportunity to commit an offence without acting on a reasonable suspicion that this person is already engaged in criminal activity or pursuant to a *bona fide* inquiry; or
- Having a reasonable suspicion or acting in the course of a *bona fide* inquiry, the police go beyond providing an opportunity and induce the commission of an offence.

To establish entrapment, the accused is required to demonstrate only that one of the two branches of the test has been met. If successful, the remedy is a stay of proceedings.

According to the guidelines set out by the Supreme Court of Canada, the police are required to have a reasonable suspicion that the accused is already engaged in criminal activity, or must be acting pursuant to a *bona fide* inquiry. The rationale for requiring reasonable suspicion is *"because of the risk that the police will attract people who would not otherwise have any involvement in a crime and because it is not a proper use of the police power to simply go out and test the virtue of people on a random basis."*[55]

In determining whether police conduct goes further than providing an opportunity, a court will assess the following non-exhaustive list of factors:

- The type of crime being investigated and the availability of other techniques for the police detection of its commission;
- Whether an average person, with both strengths and weaknesses, in the position of the accused would be induced into the commission of a crime;
- The persistence and number of attempts made by the police before the accused agreed to commit the offence;

[54] (1988) 44 C.C.C. (3d) 513 (S.C.C.).
[55] *Ibid.*, at page 560.

- The type of inducement used by the police, including deceit, fraud, trickery or reward;
- The timing of the police conduct, in particular whether the police instigated the offence or become involved in ongoing criminal activity;
- Whether the police conduct involves an exploitation of human characteristics such as the emotions of compassion, sympathy and friendship;
- Whether the police appear to have exploited a particular vulnerability of a person such as a mental handicap or a substance addiction;
- The proportionality between the police involvement, as compared to that of the accused, including an assessment of the degree of harm caused or risked by the police, as compared to the accused, and the commission of any illegal acts by the police themselves;
- The existence of any threats, implied or express, made to the accused by the police or their agents; and
- Whether the police conduct is directed at undermining other constitutional values.[56]

The Supreme Court of Canada stated that the claim of entrapment is a very serious allegation against the state, and that the state must be given substantial room to develop techniques which assist in its fight against crime in society. It is only when the police and their agents engage in conduct which offends basic values of the community that the doctrine of entrapment should apply. The Court indicated that a stay should be entered only in the *"clearest of cases."*[57]

In *Mack*, the Supreme Court of Canada stated that with respect to the crime of drug trafficking, the state must be given substantial leeway. This offence *"is not one which lends itself to the traditional devices of police investigation."* The Court added that it is a *"crime of enormous social consequence which causes a great deal of harm in society generally."* The Court concluded *"this factor alone is very critical."*[58]

Although the Supreme Court of Canada stated in *Mack* that random virtue-testing will not be permitted because there is a risk of attracting innocent individuals into the commission of an offence, it does make an exception to the requirement to have reasonable suspicion with respect to the individual in the case of a *bona fide* investigation related to an area where it is reasonably suspected that criminal activity is taking place.

It is clear that such an exception can apply to known locations of drug trafficking. An example of this can be seen in *R.* v. *Barnes.*[59] The accused was charged with a number of offences, including trafficking in cannabis. An undercover police officer had approached the accused and his friend because they generally fitted the description of persons who may possess and sell drugs. After a short conversation, the accused agreed

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[56] *Ibid.*, at page 560.
[57] *Ibid.*, at page 567.
[58] *Ibid.*, at page 69.
[59] (1991) 66 C.C.C. (3d) 1 (S.C.C.).

to sell hashish to the undercover agent. The place where the arrest took place (a six-block pedestrian mall) was a well-known area where trafficking occurred, and the police were conducting what are known as "buy-and-bust" transactions. The accused relied on the defence of entrapment.

The Supreme Court of Canada reiterated the circumstances when entrapment occurs. Because in this case the police did not have reasonable suspicion of the accused's involvement in unlawful drug-related activity, its conduct would amount to entrapment unless it was part of a *bona fide* inquiry. Thus, although the basic rule is that the police may only present the opportunity to commit an offence to a person for whom they have a reasonable suspicion that they are already engaged in criminal activity, there is an exception where the police conduct is part of a *bona fide* investigation directed in an area where it is reasonably suspected that criminal activity is occurring. If the location is defined with *"sufficient precision,"* the police may present any person associated with the area with the opportunity to commit the particular offence. In these circumstances, the police conduct would not be considered to be random virtue-testing.

In summary, the key issue with respect to entrapment is whether the police had reasonable grounds or suspicions to target an individual or were acting pursuant to a *bona fide* inquiry. In addition, even if the first branch of the test is satisfied, one must consider whether the police conduct went beyond providing an opportunity by determining whether the tactics used by the police were designed to induce an average person into the commission of an offence. It is important to note, however, that with respect to entrapment the *"fact situations can vary enormously, which is why, although the general principles are beginning to emerge, their application is not always easy and can lead to disagreement."*[60] The courts have indicated that each case must be determined on its own facts, making it difficult to provide more precise rules regarding police conduct.

Illegal activities

As has been discussed, as criminal offenders become more sophisticated, the police have adopted new investigative tools in an attempt to keep pace (including cases where police officers have breached the law while in the performance of their duties). This occurs in drug investigations, for example, when police conduct buy-and-bust operations and reverse sting operations. The use of illegal police activity to combat crime raises the issue of whether such conduct leads to an abuse of process such that a stay of proceedings will be granted. The Supreme Court of Canada has stated that illegal police activity does not automatically amount to an abuse of process. The legality of police actions is but a factor to be considered, "albeit an important one." Although the issue of illegal police activity is important, it has less of an impact on the

[60] Mewett, A.W. and S. Nakatsuru, (2000) *An Introduction to the Criminal Process in Canada*, Fourth Edition, Carswell, page 180.

enforcement of drug legislation. The reason is that the drug legislation provides police immunity for activities such as buy-and-bust operations and reverse sting operations.[61]

The leading case with respect to illegal police activities is *R.* v. *Campbell*.[62] The police in this case had conducted a reverse sting operation in which undercover officers portrayed themselves as large-scale hashish vendors. The accused argued that the police conduct was illegal because they had committed the offence of trafficking themselves (the CDSA and the exemption it provides for such police conduct having not yet been passed). They added that this amounted to an abuse of process.

According to the Supreme Court of Canada, the police are not immune from criminal liability for acts committed in the course of an investigation, unless this is authorized by legislation. The Court added that the issue should be left to Parliament: *"If some form of public interest immunity is to be extended to the police to assist in the 'war on drugs,' it should be left to Parliament to delineate the nature and scope of the immunity and the circumstances in which it is available…"*[63] Where alleged illegal police activity is authorized within the legislative scheme, there is no abuse of process issue. The Supreme Court of Canada added, however, that illegal police activity does not automatically amount to an abuse of process. The legality of police actions is but a factor to be considered, "albeit an important one."

Although this decision may have had a significant impact on general law enforcement in Canada, the impact was less severe in the case of drug enforcement. This is because drug legislation was amended to allow police officers to conduct the type of activities that were at issue in *Campbell*.

The CDSA proscribes various activities such as possession, trafficking and manufacturing of drugs, while allowing various regulatory exceptions, for example the importation by licensed dealers and the sale by pharmacists. The Act also allows for the making of regulations dealing with enforcement matters such as exempting police officers from application of the Act on such terms and conditions as specified in the regulations. In addition, the Act allows for the making of regulations *"that pertain to investigations and other law enforcement activities conducted under this Act by a member of a police force and other persons acting under the direction and control of a member."* Thus, the regulations provide a legal framework for specialized enforcement techniques (including buy-and-bust, and sting operations) and set out the parameters for such activities. The police rely on these regulations for protection against prosecution.

Section 3 of the *Narcotic Control Regulations* authorizes members of police forces to possess narcotics where such *"possession is for the purposes of and in connection with such employment."* In addition, the CDSA (*Police Enforcement) Regulations* exempt police officers from the offences of trafficking, importation or exportation and production. The regulations set out the eligibility requirements for the exemption. Different rules apply

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[61] Illegal activities by a police officer also raise the issue of whether the police officer may be liable to prosecution. The issue is beyond the scope of this paper.
[62] (1999) 133 C.C.C. (3d) 257 (S.C.C.).
[63] *Ibid.*, at page 282.

depending on the source of the drugs. At all times, the individual must be an active member of a police force and must be acting in the course of his or her responsibilities for the purposes of the particular investigation.

Thus, special immunity for police officers is set out in the CDSA. Canadian criminal legislation has recently been amended to provide a general exemption from criminal liability for police officers. The legislation provides police with protection from criminal liability for certain otherwise illegal acts committed during the course of a *bona fide* investigation or other law enforcement duties, as long as certain conditions are met.[64]

Conclusion

Clearly, Parliament and the courts have recognized that, as criminals become more sophisticated, the police must be given more sophisticated tools to fight them. In addition, they generally view the illegal drug trade as a serious challenge. Courts often mention the sinister nature of the drug trade and the impact it has on society in rendering their decisions. They may be influenced by these concerns in determining where to draw the line with respect to police conduct. They recognize the difficult job police have and are often willing to grant them "considerable latitude." An example of this attitude is the following statement by the Supreme Court of Canada with respect to the selling of drugs: *"It is a crime that has devastating individual and social consequences. It is, as well, often and tragically coupled with the use of firearms. This crime is a blight on society and every effort must be undertaken to eradicate it."*[65] In another case, the following was stated: "… *this Court must also consider the societal interest in law enforcement, especially with regard to the illicit drug trade. This pernicious scourge in our society permits sophisticated criminals to profit by inflicting suffering on others*."[66] However, the police have not been given "carte blanche" to do what they want to solve a crime. Their activities are scrutinized so as to ensure that their conduct does not shock the community and in any way detract from the fairness of an accused's trial.

STATISTICS

The following sections will review key criminal statistics related to enforcement of illicit drug legislation. This information must be carefully interpreted. It is generally thought that police-reported crime statistics are much more a reflection of police activity than actual societal changes, particularly in the case of consensual type offences.

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[64] SC 2001, Chapter 32.
[65] *R.* v. *Silveira*, (1995) 97 C.C.C. (3d) 450 at page 496.
[66] *R.* v. *Grant*, (1993) 84 C.C.C. (7d) 173.

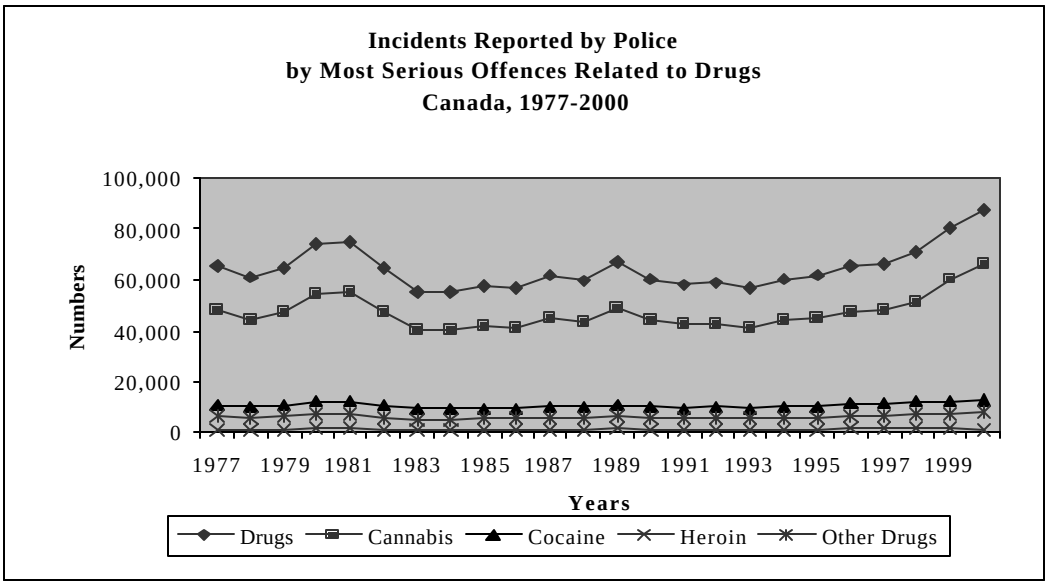
As in many other drug related areas, Canadian statistics are fairly weak–for example, other than fairly basic information, it is very difficult if not impossible to identify some of the essential characteristics of individuals entering the criminal justice system.

Reported incidents [67]

Reported incidents are incidents that come to the attention of the police and are captured and forwarded to the Canadian Centre for Justice Statistics according to a nationally approved set of common crime categories and definitions. Thus the actual number of drug offences would be much higher, since it can be assumed that most drug offences do not come to the attention of police. As with other consensual types of offence, it is impossible to determine accurately the amount of illegal activity. In addition, the survey counts only the most serious offence committed in each criminal incident, which consequently underestimates the total number of drug-related incidents, particularly offences with less severe penalties. The number of reported incidents should also not be confused with the number of charges that are laid by the police. Because police have wide discretion in whether to lay a charge, it is clear that the number of charges will be lower than the total reported incidents.

The figure below shows trends in the number of incidents reported by police according to the most serious crime. It reveals that, from 1983 to 1995, incidents related to drug offences were relatively stable, hovering around 60,000 per year. However, from 1995 to 2000, there was an increase of approximately 50%, with the number of reported incidents reaching nearly 88,000. In 2001, the number reached 91,920, an increase of 3.3% in relation to the previous year.

[67] The Canadian Centre for Justice Statistics warns that crime statistics may be influenced by many factors, including: reporting by the public to the police; reporting by the police to the Canadian Centre for Justice Statistics; the impact of new initiatives such as changes in legislation, police or enforcement practices; and social, economic and demographic changes.



Most of the increase in recent years can be attributed to cannabis-related offences. In 2001, these increased by 5.5% in relation to the previous year. These offences account for the majority of all drug-related offences in Canada. In 2001, cannabis-related offences accounted for 71,624 of reported incidents, **almost 77% of all drug-related incidents**. Of those 71,624 offences, 70% were for possession, 16% for trafficking, 13% for cultivation, and 1% for importation.[68] This means that **approximately 54% of all reported drug-related offences are for the possession of cannabis**. The following are reported incident rates per 100,000 people for offences related to cannabis, cocaine and all drugs.

Selected drug offences per 100,000, Canada 1994-2001

	1994	1995	1996	1997	1998	1999	2000	2001
Cannabis	138	148	157	160	168	197	215	227.22
- possession	97	103	110	108	115	130	147	
Cocaine	42	38	37	38	40	39	42	39.4
Total all drugs	207	208	217	222	235	263	286	295.7

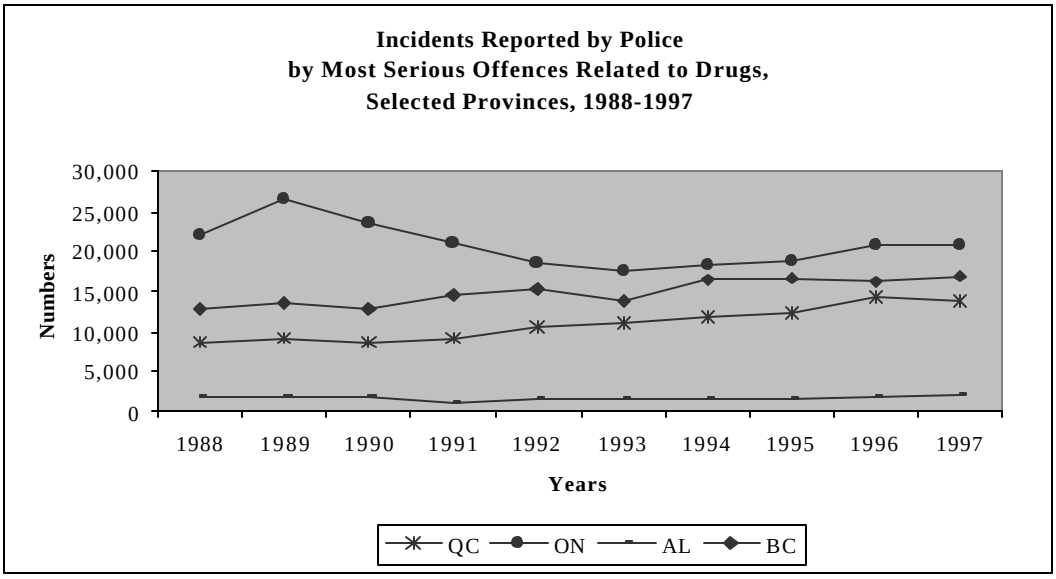
From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5; for cocaine-related offences, –31.5; for heroin-related offences, –36.1; and for other drugs, +15.0. **This means that, based on the**

[68] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, Catalogue no. 85-002-XIE Vol. 22, no. 6, page 11.

same population, reported cannabis-related offences have almost doubled in the last decade.

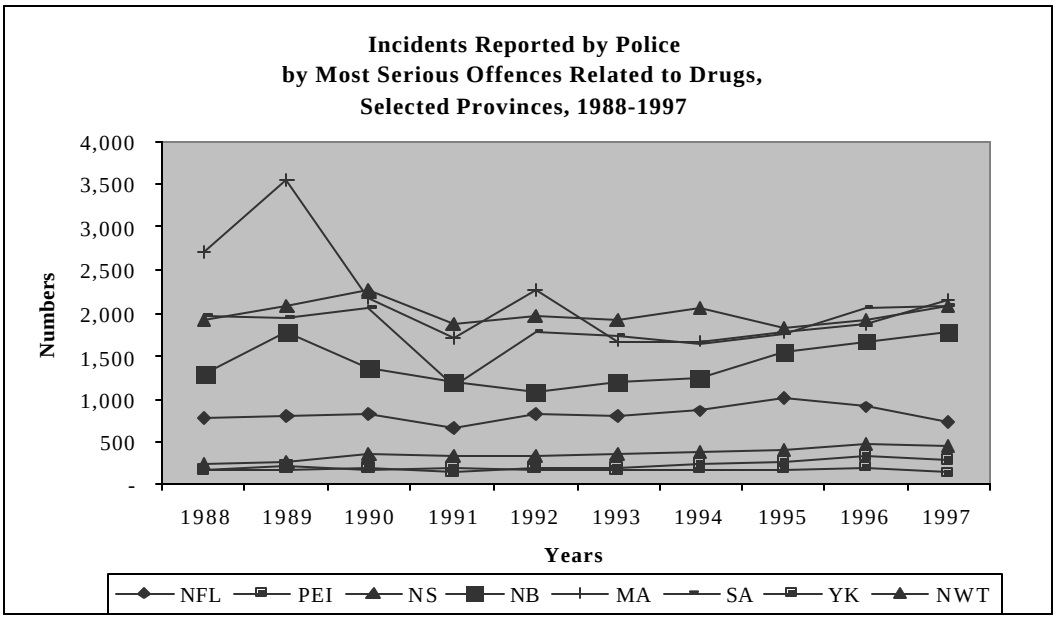
In recent years, the cultivation of cannabis, particularly in British Columbia, has raised concerns. This type of offence has also seen a significant increase over the past decade: from a rate of 7 incidents per 100,000 people in 1990 to 29 in 2001.[69] A recent report indicates that in British Columbia, the number of growing operations is increasing by an average of 36% per year and average size is increasing at a rate of 40% per year. The report adds that the vast majority of cases coming to the attention of the police in British Columbia do so as a result of public complaints, meaning that the increase in cases is not due to increased proactive police enforcement.[70]

The two figures that follow provide information on the location of reported incidents from 1988 to 1997. Not surprisingly, the most populated provinces are at the top, with Ontario in the lead followed by British Columbia, Quebec and Alberta.



[69] *Ibid.*

[70] Plecas, D., et. alii., (2002) *Marihuana Growing Operations in British Columbia – An Empirical Survey (1997-2000)*, Department of Criminology and Criminal Justice – University College of the Fraser Valley and International Centre for Criminal Law Reform and Criminal Justice Policy.



A better indication of the level of crime in a province, however, is a calculation based on rates per 100,000 population. British Columbia has historically had the highest provincial rate of drug crime in the country. [71] For example, in 2001, the rate was 563.5 incidents per 100,000, almost double the national figure of 295.7. The rates for the other provinces and territories are as follows: Newfoundland and Labrador–173.1; Prince Edward Island–192.0; Nova Scotia–218.3; New Brunswick–346.9; Quebec–262.1; Ontario–256.1; Manitoba–215.9; Saskatchewan–278.4; Alberta–235.3; Yukon –478.5; Northwest Territories–597.2; and Nunavut–806.1. It is obvious that the level of drug-related crime varies considerably from one province and territory to another.

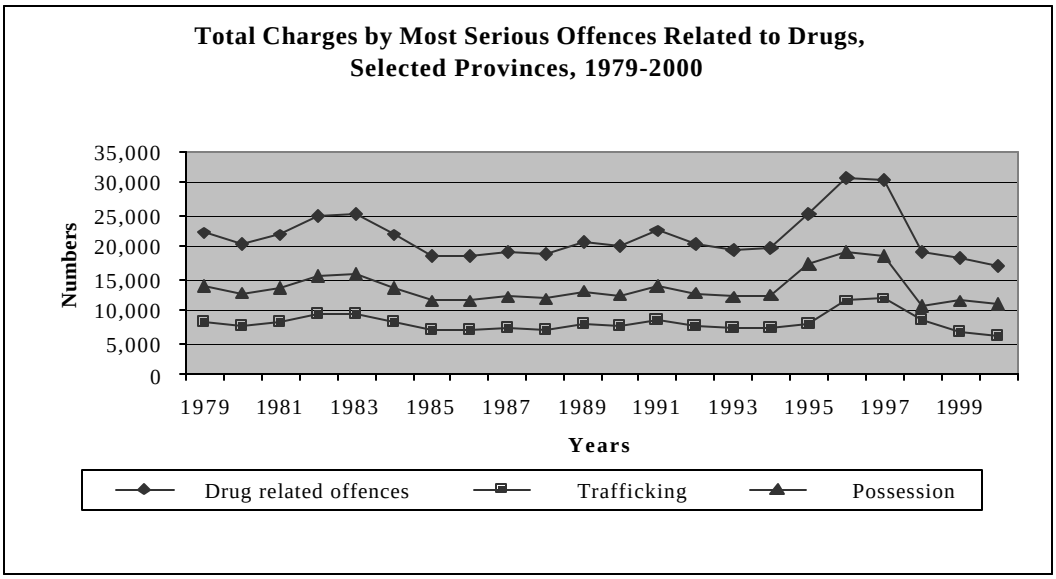
Charges

From the available data presented in the following figure, it would seem that trafficking and possession charges for drug-related offences have declined noticeably since 1997. It should be remembered that the number of reported incidents (discussed previously) is not equivalent to the number of charges that are laid by the police. In some cases, the police will report a drug incident to Statistics Canada but will decide not to charge the offender. The wide discretion given to police can lead to serious concerns regarding the enforcement of the legislation. These concerns are discussed later in this chapter. The reader should be aware that this figure does not include data

[71] It should be noted that in 1997 the rate in both Yukon and Northwest Territories was even higher than in British Columbia.

from three provinces (New Brunswick, Manitoba and British Columbia) and from one territory (Nunavut). In addition, data from certain courts in Quebec are not included.[72]

Because data from three provinces are not included–in particular, British Columbia–the actual number of drug charges in Canada was actually much higher than the figure suggests. As was previously explained, British Columbia has, in the past, consistently reported the highest rate of drug crime.



Statistics from 1997 show, however, that with respect to charging drug offenders, British Columbia is more lenient than other provinces:

> *Among provinces and territories, police departments in British Columbia reported the lowest charge rate (47%) for drug offences. Only 35% of cannabis incidents and 36% of "other drug" incidents resulted in charges, compared to 79% and 81% for all the other provinces combined.* [73]

For example, Superintendent Ward Clapham of the Richmond RCMP indicated that, for possession of marijuana under 30 grams, only 40 people were charged out of 700 reported cases in the year 2000; and in 2001, only 30 people were charged out of 605 reported cases. Once again, it is clear that the enforcement of the legislation varies considerably from one area of the country to another.

With respect to cannabis offences in 2001, the male population was much more likely to be charged with an offence. For both youths (12 to 17) and adults, 88% of the

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[72] Also, the data prior to 1995 are based on approximations made from the average distribution of charges during the period covering the years 1995 to 2000.

[73] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Illicit Drugs and Crime in Canada, Catalogue no. 85-002-XIE, Vol. 19, No. 1, page 5. In this case, "other drugs" means: 1) illegal drugs other than cannabis, cocaine or heroin, and 2) controlled drugs.

people charged with cannabis offences are male.[74] In addition, while adults are much more likely to be charged than youths, 18% of cannabis-related charges relate to youths.[75]

While the previous figure seems to indicate that there were fewer than 20,000 drug-related charges in 1999, the Auditor General's 2001 report indicates that during that year, just under 50,000 people were charged with drug offences under the CDSA (in cases where the most serious offence was drug-related). One of the drawbacks of recording offence statistics according to the most serious offence is that this leads to severe underreporting of offences, particularly offences with less severe penalties. In the hierarchy of criminal offences (of which there are 152), marijuana offences are ranked as follows: importation or exportation– 44; trafficking of more than 3,000 grams–46; production–52; trafficking of 3,000 grams or less–59; possession of more than 30 grams–120; and possession of 30 grams or less--121.

Of the approximately 50,000 drug-related charges laid in 1999, cannabis was involved in 70% of the charges. **In 43% of the drug-related cases (21,381), the charge was for possession of cannabis.** Overall, 54% of the drug offences were for possession. Since the number of reported incidents has continued to climb, one can only assume that today even more people are being charged with drug offences, particularly cannabis offences.

With over 34,000 charges per year for cannabis-related offences and with over 21,000 charges per year for possession of cannabis, can one conclude that police are actively seeking out cannabis possession offences? After reviewing the evidence, we do not believe this to be the case. Nonetheless, over 21,000 people per year enter the criminal justice system in cases where their most serious offence was that of possession of cannabis. It bears repeating that these statistics are based on the most serious offence in a given incident.

Several reasons were advanced to explain the high number of possession offences. Those enforcing the CDSA stated that they do not actively seek out such offences, but rather they are discovered in the normal course of their duties. This was repeated time and time again. While we do not doubt the sincerity of these statements, in certain cases–as will be discussed below–police tactics can be questioned. In addition, we were told that while the offence of trafficking, if it occurs over a period of time, is recorded as one offence–the continuing offence rule–this rule does not apply to possession offences.

Concerns

While there may be valid reasons for the high incidence of possession charges, many have raised serious concerns with respect to the discretion used by the police in

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[74] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Crime Statistics in Canada - 2001, Catalogue no. 85-002-XIE, Vol. 22, No. 6, page 19.
[75] *Ibid.*

regard to drug-related possession charges – in particular, cannabis possession cases. As mentioned earlier, the number of reported incidents and the charge rate vary considerably from province to province.

The uneven application of the drug legislation in the various provinces, even within the same province, raises serious concerns. Mr. Kash Heed from the Vancouver Police Department indicated that small-scale possession of any drug in Vancouver is virtually unenforced by the police department unless there are aggravating circumstances. Their focus is on those who profit–traffickers and producers. He added that the number of prosecutions in British Columbia for cannabis possession is quite small in comparison to other provinces. He concluded that total prohibition had "resulted in costly enforcement, alienation of groups of people, discriminatory enforcement, little deterrence in supply, and minimal deterrence of use." Heed added that, even in British Columbia there are discrepancies–centres outside of Vancouver having higher rates of prosecution for possession of cannabis than does the City of Vancouver.

We have estimated that approximately 2.5 million people in Canada used cannabis in the last year. In 1999, 21,381 people were charged with the possession of cannabis. This means that only 0.85% of cannabis users were actually charged with possession. It is also important to remember that of the number of people who used cannabis in the last year, many would have used it more than once. As a result, the actual chance of being charged for possession of cannabis in relation to the actual number of offences is in all likelihood much lower than 1%. This certainly raises concerns regarding fairness. In addition, both the effectiveness of the legislation and any deterrent effect it may have are seriously in doubt.

So what are the potential consequences of uneven enforcement of the legislation and unfettered discretion as to whether or not to proceed with laying a charge? Marie-Andrée Bertrand, referring to a paper prepared by Nicolas Carrier[76] stated the following:

> *A recent qualitative study of members of the Montreal Urban Community Police Department underscores the ambivalence and confusions of frontline police officers and their varied reactions to the "drug problem." The extent of the problem is perceived quite differently depending on the officers in question and the neighbourhoods they patrol. In the minds of some, particularly in the case of young drug users and "exchangers", although "the law is the law" and must undoubtedly be enforced, drug possession and use do not really concern the police. The prohibition is simply not enforceable. It is impossible to determine cases of possession in the absence of search and seizure powers, except "on a hunch" or in arresting suspects for other "crimes". Once possession cases and drug deals in public places are discovered either by accident or in the course of investigating other offences, police officers react in various ways depending on their professional aspirations. Those seeking promotion and specialization (who want to join the drug or victimless crimes squads) pass the information along to the appropriate*

[76] Carrier, N. (2000) *Discours de patrouilleurs montréalais sur la détection de l'infraction de possession de drogues prohibées.* Mémoire de maîtrise. École de criminologie, Université de Montréal.

divisions. Patrolmen who intend to remain patrolmen close their eyes or question suspects to obtain trafficking information in exchange for promises of immunity, or else take substances abusers to treatment services, call the parents of a minor, etc. [77]

The uneven application of the legislation is one of our greatest concerns, for a variety of reasons. First, there is the danger that this can lead to discriminatory enforcement, where certain people are more likely to be charged than others because of their personal characteristics. While current national statistics do not allow such an analysis, there is some evidence that the law is applied discriminatorily.

The Carrier paper discussed above was the result of interviews with 21 Montreal area patrol officers. It discusses the difficulties of detecting possession offences due to the lack of a "victim," the discreetness of the offences and the constitutional limits on unwarranted searches. The paper explains that a police officer's actions depend on several factors, such as how serious the officer perceives the drug problem to be and what are the officer's career aspirations–those wanting promotions respond more proactively to drug offences than those wishing to remain as patrol officers, who tend to be more reactive. Police are generally frustrated by the limits imposed on searches.

So how do they go about detecting possession offences? The officers indicated that most possession offences are detected when a person is stopped for another criminal matter–the arrest allowing an officer to conduct a search of the person. On rare occasions, officers detected the offence when a person openly flouted the law.

Of note, officers also indicated that certain people attracted their attention and some indicated that there are "signs" which lead them to believe that people are in possession of illegal substances. With respect to people in cars, the following factors were mentioned: the appearance of passengers in a vehicle; the vehicle's model and value; the person's driving habits; and a computer check of the licence plate indicating that the owner had a criminal record. Officers are allowed to stop people to ensure they have the proper documentation, and this may lead to the discovery of an offence that would result in a search. With respect to pedestrians, the following factors were mentioned: the person is known as a drug user; physical appearance; the person's activities; associating with other "suspects"; and association with dwellings suspected for trafficking. Certain officers indicated that questioning such suspects can lead to an arrest–for example, an outstanding warrant of arrest–and a search. Officers also indicated that on occasion they selectively applied municipal by-laws and other provincial legislation in order to obtain a person's name, after which the person can be investigated. If a person refuses to give his or her name, the person may be arrested and searched. Officers also indicated they had used techniques to "go fishing." While the evidence would not be admissible in court, in certain circumstances it allowed the

[77] Voir aussi la discussion qu'en fait M. Guy Ati-Dion lors de son témoignage devant le Comité spécial du Sénat sur les drogues illicites, Sénat du Canada, première session de la trente-septième législature, 29 octobre 2001, fascicule 8, pages 73-74.

officer to obtain information from the person in exchange for “not laying a charge,” or allowed the officer to seize the illegal substance.

While this study is of limited scope, it does provide an indication of how police discretion in enforcing drug legislation may lead to discrimination based on factors such as a person’s appearance.

Another concern is the danger of alienating certain groups of society. Those targeted by enforcement may lose respect for police and the criminal justice system in general. Inconsistent legal responses are likely to create an atmosphere that brings the administration of justice into disrepute. As Parliamentarians, we find this unacceptable.

Finally, there is the basic issue of fairness and justice. No one seems able to explain why some people are charged and others are not. It is not surprising that this legislation faces such fierce criticism.

Customs Act - fines

In general, when one thinks of drug enforcement, one thinks of charges laid by police under the CDSA and seizures made by them. Other legislation can be applied in certain circumstances, however. For example, the *Customs Act* allows for the seizure of prohibited goods and also of vehicles used in contravention of that act. In this case, a civil "penalty" may be imposed against the importer, because a Customs officer may return the vehicle to the importer only upon payment of the assessed monetary penalty. The penalty is based on the quantity of drugs found.

Amount	Marihuana	Hashish	Hashish oil	Controlled drugs	Hallucinogens	Cocaine Opiates
*$220	over 8 grams not over 15 grams	over 2 grams not over 4 grams	over 1 gram or less	over 10 pills not over 20 pills	over 1 dosage not over 4 dosages	1 gram or less $400
$440	over 15 grams not over 30 grams	over 4 grams not over 8 grams	over 1 gram not over 2 grams	over 20 pills not over 40 pills	over 4 dosages not over 8 dosages	
$550	over 30 grams not over 60 grams	over 8 grams not over 16 grams	over 2 grams not over 4 grams	over 40 pills not over 60 pills	over 8 dosages not over 12 dosages	
$660	over 60 grams not over 100 grams	over 16 grams not over 24 grams	over 4 grams not over 6 grams	over 60 pills not over 80 pills	over 12 dosages not over 16 dosages	
$770	over 100 grams not over 150 grams	over 24 grams not over 32 grams	over 6 grams not over 8 grams	over 80 pills not over 110 pills	over 16 dosages not over 20 dosages	
$880	over 150 grams not over 200 grams	over 32 grams not over 40 grams	Over 8 grams not over 10 grams	over 110 pills not over 140 pills	over 20 dosages not over 24 dosages	
$990	over 200 grams not over 250 grams	over 40 grams not over 46 grams	Over 10 grams not over 12 grams	over 140 pills not over 160 pills	over 24 dosages not over 28 dosages	
$1100	over 250 grams not over 300 grams	over 46 grams not over 56 grams	Over 12 grams not over 14 grams	over 160 pills not over 180 pills	over 28 dosages not over 32 dosages	

For amounts in excess of the above stated sums:

over 300 grams: $4 for each additional gram	over 56 grams: $20 for each additional gram	over 14 grams: $70 for each additional gram	over 180 pills: $8 for each additional pill	over 32 dosages: $40 for each additional dosage	over 1 gram: $400 for each gram

The CCRA will also arrest the importer, under the authority of the *Customs Act*, for smuggling goods into Canada, that are prohibited, restricted or controlled by the Act or by any other Act of Parliament (for example, the CDSA). Once the CCRA has seized the drugs and made an arrest, the responsible police force is contacted and will decide whether or not to proceed and lay charges. As will be discussed later, in some cases, the CCRA has entered into Criminal Charge Agreements with police forces. The Crown Attorney will then decide whether or not to prosecute, based on case-by-case specifics.

Under section 6 of the CDSA importing drugs, except as authorized under the regulations, is an offence regardless of quantity. Therefore, in the case of importing, there is no "threshold" in the CDSA below which a lesser sentence or fine can be imposed. However, if the amount imported is of a quantity normal for personal use, rather than resale, the Crown may choose to prosecute for possession rather than importing.

The CCRA in Windsor has a Criminal Charge Agreement with the Windsor RCMP which sets out guidelines for criminal prosecution for border seizures. The amounts are to be used only as a guide, but generally a person will not be charged by the RCMP for importation of less than 50 grams of marijuana, less than 20 grams of

hashish or less than 15 grams of hash oil. In these cases, enforcement will be done under the *Customs Act.* From 1996 to 2001, almost 99% of the 4,055 marijuana seizures in the Southern Ontario region were for less than 50 grams.

SEIZURES

The following table provides information on seizures made by the RCMP, CCRA, Sûreté du Québec, Ontario Provincial Police and the municipal police forces of Montreal, Laval and Toronto.

Drugs Seized in Canada: 1993–2001

	1993	1994	1995	1996	1997	1998	1999	2000	2001
heroin	153	85	128	83	95	105	88	168	74
cocaine	2,731	7,915	1,544	3,110	2,090	2,604	1,116	1,851	1,783
ecstasy				1,221	10,222	68,496	400,000	2,069,709	1,871,627
marihuana (kg)	7,314	6,472	5,500	17,234	50,624	29,598	23,829	21,703	28,746
marihuana (plants)	238,601	288,578	295,999	675,863	689,239	1,025,808	954,781	1,102,198	1,367,321
hashish	56,721	36,614	21,504	25,155	6,118	15,924	6,477	21,973	6,677
liquid hashish	669	659	663	805	824	852	434	1,240	397

(Weights in kilograms; Ecstasy in dosage units)

According to Professor Steve Pudney, Public Sector Economics Research Centre, Department of Economics, Leicester University, "seizure data provide the most direct information on availability of drugs even though drugs seized are not contributing to the available supply."[78] If one looks at RCMP drug seizure trends, however, it becomes obvious that the data must be used cautiously, because the number of interceptions or the amount seized in one year is not necessarily a true indicator of an increase or decrease in the drug situation. Rather, it is an indication of the impact of active and passive policing.

> *Seizures are likely to be passive in the sense that there is a more or less constant seizure rate achieved by routine monitoring and investigation. The greater the amount of drugs entering the market, the greater the background level of seizures, on a purely statistical basis. Passive seizures are thus a positive*

[78] Appendix B. 'Referee's Comments.' In Bramley-Harker (2001) *Sizing the UK market for illicit drugs.* London: Home Office. RDS Occasional Paper no 74.

indicator of the size of the market. However, drug policing also has active aspects. Investigations based on criminal intelligence often lead to the closing down of pipelines of supply and the removal of significant quantities of the product from the domestic market. Seizures of this type are negatively related to market size in the sense that a large seizure, rather than being an indicator of supply growth, is a cause of supply contraction. When these two aspects are present, it is difficult to draw any clear conclusion about supply from information on seizures. [79]

While passive seizures may indeed be a positive indicator of the size of the drug market, one must remember that passive seizures may also be somewhat inaccurate, because Canada's vast borders and coastline make it difficult for Canadian officials to make consistent interceptions and seizures each year. Importers continually find new ways of avoiding authorities by means of different ports of entry, as well as larger, infrequent shipments or vice versa.

Despite these problems with seizure data, the trends indicate that the seizures of cannabis, both in kilos and plants, have seen a fairly significant increase in the last few years, particularly when compared to seizures relating to cocaine and heroin.

What is clear from the seizure data is that police have, in recent years, placed increased emphasis on marijuana cultivation offences. In 1993, police seized fewer than 250,000 marijuana plants, while seizures in 2001 totalled more than 1,350,000 plants. This would seem to suggest an increase in cultivation in Canada and also a shift in police priorities to cultivation offences.

CONCLUSIONS

Conclusions of Chapter 14	
	➢ **Annual costs for drug enforcement in Canada can be estimated at between $700 million and $1 billion.** ➢ **Reduced law enforcement activities resulting from amendments to the drug legislation on cannabis could produce either substantial savings or significant reallocations of funds by police forces to other priorities.** ➢ **Due to the consensual nature of drug offences, police have been granted substantial enforcement powers and have adopted highly intrusive investigative techniques; these powers are not unlimited, however, and are subject to review by Canadian courts.** ➢ **Over 90,000 drug-related incidents are reported annually by police; more than three-quarters of these incidents relate to cannabis and over 50% of all drug-**

[79] *Ibid.*

	related incidents involve possession of cannabis. ➢ **From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5– thus, the rate of reported cannabis-related offences has almost doubled in the last decade.** ➢ **Reported incidents related to the cultivation of cannabis have seen a dramatic increase in the last decade.** ➢ **Reported incident rates vary widely from province to province.** ➢ **Cannabis was involved in 70% of the approximately 50,000 charges in 1999. In 43% of cases (21,381), the charge was for possession of cannabis.** ➢ **Charge rates for drug offences vary significantly from province to province.** ➢ **The uneven application of the law is of great concern and may lead to discriminatory enforcement, alienation of certain groups within society, and creation of an atmosphere of disrespect for the law; in general, it raises the issue of fairness and justice.** ➢ **Seizure statistics would seem to confirm an increase in cannabis cultivation in Canada and also a shift in police priorities regarding this offence.**

CHAPTER 15

THE CRIMINAL JUSTICE SYSTEM

The previous chapter examined how people first come into contact with the criminal justice system through the enforcement of criminal legislation. Several questions remain, however. What happens once a person has been charged with a drug offence? Who is responsible for prosecuting drug cases? What type of punishment do people receive? Who ends up with a criminal record? Have there been any challenges to the constitutional validity of drug legislation? These issues and others related to the criminal justice system are reviewed in this chapter.

PROSECUTION

The Federal Prosecution Service (FPS) is the lead prosecution agency with respect to drug offences in Canada. Its mandate is to prosecute offences in every province and territory under a variety of federal statutes, including the CDSA. Its work consists mostly of drug prosecutions.

Under the CDSA, provinces can exercise jurisdiction to prosecute if a drug proceeding was commenced at the instance of the provincial government. Presently, only two provinces–Quebec, and to a lesser extent New Brunswick–have exercised this jurisdiction. Thus, in Quebec, the FPS prosecutes only offences that have been investigated by the RCMP. In the rest of Canada – apart from New Brunswick – the service prosecutes drug offences that have been investigated by a provincial or municipal police force or the RCMP.

The FPS has 300 full-time in-house lawyers in 13 offices across the country and approximately 750 standing agents from the private sector, who conduct drug prosecutions on behalf of the Attorney General of Canada. Generally, the police investigate an offence and lay a charge, which is followed by a prosecution. In certain provinces – such as British Columbia, Quebec and New Brunswick–the police are required to seek Crown approval before laying a charge.

While complex cases still represent a fairly small percentage of cases prosecuted by the FPS, they are becoming more common and are already very time consuming for prosecutors.

> *…Most cases are of low or medium complexity; however, the complexity of cases is increasing and complex cases are becoming more common. Currently, it is estimated that complex cases make up 7 percent of the caseload but use 60 percent of prosecutors' time. Complex organized crime cases require the involvement of Justice at an early stage because of the legal issues associated with the collection, organization, and admissibility of evidence.* [1]

The total cost of drug-related prosecutions conducted by the FPS is approximately $57 million per year–$35 million for in-house counsels and $22 million for standing agents. The FPS estimates that for the year 2000-2001, the cost of prosecuting cannabis possession was approximately $5 million, or roughly 10% of the total budget of $57 million.[2]

COURTS

During our deliberations, we were not given much detail on the costs to the provincial court system of drug-related prosecutions. The 1996 study by CCSA already presented in a previous chapter[3] estimated court costs for 1992 at approximately $60 million. One would assume that, with nearly 50,000 people currently charged per year for drug offences, and with the increased complexity of these cases, court administration costs would be significantly higher than the amount estimated in 1992.

The Auditor General estimated that in 1999 Canadian criminal courts heard 34,000 drug cases that involved more than 400,000 court appearances.[4] Other court-related costs are the considerable resources spent on legal aid. While we did not receive information on how much of these costs should be allocated to drug-related offences, we do know that in 1996/1997, $860 million was spent on court administration costs, and that in 1997/1998, $455 million was spent on legal aid.[5]

Drug treatment courts

Drug courts originated in the USA in the late 1980s as one of the measures in the "war on drugs". The arrangement essentially involves permitting the judge hearing a

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[1] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 12.

[2] Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 54.

[3] Single, E. et. al., (1996) *op. cit.*

[4] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 4.

[5] Statistics Canada, Canadian Centre for Justice Statistics, *Juristat*, Justice Spending in Canada, Catalogue no. 85-002-XIE Vol. 19, no. 12, pages 7-9.

case involving narcotics to order treatment measures instead of any other form of sentence. There are now approximately 2,000 drug courts in the USA and they have apparently dealt with about 200,000 individuals. The primary task of these courts is to deal with offenders whose offences did not involve violence and who have a history of drug use (including alcohol). Two approaches are taken: one is applied before sentencing and the other after sentencing. In the former case, the charges are suspended and in the latter case it is the sentence of probation or imprisonment that is suspended. Responses include intensive judicial supervision, long-term clinical treatment, frequent random urine tests, and related services (housing, employment, etc.). Various assessments of the system claim that the benefits include a reduction in drug use and delinquency as well as a reduction in the costs to the criminal justice system (it costs approximately US $2,000 to deal with a delinquent in the drug court system as compared with between US $20,000 and $50,000 for a criminal conviction combined with a prison sentence).[6]

Drug courts have also been established in Australia (1999), Ireland (1998) and England (1998).

The Committee visited Canada's first drug treatment court (DTC) during its travels to Toronto. Established in 1998 as a pilot project with funding support from the National Strategy on Community Safety and Crime Prevention, this initiative brought together many players including Justice Canada, Solicitor General Canada, FPS, the Ontario government, the provincial court, the Centre for Addiction and Mental Health (CAMH), the Toronto Police Service, the City of Toronto Public Health Department and a range of community-based service organizations. The pilot project is currently funded to December 2004.

A second drug treatment court pilot project was established in Vancouver in December 2001. It also uses an inter-sectoral model and is intended to ensure intensive case management and linking of participants to community resources and skills development programs, as required. While the Toronto DTC uses the Centre for Addiction and Mental Health as its treatment provider, treatment providers in Vancouver tend to be more locally based.

Drug treatment courts are specifically designed to supervise cases of drug-dependent offenders and are based on knowledge that incarceration alone does not lead to a reduction in drug use and related criminal activity. Typically, the criminal justice system does not address substance abuse problems or the root causes of these problems – which may include unemployment, homelessness, physical and sexual child abuse histories, family discord and a range of mental and physical health problems. DTCs are based on research that demonstrates that offenders with substance abuse problems commit fewer crimes when they are enrolled in treatment programs.

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[6] See, *inter alia*, the document prepared by the Canadian Centre on Substance Abuse (2000) *Drug treatment courts: Substance abuse intervention within the justice system*. Ottawa: author.

> *Another underlying assumption is that through therapeutic jurisprudence approaches such as drug courts, which are intended to provide rehabilitative and reintegration outcomes for drug-addicted offenders, the criminal justice system, in partnership with treatment providers and community services, can act as a change agent in altering the course of the addict's life.* [7]

The Toronto DTC provides court-supervised treatment for people who have a dependency on cocaine and/or opiates. Non-violent drug-dependent offenders charged with possession of, or trafficking in, small amounts of crack/cocaine or heroin, or with prostitution-related offences, are eligible for the program. In all cases, the offender is screened and assessed by a treatment provider. Admission is voluntary but must be approved by the Crown. Factors considered include other current criminal charges, the potential for risk to the community and the seriousness and circumstances of the offence. Two tracks have been established. In general, the first track is for those with limited or no criminal record and a charge of simple possession. They are eligible to enter the DTC prior to plea–once the program is completed, the charge is stayed or withdrawn. The second track is for those with more serious criminal records or a trafficking charge. They are required to plead guilty–once phase I of the program is completed, the offender receives a non-custodial sentence and is placed on probation (phase II). Failure to complete phase I results in the offender being expelled and sentenced.

The system is based on close collaboration between the Court and treatment systems. The offenders attend court sessions on a regular basis–the court sits twice a week–where the judge, in consultation with the DTC treatment team, reviews their progress. The DTC team includes the DTC judge, crown prosecutor, duty counsel, a representative of probation services, court staff, community/court liaison staff and treatment staff. Decisions are made regarding future treatment and judicial involvement. Continued compliance is encouraged through a system of graduated incentives and sanctions–this is accomplished by releasing the offender on bail with appropriate conditions that must be satisfied. Relapses are anticipated as part of the recovery process and do not automatically lead to expulsion. Honesty and accountability are important, however. Failure to meet other conditions, such as attendance in court or providing a urine sample, can result in a range of sanctions, including revocation of bail for up to five days.

The offender is involved in a structured outpatient program geared to his or her specific needs. Treatment lasts approximately one year, during which the offender works closely with a case manager. Treatment includes: group and individual counselling, ongoing case management, regular and random drug screening, and addiction medicine services – including methadone maintenance where appropriate. Treatment staff also collaborate closely with community resources and agencies to meet

[7] Patricia Begin, Director, Research and Evaluation, National Crime Prevention Centre, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 57.

the needs of participants. To complete the program, the offender must not have used crack/cocaine and/or heroin for an extended period of time and must also demonstrate a fundamental life-style change involving improved interpersonal skill development, stable and appropriate housing, and educational and vocational success.

The DTC initiative seems very encouraging although it is clear that evaluations will have to be conducted to ensure that these programs are effective. We were told that there are very few existing comprehensive, well-designed evaluations of drug treatment courts but that results of more comprehensive evaluation should be ready in 2002-2003. Problems to date include the following: most of the evaluations or research have taken place within very limited time frames; there has been no significant follow up to look at whether there has been re-use or abuse of drugs and criminal recidivism; and there has been a lack of adequate comparison groups from which to draw conclusions about the impact and effects of the program. Also discussed were differences from American drug courts, where mandatory minimum sentences and harsher penalties in general are a significant incentive for American participants to remain with the program.[8] Patricia Begin, Director of Research and Evaluation at the National Crime Prevention Centre, provided the following preliminary details of the Toronto DTC:

> *Briefly, the Toronto evaluation is using a quasi-experimental design. The comparison group is composed of those clients who were assessed as eligible to enter the program and made the decision not to participate in the drug treatment court, but rather go through the traditional criminal justice processing.*
>
> *Between April 1999, when the evaluation data started to be collected, and October 5, 2001, there were 284 clients involved in the drug treatment court. Eighty-three per cent, or 234, are the experimental group, and 17 per cent constitute the comparison group of 50 clients.*
>
> *In the experimental group, 16.7 per cent are still in the program; 13.7 or 14 per cent have graduated, which is 32 graduates; and 62 per cent have been expelled. The overall retention is 31 per cent.*
>
> *One of the things the research has illuminated is that for those drug treatment court clients who make it past the three-month period, the retention rate rises to 50 per cent. The court is attempting, through the data, to better understand the characteristics of those clients who are deemed to be eligible but do not make it, and who are expelled or withdraw in the first three months.*
>
> *…The evaluation has found that the comparison group is more likely than the experimental group to be younger, unemployed, have an income source from illegal activity, more criminal convictions, have been incarcerated more often and been charged with a new offence since admission to the drug treatment court. In many respects, the comparison group is at much higher risk than the experimental group.*
> *Lower reoffending rates for those receiving the drug treatment court program and related services may be related to their level of risk. We would like to explore further whether it is participation in the program, or lower risk and motivation to change one's life that is accounting for these differences.*

[8] *Ibid.*, page 8.

The evaluation data that we have to date has told us the following: The drug treatment court in Toronto is able to engage and retain offenders. Those who stay in the program tend to complete it and graduate, and the limited follow-up data that has been collected so far would indicate that they do have lower recidivism rates and reduced drug use.

There is also a reduction in drug use and criminal activity while offenders are in the program. There tend to be lower re-arrest rates for the experimental group compared with the expelled or the comparison group. One of the evaluation challenges over the next couple of years will be to try to identify a better matched group of offenders in order to define the outcomes, impacts and effects of the drug treatment court experience on some of the key outcome measures, which have to do with drug use, criminal activity, re-insertion in a pro-social way into the community, family stability and things of that nature. [9]

We look forward to the results of more comprehensive evaluations. Of note, the cost of incarceration in Ontario is approximately $45,000 per year while treatment costs related to drug courts are estimated at $4,500 per year. Clearly, increased use of DTCs could lead to substantial savings to the criminal justice system while at the same time showing promising results in reducing substance abuse problems.

DISPOSITION AND SENTENCING

While the quality of criminal justice statistics has been discussed in other chapters, the weakness in these numbers is particularly evident with respect to the disposition and sentencing of drug-related offences. This issue was also raised in the Auditor General's report for 2001.

There are weaknesses in some aspects of law enforcement statistics. First, there are no national statistics on illicit drug convictions and sentencing. For example, British Columbia, Manitoba, New Brunswick, and Nunavut do not provide adult criminal court data to Statistics Canada. The use of statistics requires good analysis and interpretation to understand underlying trends and causes. Because Canada does not have national data, it cannot monitor important trends such as sentence lengths, emergence of new drugs, and regional differences…

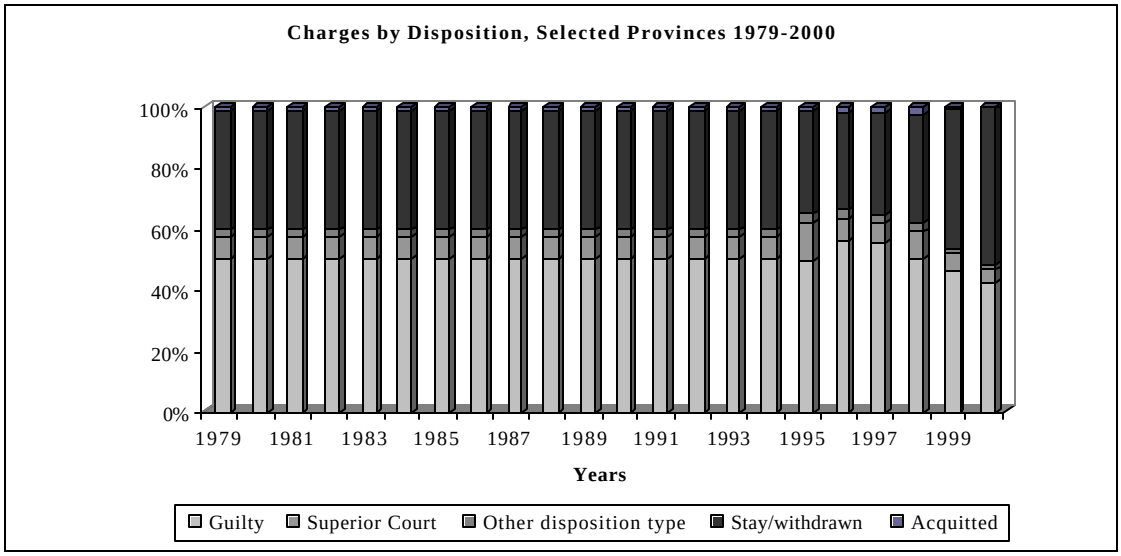
A second weakness is that the statistics on drug convictions and sentencing, which are reported according to the categories under the Controlled Drugs and Substances Act, are limited in detail. While the national statistics on police charges break down the number of drug charges by both type of substance (for example, heroin, cocaine, and cannabis) and act (for example, possession, trafficking, importation, and cultivation), the statistics on convictions are broken down into only two categories - possession and trafficking. The Inter-American Drug Abuse Control Commission's 1999-2000 report on Canada's

[9] *Ibid.*, pages58-60.

progress in drug control stated that improvements were needed in the justice system's statistics on drug offences. [10]

Despite these weaknesses, data relating to the disposition and sentencing of drug-related offences will be reviewed.

The following figure details the outcome of those charged with drug offences in selected provinces. It would appear that, from 1995 to 2000, there was a fairly significant increase in the percentage of cases in which the charges against the accused were either stayed or withdrawn. Not surprisingly, the percentage of people being found guilty of drug offences once they had been charged was lower. It is important to note, however, that this figure does not include data from three of the provinces (New Brunswick, Manitoba and British Columbia) and from one of the Territories (Nunavut); nor does it include data from certain courts in Quebec. Also, the data prior to 1995 are based on approximations of the average distribution of charges during the period covering the years 1995 to 2000.



For the year 1996-1997, 64% of persons convicted of drug trafficking were sentenced to imprisonment. The median sentence was four months. Probation was imposed as the most serious sentence in 24% of these cases and fines, in 9%.[11]

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[10] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 15.

[11] Statistic Canada, Canadian Centre for Justice Statistics, *Juristat*, Illicit Drugs and Crime in Canada, February 1999, page 7.

With respect to possession, a fine was imposed in 63% of the cases, with a median amount of $200. A fine was imposed as the most serious sentence in 55% of cases, probation in 22% and imprisonment in 13%.[12]

We were informed that the FPS is attempting to identify and implement alternatives to prosecution where appropriate. For example, "diversion" – whereby first-time offenders who have been charged with simple possession of cannabis are diverted out of the formal criminal justice system – was mentioned. Also discussed were the drug treatment court pilot projects in Toronto and Vancouver, whereby addicted offenders are referred to a fairly rigorous court-monitored treatment program. In addition, we were told about the recent implementation of the "deferred prosecution pilot project," in which prosecutors post a peace bond for offenders who have been charged with possession of cannabis in Manitoba. In these cases, the charges would be stayed, and as long as the offender is not back before the court system within a period of one year, the matter would be discontinued. Other "diversion" programs across Canada were mentioned.[13]

While Canada's disposition and sentencing data are incomplete, a few studies of limited scope suggest what is happening in Canada. A document prepared by the *Comité permanent de lutte à la toxicomanie* reviews police and judicial practices based on Quebec statistics from 1985 to 1998.[14] The report found that practices varied from one region to another in Canada and also from one region to another in Quebec. It notes that while there is a trend towards greater use of diversion in cannabis possession cases, it is far from being a standard practice. Diversion was used more often in the case of minors and, in their case, is on the rise (20.6 % in 1990, 48.2 % in 1995, 55.9 % in 1996 and 63 % in 1997). Once again, this varies considerably from one region to another.

Of those charged with cannabis possession, approximately 80% were adults and mostly male (roughly 90%). The report noted that penalties were not severe, particularly where it involved only one offence. For adults, the majority of the penalties imposed by the courts were fines and probation, and very rarely imprisonment. For minors, the most common penalty was community work or probation; detention was rarely imposed. Data from Montreal in 1998 indicate that incarceration for cannabis possession was less likely (13.8 % of all sentences) than for other substances, and that such penalties were shorter (50% were for 1 day and none was for more than 10 days). In addition, fines were smaller (average fines for cannabis were $186 while they were $277 for cocaine).

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[12] *Ibid.*

[13] Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section, Department of Justice, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, pages 54-55.

[14] Comité permanent de lutte à la toxicomanie, *La déjudiciarisation de la possession simple de cannabis*, June 1999, pages 11-13.

Patricia Erickson, a researcher from the Centre for Addiction and Mental Health, provided information on cannabis criminals based on three studies conducted in Toronto in 1974, 1981, and 1998. The studies indicate that cannabis criminals were overwhelmingly young men (about 90% were male and more than half were aged 21 years or less). Of the sample group, 80% were employed or in school and about half lived with parents. Most offenders were charged with only one count of simple possession and the amounts involved were small. In over 75% of the cases, charges were based on possession of less than 14 grams of cannabis. Of the whole sample interviewed in 1998, 50% had 1 gram or less of cannabis as the basis for their cannabis possession charges.

With respect to sentencing, in the first two studies, an absolute or conditional discharge was ordered in a large proportion of the cases. In 1998, 43% were diverted and the rest were awaiting disposition. It was indicated that penalties seemed to be given out randomly and that there "*was no correlation between sentence received and the type of person they were, or the case characteristics, charge and amount of drug.*"[15]

Also discussed was the issue of deterrence. The first study noted that 92% were still users one year later (in the later studies, about 80% intended to use cannabis or were still using it). In addition, the studies noted that the severity of the penalty was not relevant in deciding whether to use it in the future. The factor that best predicted an end to use after the user was arrested was simply the quantity the offender had used in the past–the less used the more likely the user was to stop. There was also no evidence of general deterrence, although it was indicated that this is much more difficult to measure.

While diversion programs are certainly an improvement on the traditional justice system response, it would seem that these programs are being developed on an ad hoc basis and are not consistently available across the country. Thus, while some offenders may benefit, others are left to face the traditional criminal justice system. In addition, it is not clear whether the admission criteria are similar under the various diversion initiatives. This would suggest an uneven application of the criminal law with respect to offenders who have committed the same offence, with the disposition of a case based not on the offence itself but rather on where it was committed.

CORRECTIONS

[15] Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, page 90.

Correctional Service Canada (CSC) is responsible for offenders serving sentences over two years, including individuals convicted of serious drug offences. CSC estimates that:

- nearly 70% of federal offenders have problems with alcohol and/or drugs;
- more than half used drugs or alcohol when they committed their current offence; and
- approximately 20% of incarcerated offenders have been convicted of drug-related offences.

With such numbers, it is obvious that substance abuse should be a high priority for CSC. This raises two issues: (1) how to address the supply of drugs in federal institutions; and (2) how best to provide treatment and rehabilitation for offenders with substance abuse problems.

With respect to security measures, CSC conducts searches, does urinalyses and works with police to share intelligence about drug issues. In addition, ion scanners have recently been set up in every institution to help detect the introduction of drugs. There are also plans to have a drug detection dog in every institution. Despite all these security measures, it would be difficult for CSC to argue that it is successfully keeping psychoactive substances out of prisons. The national results from a random urinalysis sample program in 2000-2001 found that 12% of samples tested positive for at least one intoxicant.[16] In addition, a recent study in Quebec penitentiaries shows that 29% of inmates admit to illicit drug use, the majority of them taking cannabis.

> *Imprisonment does not necessarily address the problem. A study that we conducted recently in Canadian penitentiaries in Quebec showed that inmates are taking drugs there too. We asked inmates to tell us about their drug use habits over the past three months of imprisonment. All the inmates were men. Sixteen per cent of them told us that they had consumed alcohol, whereas 29 per cent said that they had taken illicit drugs. In the majority of cases, these inmates were taking cannabis, whereas on the outside, the same inmates used to take cocaine. This is a significant change. Why were these people consuming cannabis, which is more readily detectable by its smell and by the traces it leaves in urine? Cannabis is detectable for 15 days after it was consumed, whereas cocaine can only be detected for 48 hours afterwards. Inmates want to escape. Cocaine is a stimulant which brings the inmate back to reality and this is not the desired effect. These people want to escape. Tranquillizing substances are the favourite. Sometimes they take benzodiazepine. However, they are easily able to get their hands on cannabis.* [17]

CSC provides substance abuse and treatment programs to offenders with drug problems. A range of programs is available to help offenders break the cycle of

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[16] Paul E. Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch, Department of the Solicitor General, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001-02, Issue no. 22, page 10.

[17] Serge Brochu, Professor, University of Montréal, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 12, pages 23-24.

addiction and safely reintegrate back into the community. Programs include the Offender Substance Abuse Prevention Program, the CHOICES Program and the Substance Abuse Program for Long-Term Offenders. CSC has also introduced Intensive Support Units, which include added searching and testing to support offender efforts to change substance abuse behaviour. The Auditor General estimates that 53% of offenders participate in substance abuse programs while serving their sentences.[18]

With respect to harm reduction, CSC provides methadone treatment to some opiate-addicted injection drug users and also makes bleach available in prisons to sterilize needles. CSC also has other initiatives to prevent the spread of infectious diseases, such as immunization for Hepatitis B. In early 2002, CSC announced an expanded methadone treatment program for federal prisoners addicted to heroin and other opiates.

CSC's Addictions Research Centre (ARC) opened in Montague, Prince Edward Island, in May 2001. The mandate of the ARC is to conduct applied research to assist the CSC in understanding issues surrounding substance abuse and to develop programs that assist offenders in breaking their drug dependency. It is the only research centre established by a correctional organization to specifically address the challenges of addictions. With a staff of 20, it currently focuses on four areas: program development – which is currently focused on culturally sensitive programs for women and Aboriginal offenders; program research – in areas such as community intervention, methadone maintenance, intensive support units and fetal alcohol syndrome; assessment and monitoring – to measure trends over time to evaluate the success of interventions; and knowledge dissemination.

Obviously, CSC's largest cost is related to incarceration. The Auditor General estimated that in 1999, CSC spent $169 million to deal with illicit drugs: $154 million to deal with offenders serving sentences in whole or in part for drug-related offences; $8 million on substance abuse programs (including alcohol); $4 million for treatment programs (e.g., methadone); $3 million on urinalysis testing. The cost of other security measures to control supply in institutions were unknown.[19] Of the current population of approximately 13,000 federal inmates, roughly 7,000 participate in substance abuse programs while serving their sentences. About $1,150 is spent per participating offender on substance abuse programs.

As of 31 December 2000, 5,779 convicted drug offenders were under federal jurisdiction (either serving their sentence: (1) in a federal institution or (2) on conditional release). Of these, 3,890 were serving sentences for trafficking, 621 for

[18] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 13.

[19] *Report of the Auditor General of Canada to the House of Commons*, 2001, Chapter 11, "Illicit Drugs: The Federal Government's Role", page 16.

importation, 225 for cultivation and 2,221 for possession.[20] Inmates serving in federal institutions are those who have been sentenced to imprisonment for two years or more.

Of those same 5,779 convicted drug offenders serving their sentences as of 31 December 2000, 2,548 were in federal correctional institutions: 1,613 for trafficking, 113 for importation, 82 for cultivation and 1,318 for possession.[21] In addition, 3,231 were on conditional release: 2,312 for trafficking, 508 for importation, 145 for cultivation and 946 for possession.[22]

In the five-year period from 1995 to 2000, the total federal drug offender population increased by almost 9%. Most of the growth involved those on conditional release, as this population increased by 19% over this period. At the same time, the number of those serving their sentence in institutions decreased by 2%.[23]

At the end of 2000, the average time served by drug offenders in federal custody was 2.2 years. With respect to conditional release, the average time served was 3.7 years. While this figure is lower than the average for non-drug offences, it is interesting to note that the average time served in custody for possession offences was 2.52 years, while it was 1.89 years for trafficking, 1.48 years for importation and 0.88 years for cultivation. For those on conditional release, the average time served for importation was 4.6 years, while it was 3.6 years for possession, 3.5 years for trafficking and 2.2 years for cultivation.[24] CSC indicated the reason that offenders appeared to be serving longer sentences for possession offences than for other drug-related offences such as trafficking is that they may also be serving time for other more serious offences, a situation making comparisons extremely difficult.

The following figure provides details of the number of admissions by region in federal correctional institutions in relation to drug offences for the year 2000, and the number of inmates incarcerated in different regions of the country as of 31 December 2000.

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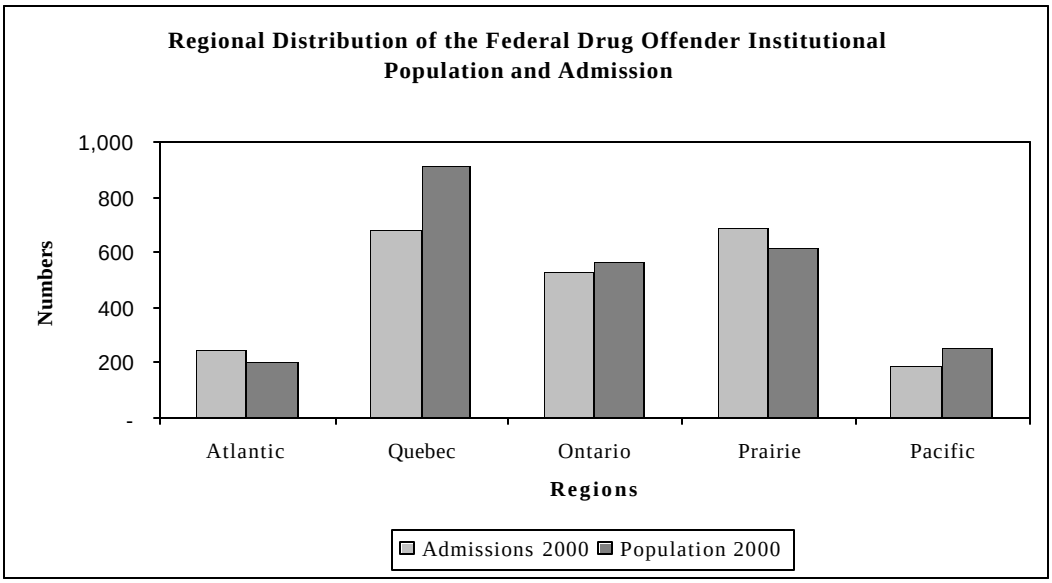
[20] Correctional Service Canada, Forum on Corrections Research, Volume 13, no. 3, September 2001, page 25. Please note that possession for the purpose of trafficking is included in the trafficking numbers.

[21] *Ibid.* It should be noted that some offenders might be represented in more than one drug offence category.

[22] *Ibid.* It should be noted that some offenders might be represented in more than one drug offence category.

[23] *Ibid.*

[24] Correctional Service Canada, *Forum on Corrections Research*, Profiling the drug offender populations in Canadian federal corrections, September 2001, Volume 13, Number 3, page 26.



CRIMINAL RECORD

So what are the consequences of a criminal conviction? There are pre-disposition costs related to the criminal justice system such as legal fees, time off from work, etc. Often, the liberty of the offender is compromised by virtue of having to go to the police station. There are also the emotional costs of worrying about having been charged with a criminal offence. Even if the charge is later withdrawn, offenders have experienced costs.[25]

Sanctions imposed in court are another obvious cost to the offender. They could include probation, a fine or some other sentence. Finally, there are also post-conviction costs. For example, a criminal conviction can have a negative impact on a person's employment opportunities and can be an impediment to travel to other countries. The general stigma of criminalization affects all offenders. Those offenders receiving harsher sentences generally feel unfairly treated, a feeling that can lead to a lack of respect for the administration of justice.[26]

[25] Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, pages 82-90.
[26] *Ibid.*,

Allan Young made the following statement

> *I get two to three calls a week from otherwise law-abiding citizens who are pot smokers who have been fired from their jobs or have been denied entry into the United States or access to their children or government employment. These people have been treated like common criminals. This is the biggest problem with the marijuana prohibition: If you treat someone who is otherwise law-abiding as a common criminal, they will start to disrespect people like Chief Fantino and the other people who really do try to serve and protect our interests.* [27]

With respect to the costs of cannabis prohibition, Dr. Patricia Erickson indicated that we do have choices.

> *It is evident in U.S. drug policy that, the people for whom drug use is a moral issue, the cost is unimportant. The costs are irrelevant to them. What is relevant is making sure that the use of drugs is seen as wrong. In Canada, however, we have always been more balanced and more evidence-based. That is a good distinction from the U.S. Canadians are at least able to measure and discuss the costs of policy and consider alternatives. We are not willing to pay any price.* [28]

A criminal conviction can also be an important factor in future dealings with the criminal justice system. For example, a person's prior conviction: may influence a police officer to lay a charge in cases where he or she might otherwise have used their discretion not to lay a charge; may influence a crown prosecutor to proceed by indictment rather than by summary conviction; may be used in limited circumstances in subsequent criminal proceedings; and may lead a judge to impose a more severe sentence. These are not trivial matters for those who have been convicted of a drug-related offence–in particular, the offence of possession of cannabis.

What happens in the case of a conditional or an absolute discharge? Section 730 of the *Criminal Code* indicates that such a person is deemed not to have been convicted of the offence. However, such a person would in likelihood have to answer yes if he or she were asked whether they had ever been arrested for, found guilty of, or pleaded guilty to a criminal offence.

A conviction does not necessarily mean that a person has a “criminal record,” that is, a record in the Canadian Police Information Centre (CPIC) System. This computerized information system for law enforcement use provides information on crimes and criminals. The Identification Data Bank–one of four CPIC data banks–contains the Criminal Record Synopsis File in which records are entered based on information contained on criminal fingerprint forms. This file contains tombstone data respecting the file–such as status of the record, subject description, subject history

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[27] Alan Young, Associate Professor, Osgoode Hall Law School, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 5, page 27.
[28] Dr. Patricia Erickson, Researcher, Centre for Addiction and Mental Health, Proceedings of the Special Committee on Illegal Drugs, Senate of Canada, First Session, Thirty-seventh Parliament, 2001, Issue no. 2, page 99.

(record, offence type) and subject aliases – and the complete Criminal Record is available to all CPIC terminal agencies upon request.

In the case of adult offenders, the Criminal Record file will be destroyed the earlier of either three years after their death and the date the individual reaches 80 years of age (although this will not apply in certain circumstances, such as where the individual has been charged with an offence within the previous 10 years). Absolute and conditional discharges will be removed to an archive as follows: absolute discharge on or after 24 July 1992 upon the expiration of one year from the date of sentencing (it is archived for five years and then destroyed); and conditional discharge on or after 24 July 1992 upon the expiration of three years from the date of sentencing (it is archived for five years and then destroyed). Discharges prior to 24 July 1992 will be destroyed on written request. Where a pardon is granted, the information about this offence is removed from CPIC to secured storage, separate and apart from all other criminal records (it is destroyed following the guidelines set out above for regular criminal record files). In the case of a charge not resulting in a conviction, the accused may make a request to the police agency that handled the case to have the information removed from local police files and RCMP records. The RCMP will return a person's fingerprints and remove the offence information from CPIC, only on the request of the police agency that handled the case. Special rules apply to young offenders.

As explained previously, even though a person does not have a "criminal record," it does not mean that the person has not been convicted of a criminal offence. While the presence of a criminal record is more likely to lead to negative consequences for the individual, many of the issues raised above also apply to those who have been convicted of a criminal offence but who do not have a "criminal record." Depending on the circumstances and on the way the question is formulated, the lack of a criminal record is irrelevant.

Because the offence of possession of less than 30 grams of marijuana is currently a summary conviction offence, a person should not be fingerprinted following arrest. Because fingerprints are the basis for a "criminal record," no such record will be entered in CPIC based only on this offence. However, before 1996, people had a criminal record, and it has been indicated that by the early 1990s, over 500,000 Canadians had a criminal record for cannabis possession.[29]

Because of the complexity of this issue, one wonders whether people who have been convicted of an offence, notwithstanding the sentence imposed or whether they have received a pardon, know their legal rights. For example, most people would probably have difficulty answering certain criminal-related questions found on employment application forms.

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[29] Patricia Erickson and Benedikt Fisher, Canadian Cannabis Policy: The Impact of Criminalization, the Current Reality and Future Police Option, paper presented an the International Symposium on Cannabis Policy, Criminal Law and Human Rights, Bremen, Germany, October 5-7, 1995.

COURT CHALLENGES [30]

Not surprisingly, the cases that have challenged the substantive validity of drug prohibition laws under the Charter have so far specifically dealt with marijuana, rather than with harder drugs, such as cocaine and heroin. Cases dealing with the right to use cannabis for medical purposes have been discussed in Chapter 13. This section will review cases where a right to non-therapeutic (or recreational) drug use is claimed. Although the medical cases have met with greater success, Charter challenges to marijuana prohibition by recreational users have been taken more seriously by the courts than they were a few years ago.

So far, Canada's legislative prohibition on marijuana – as it relates to non-therapeutic use – has been consistently upheld by the courts. However, the court's reasons have become more elaborate and more extensive in recent cases than in earlier cases. Undoubtedly, this reflects, at least in part, a change in judicial perceptions of the scope of section 7 of the Charter.

No cases could be found which dealt with challenges to the ban on marijuana or other drugs under the *Canadian Bill of Rights*. Undoubtedly, this can at least in part be explained by the courts' approach to the Bill of Rights generally, and to the "due process" clause specifically. The courts took a rather cautious approach to applying the Bill of Rights which, being an ordinary statute, was not taken to "reflect a clear constitutional mandate to make judicial decisions having the effect of limiting or qualifying the traditional sovereignty of Parliament."[31] Moreover, the prevailing view of the "due process of law" standard was that it was restricted to procedural fairness, and the "liberty" interest was undoubtedly assumed to refer only to freedom from physical restraint.

The earliest case concerning a Charter challenge to the offence of possession of an illegal narcotic–in this case, marijuana–was the Quebec Superior Court judgement in *R. v. Lepage* (8 May 1989, unreported).[32] However, this case was unreported and a copy of the decision could not be found, so the reasons for the decision, including the provisions of the Charter under which the decision was made, are not available.

The British Columbia Supreme Court decision of *R. v. Cholette* (1993)[33] was the first case located that dealt squarely with a section 7 challenge to the ban on the use of marijuana. In this case, the accused claimed that the ban violated his right to security of the person under section 7. The accused cited the benefits which he derived from using marijuana and questioned the motivation of the government's original decision to ban

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[30] This section relies to a great extent on *Drug Prohibition and the Constitution*, a paper prepared for the Special Senate Committee on Illegal Drugs by David Goetz, Law and Government Division, Parliamentary Research Branch, Library of Parliament, 1 March 2001.

[31] *R.* v. *Therens*, [1985] 1 S.C.R. 613, at page 639, per Le Dain J.

[32] Bruce A. MacFarlane, Robert J. Frater and Chantal Proulx, *Drug Offences in Canada*, Aurora, Ont.: Canada Law Book, 1996 (rev. November 2000) (loose-leaf), pages 4-27.

[33] [1993] B.C.J. No. 2616.

marijuana in 1923 (on the basis that it reflected anti-Asian bias and stereotyping), and its continued retention of the ban, on the grounds that there is no evidence of any significant harmful effect to society. Justice Dorgan rejected the accused's argument and concluded that the accused had failed to demonstrate that the ban on marijuana "interferes in any real way with the right of access to medical treatment for a condition representing a danger to the life or health of the accused…"[34]

Four months after the *Cholette* case, similar arguments were being weighed by the Quebec Court of Appeal in *R. v. Hamon* (1993).[35] This time, the accused relied on the broader conception of the liberty interest advanced by Wilson J. in *Morgentaler* arguing that the decision to use marijuana was a fundamental personal decision. He further claimed that, as marijuana is not really harmful to society – or, at least, no more harmful than tobacco or alcohol – the ban is arbitrary and irrational, and thus contrary to the principles of fundamental justice. Justice Beauregard, for the court, was prepared to assume that an arbitrary criminal prohibition would be contrary to the principles of fundamental justice.[36] However, the Court concluded that the ban was not arbitrary and accepted the expert evidence adduced by the government to the effect that cannabis use did have harmful effects on individual users and society.[37] Moreover, the court rejected the suggestion that there was anything unjust in the government's decision to treat cannabis differently from tobacco or alcohol.[38] Leave to appeal this decision to the Supreme Court of Canada was refused.

In the 1997 case of *R. v. Hunter*,[39] Justice Drake of the British Columbia Supreme Court addressed a challenge to the prohibitions on marijuana and psilocybin under various Charter provisions. With respect to the accused's arguments that the prohibitions violated his section 7 liberty and security of the person interests, Justice Drake summarily dismissed them, stating simply that *"the two statutes contain reasonable prohibitions against certain conduct, and these are not unduly broad in their application"* and referring with approval to the Quebec Court of Appeal decision in *Hamon*.[40]

In the preceding cases involving challenges to the ban on marijuana (and psilocybin, in the case of *Hunter*) under section 7 of the Charter, the courts dismissed the arguments with little detailed reasoning. However, in two provincial courts of appeal decisions released in 2000, similar arguments were the subject of more extensive analysis.

The first of these two cases was *R. v. Malmo-Levine* (and its companion case of *Regina v. Caine)*,[41] a decision of the British Columbia Court of Appeal released on

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[34] *Ibid.*, at para. 9.
[35] 20 C.R.R. (2d) 181, [1993] A.Q. no. 1656.
[36] *Ibid.*, at p. 183 C.R.R. and para. 14, [1993] A.Q.
[37] *Ibid.*, at p. 183-84 C.R.R. and paras. 17-20, [1993] A.Q.
[38] *Ibid.*, at p. 185 C.R.R. and paras. 22-26, [1993] A.Q.
[39] [1997] B.C.J. No. 1315.
[40] *Ibid.*, at para. 15.
[41] [2000] B.C.J. No. 1095.

2 June 2000. In this case, a majority of the court upheld the criminal prohibition on simple possession of marijuana as being in conformity with section 7 of the Charter.

First, the Court decided that the accused's section 7 liberty interest was engaged by the fact that the penalty for the offence provided for possible imprisonment; and that it was therefore unnecessary to decide whether personal recreational use of marijuana was independently protected as an element of "liberty."[42]

Justice Braidwood, for the majority, then turned to the task of identifying and defining the principles of fundamental justice applicable in the case. After considering relevant common law and constitutional jurisprudence, scholarly legal and philosophical writings (in particular, those of John Stuart Mill), and law reform commission reports, the Court accepted the accused's argument that the principles of fundamental justice as set out in section 7 of the Charter include a precept referred to as the "harm principle," pursuant to which a person ought not to be imprisoned unless there is a potential that his or her activities will otherwise cause harm to others.[43] Moreover, this principle requires that the degree of harm involved "must be neither insignificant nor trivial."[44]

Recognition of the "harm principle" as a principle of fundamental justice is consistent with the assumption made by the Quebec Court of Appeal in *Hamon*, that a prohibition that was arbitrary and irrational would be contrary to section 7 of the Charter.

As in *Hamon*, the majority of the Court in *Malmo-Levine* found that the prohibition was not arbitrary. Justice Braidwood, for the majority of the Court, held that the criminal prohibition on possession of marijuana satisfied the harm principle. The majority concluded that Parliament had a "reasonable basis" to ban marijuana based on the following findings concerning the health risks associated with its use:

- Impairment of ability to drive, fly, or operate complex machinery–in this regard, users represent a risk of harm to others in society as well as to themselves (however, the number of accidents attributable to marijuana use cannot be said to be significant).
- Risk that the person will become a "chronic" user. Approximately 5% of marijuana users are chronic users; and it is impossible to tell in advance who is likely to become a chronic user. There is a risk that marijuana use, and with it the total number of chronic users, would increase if it were legalized.
- Increased health risks to "vulnerable persons" such as young adolescents.
- Risk of added costs to the health care and welfare system with increased use of marijuana (although, at current rates of use, such costs would be "negligible" compared with those associated with tobacco or alcohol use).[45]

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[42] *Ibid.*, at para. 69.
[43] *Ibid.*, para. 134.
[44] *Ibid.*, para. 138.
[45] *Ibid.*, para. 142.

Justice Braidwood then proceeded to weigh the interests of the state versus the rights of the individual, as prescribed by the Supreme Court of Canada in *Cunningham*, to determine if the criminal prohibition on marijuana possession struck "the right balance" between the individual and society. On the side of the individual, the Court weighed the deleterious effects on the individual and his or her family of imprisonment, and of having a criminal record. The Court also noted the disrespect and distrust for the drug laws fostered by the prohibition on marijuana possession. With respect to the state interest in retaining the ban on marijuana possession, the Court weighed the fact that it serves to minimize the harm to potential users and to society associated with cannabis use which, "however small, … is neither insignificant nor trivial."[46] The Court also noted that, in practice, a person convicted of simple possession of marijuana can likely expect a minor fine or a discharge, unless the person is a repeat offender.[47] Nonetheless, the Court observed, the threat of imprisonment remains and, in any event, "every year thousands of Canadians are branded with criminal records for a 'remarkably benign activity.' "[48]

In the end, Justice Braidwood observed that the result of the balancing of interests was "quite close," and that "there is no clear winner."[49] However, he noted that Parliament is owed some deference in matters of public policy and returned to his conclusion that, although the threat posed by marijuana was not large, it did not need to be for Parliament to act.[50] The principles of fundamental justice demand only a "reasoned apprehension of harm."[51] As this had been demonstrated, the majority dismissed the accused's section 7 challenge to the prohibition on marijuana possession.

In a dissenting opinion, Justice Prowse, while agreeing with much of Justice Braidwood's analysis, found that section 7 and the harm principle required a greater degree of harm to justify a criminal prohibition than merely non-trivial or not insignificant. Because the accused was able to demonstrate the absence of evidence indicating a reasonable apprehension of "serious, substantial or significant" harm, Justice Prowse would have ruled that the criminal prohibition on simple possession violated section 7 of the Charter.[52]

The Ontario Court of Appeal decision in *R. v. Clay*,[53] released on 31 July 2000, dealt with almost the same issues and arguments as those in *Malmo-Levine*. Moreover, a unanimous panel of the Ontario Court of Appeal reached the same conclusion as the majority in the British Columbia Court of Appeal judgement released the previous month.

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[46] *Ibid.*, at para. 150.
[47] *Ibid.*, at para. 153.
[48] *Ibid.*, at para. 155.
[49] *Ibid.*, at paras. 155 and 156.
[50] *Ibid.*, at paras. 156 and 158.
[51] *Ibid.*, at para. 158.
[52] *Ibid.*, at paras. 165 and 167-86.
[53] (2000), 49 O.R. (3d) 577.

In *Clay*, Justice Rosenberg, for the court, accepted the "harm principle" elucidated by Justice Braidwood in *Malmo-Levine*.[54] Justice Rosenberg noted, among other things, that the notion of a "harm principle" encompassed by section 7 would be consistent with Justice Sopinka's statement in *Rodriguez* that where the *"deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems … that a breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose."*[55]

Moreover, in applying the "harm principle" to the criminal prohibition on marijuana possession, the Court came to the same conclusion as the majority in *Malmo-Levine*: Because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to act as it has done and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7.[56]

Justice Rosenberg, for the Court in *Clay*, noted that while the original basis for extending the ban on narcotics to include marijuana may have involved *"racism"* as well as *"irrational, unproven and unfounded fears,"* the valid objective of protecting Canadians from harm has remained constant.[57] The Court also rejected the relevance (for the purposes of constitutional analysis) of arguments and evidence showing that other legal substances, such as alcohol and tobacco, cause greater harm than marijuana: *"[t]he fact that Parliament has been unable or unwilling to prohibit the use of other more dangerous substances does not preclude its intervention with respect to marijuana, provided Parliament had a rational basis for doing so."*[58] The Court concluded that it did and upheld the prohibition on marijuana possession, except as it related to persons who need it for medical reasons (which was dealt with by the Court in the companion case of *R. v. Parker*–discussed below).[59]

As in *Malmo-Levine*, the Court in *Clay* found that section 7 of the Charter was triggered by the possibility of imprisonment, which implicated the accused's liberty interest. However, the Court in *Clay* went further and addressed the argument that personal use of marijuana *per se* was protected as an aspect of liberty and/or security of the person based on the expanded conception of these interests recognized by Justices of the Supreme Court of Canada in decisions such as: *B. (R.) v. Children's Aid Society of Metropolitan Toronto*; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*; and *Rodriguez* (all discussed above). The Court concluded that personal marijuana use (apart from its genuine medicinal use) did not engage the *"wider aspect of liberty"* which protected the freedom to make decisions of *"fundamental personal importance."*[60] Nor did it fall within the sphere of personal autonomy, which encompassed the right to "make

[54] *Ibid.*, at paras. 28-31.
[55] *Ibid.*, at para. 31.
[56] *Ibid.*, at paras. 34 and 37.
[57] *Ibid.*, at para. 34.
[58] *Ibid.*, at para. 36.
[59] *Ibid.*, at paras. 37 and 38.
[60] *Ibid.*, at para. 13.

choices concerning one's own body" and a right to "basic human dignity" as aspects of security of the person.[61]

The *Malmo-Levine, Caine* and *Clay* cases are currently before the Supreme Court of Canada. The cases will revolve around whether section 7 of the Charter contains the "harm principle" and the associated question of what is the appropriate threshold of harm: is it enough that the harm is "neither insignificant nor trivial" or must there be reasonable apprehension of serious, substantial or significant harm?

CONCLUSIONS

Conclusions of Chapter 15	
	➢ **The cost of prosecuting drug offences in 2000-2001 was $57 million with approximately $5 million or roughly 10% of the total budget relating to prosecuting cannabis possession offences.** ➢ **In 1999, it is estimated Canadian criminal courts heard 34,000 drug cases that involved more than 400,000 court appearances.** ➢ **The Drug Treatment Court initiatives seem very encouraging, although comprehensive evaluations are needed to ensure these programs are effective.** ➢ **Disposition and sentencing data with respect to drug-related offences are incomplete and there is an urgent need to correct this situation.** ➢ **Correctional Service Canada spends an estimated $169 million annually to address illicit drugs through incarceration, substance abuse programs, treatment programs and security measures; expenditures on substance abuse programs are unreasonably low, given the number of inmates who have substance-abuse dependence problems.** ➢ **A criminal conviction can negatively affect a person's financial situation and his or her career opportunities, and restrict travel. In addition, it can be an important factor in future dealings with the criminal justice system.** ➢ **Provincial courts of appeal have so far maintained the constitutionality of cannabis prohibition. They have found that because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to**

[61] *Ibid.*, at paras. 14-18.

	act as it has done, and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7 of the Charter. These decisions have been appealed, and the Supreme Court of Canada will soon decide whether cannabis prohibition is constitutionally sound.

CHAPTER 16

PREVENTION

Prevention is a key component of public health strategies and is increasingly part of the array of measures used to fight crime, especially crime related to the abuse of psychoactive substances. Viewed–in theory, at least–as a public health issue, an illegal drugs policy should therefore call for a strong prevention strategy.

Nothing, however, is more fluid, vague, even controversial, than prevention. The measures used to enforce the law are clear: they give power to the police and set down guidelines for the courts in dealing with people found to be in breach of the law. Correctional measures are equally clear: they implement the sentences imposed by the courts. Already, the measures used to treat people with drug problems are vague; there is no consensus on what constitutes treatment, when treatment begins and, most importantly, when treatment ends. The literature makes a distinction between primary, secondary and tertiary prevention; prevention through social development and situational development; universal, specific and indicated prevention; and prevention of use, at-risk behaviour and abuse, yet does not agree on the specific content of each field or the approach that should be taken in public policy.

When it comes to illegal drugs, the legal and political context makes the issue of prevention even harder to clarify and actions even harder to define. There are policies and initiatives in place that aim to prevent at-risk behaviour related to alcohol, such as heavy drinking, driving under the influence and domestic violence. In some circumstances and used in some forms, alcohol can be a "dangerous" substance; what we want to do is preclude those circumstances and identify the indicators of abuse so that we can prevent at-risk behaviour from leading to excessive, even pathological behaviour. It is possible to make these distinction and not deal with use *per se* because alcohol is a legal substance. But the national legal context surrounding illegal drugs and the interpretation of international drug policies (see Chapter 19 on the latter subject) are such that because they are defined *a priori* as harmful substances, illegal drugs must not be used. Another way of putting it is that any use is abuse. The glossary published by the United Nations Office for Drug Control and Crime Prevention states:

> *In the context of international drug control, drug abuse constitutes the* ***use*** *of any substance under international control for purposes other than medical and scientific.* [1] *(Our emphasis)*

If use is abuse, if individuals or organizations involved in prevention are unable to make distinctions that are essential in setting objectives and devising preventive measures, what hope is there of establishing successful prevention programs?

The international context on drugs is decidedly full of surprises. Each year, the International Narcotics Control Board, whose mandate is to monitor the implementation by Member States of the various international conventions, publishes an annual report which includes, in its first section, a commentary on a specific theme. The 1997 report commented on prevention. Regretting that the social environment was promoting drug use, the report noted:

> *Preventing the abuse of drugs is becoming an increasingly difficult endeavour, at least partly because of the rapid and growing spread of messages in the environment that promote drug abuse. Many of them can be regarded as public incitement and inducement to use and abuse drugs. Therefore, present efforts at prevention need to be strengthened and innovative prevention initiatives need to be developed and implemented.*
> *(…)*
> *While the elimination of all forms of drug experimentation, use and abuse will never be achieved, it should not be a reason to give up the ultimate aim of all prevention efforts, namely a drug-free society.* [2]

Among the various factors favourable to drug use and abuse, the Board cited popular culture (songs, films, etc.), the media, the Internet, the promotion of hemp products and political campaigns. The report equates advocating for liberal policy options to the promotion of drug use and suggests a rather disquieting notion of prevention:

> *Sensationalism, the desire to be provocative and the need for higher ratings, may also be behind the fact that several television companies in some countries in western Europe appear to be broadcasting many more programmes in support of a change in the drug law, if not the outright legalization of drugs, particularly cannabis, than programmes examining the consequences of following such a policy and the harm arising from it. Preventive education campaigns aimed at accurately informing the public in general of the effects of drugs and drug abuse will help to promote a more rational approach to drug problems and to avoid sensationalism.*
> *(…)*
> *It is possible to curb the showing by public broadcasting media, such as the press, radio, film and television, of favourable images of drug abuse. In some countries, it is possible to do this through legislation; in others it can be done through voluntary codes of practice; in still others, however, no*

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[1] UNDCP (2000), *Demand Reduction. A Glossary of Terms*, Vienna: author, page 22.

[2] International Narcotics Control Board (1997) "Preventing drug abuse in an environment of illicit drug promotion." *Annual Report of the International Narcotics Control Board for 1997*. Vienna : INCB, paragraphs 2 and 4.

> *restrictions on promoting drug abuse are in place because freedom of information and freedom of speech are considered to be more important than limiting the promotion of illicit drugs. The Governments of those countries may need to reconsider whether unrestricted access to and the propagation of such information are detrimental to the social and health conditions of their populations.*
> *(…)*
> *Election campaigns have been conducted with candidates standing for parliament on a drug legalization platform. Some campaigns, such as the successful campaigns for the "medical" use of cannabis in Arizona and California in the United States of America, have sought to change the law (…). Such political campaigns need to be met with rational arguments and unambiguous language pointing out the manifold problems that might arise from the decriminalization of drugs and that certainly would arise from the legalization of drugs, in particular the health and economic consequences of such action. (…) The Board notes with regret that despite the fact that (…) Governments of States that are parties to the 1988 Convention are required to make the incitement or inducement to take drugs a criminal offence, either this has not been done or the law has not been enforced.* [3]

If criticisms of the current public policies and demands for alternative approaches are equated with condoning drug use, if prevention means curbing freedom of speech – whether or not one agrees with these critiques – then one has to wonder what prevention is about.

Of course there are, as this chapter will show, many prevention programs that are not aimed solely or even particularly at the prevention of use, but rather the prevention of at-risk behaviour. Harm reduction, for example, is not only a general strategy for dealing with psychoactive substances, but is also a preventive approach that seeks to lower the risks associated with drugs and drug control without requiring abstinence. However, harm reduction is the subject of much controversy and criticism because it is based on the premise that use of drugs is a social reality.

Is law enforcement a preventive measure? Many practitioners, not just police officers, would surely say it is, and they would be right insofar as visible police presence or community policing does have some preventive effect. But in the current context, this is designed to prevent use, not at-risk behaviour, and does so through deterrence, not education or empowerment. And Chapter 14 showed that its effectiveness is very limited. Are sentences, including deprivation of liberty, preventive measures? Of course they are, at least for the time the offender is under supervision or in custody (although drugs are available in prison). But we saw in Chapter 15 that criminalization and penalisation do not deter use. And it is generally admitted that intervention by the justice system is in fact a sign that preventive measures have failed (or were not taken). Are citizenship education, health awareness and self-esteem programs preventive measures? They are indeed, but so, too, are social justice and fairness initiatives, efforts to reduce inequities and measures aimed at improving relations with Aboriginal peoples. If everything is prevention, what, then, constitutes the field of prevention?

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[3] *Ibid.*, paragraphs 18, 21, 25 and 27.

Addressing the issue of prevention means considering at the same time government policies on illegal drugs. This is particularly true in the case of cannabis. Preventive messages, as will be seen later, must be credible. The message that smoking tobacco causes lung cancer and cardiovascular disease is credible, at least in part because it is based on a large body of epidemiological studies that have established a strong, statistical cause-and-effect link. The same is true for impaired driving and the wearing of seatbelts. However, as Chapters 6, 7 and 8 have demonstrated, the findings for cannabis are by no means as cut and dried and the weight of the evidence would tend to indicate that it a much less harmful substance than most other psychoactive substances. Contrary to what many told us, marijuana is not illegal because it is dangerous and this is well established in the history of national drug law and international conventions.

The UNDCP glossary also states:

> *Prevention is defined broadly as an intervention designed to change the social and environmental determinants of drug and alcohol abuse, including discouraging the initiation of drug use and preventing the progression to more frequent or regular use among at-risk populations.* [4]

A careful reading of this definition is in order. It says that preventive intervention aims to prevent the abuse of drugs *and* alcohol. In the case of drugs *only*, however, one must aim to prevent people from becoming users in the first place, since drug use will progressively increase. Yet, the research on marijuana does not support this distinction. Alcohol – and before that tobacco – are far more likely than marijuana to lead to more frequent use, even at-risk use, and to be a gateway to other illegal drugs. But alcohol, like tobacco, is legal. Marijuana is not.

Any discussion of prevention entails discussion of the limits of government intervention and of how one conceives of human action. How far should government interventions go in identifying groups at risk without further stigmatizing groups already at risk? To what extent are humans rational beings who act in their best interest provided they are given the right information?

Finally, any discussion of prevention in the Canadian context necessarily has a constitutional dimension: to the extent that preventive measures are matters of health provinces have the primary jurisdiction, and to the extent that prevention is education provinces have exclusive jurisdiction. As we saw in Chapter 12 on the history of federal legislation on illegal drugs, it was no accident that the *Narcotic Control Act* was criminal in nature: since Parliament is authorized to adopt criminal legislation pursuant to the criminal law power conferred by the constitution. The federal government's role in the field of prevention of drug use is limited at best and non-existent at worst *proprio motu*.

This chapter on prevention begins with a statement that will come as no surprise to health or justice experts: when it comes to prevention, there is lots of talk, but the

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[4] *Ibid.*, page 58.

resources allocated are small and the initiatives weak. The second section asks the question: what prevention? We look at current knowledge of the factors underlying prevention initiatives and the effectiveness of some preventive measures, with special emphasis on one of the most important weapons in the war on drugs, the DARE program. The third section looks at the harm reduction approach to prevention. As in the other chapters, our conclusions are in the form of observations that may serve to guide future actions.

INITIATIVES THAT FALL SHORT OF THE MARK

When Canada's Drug Strategy was launched in 1987, the government acknowledged that most federal initiatives had focused on reducing supply and that there had to be more emphasis on prevention. Of the $210 million initially allocated to the first five-year strategy, no less than 32% was earmarked for prevention. In the second phase of the strategy, which ran from 1992 to 1997, the total budget increased to $270 million, with a similar percentage earmarked for prevention.

In 1994, the Government of Canada introduced the National Strategy on Community Safety and Crime Prevention and created the National Crime Prevention Council, now the National Crime Prevention Centre (Department of Justice). When Phase II of that strategy was launched in 1998, funding was $32 million annually; by 2001, funding had increased to more than $65 million. The strategy

> *is aimed at reducing crime and victimization by addressing their root causes through a social development approach. Crime prevention through social development (CPSD) is a long-term, proactive approach. It is directed at removing those personal, social and economic factors that lead some individuals to engage in criminal acts or to become victims of crime. The* National Strategy *is investing in projects that address risk factors in people's lives, such as abuse, violence, poor parenting and drug and alcohol abuse.* [5]

Where do things really stand? The stakeholders are probably in complete agreement that there is a need for prevention. But they are equally unanimous that the actions that have been taken are short of the mark. Otherwise stated, everyone talks prevention, but no one does much about it. The observations made before the Committee cover five sets of considerations: (1) there is not enough prevention; (2) prevention lacks focus; (3) there is not enough evaluation of preventive measures; (4) prevention and social messages about cannabis are contradictory; and (5) there are exemplary practices and successful preventive measures that need to be promoted more widely.

[5] National Crime Prevention Centre, statement of objectives, on line at www.crime-prevention.org

Not enough prevention

For many organizations, police departments and government agencies involved in the war on drugs, it is clear that there is not enough prevention. That view is measured in terms of spending levels and cuts in prevention staff.

> *Think of the last time that you saw a drug prevention message on television. Probably one that many of us would recognize is the fried egg commercial representing what happens to your brain. Unfortunately, that was an American ad. I cannot recall a recent anti-drug ad on television. We have produced proactive materials on many other issues in our country. There are campaigns on tobacco and breast cancer. We really have very little material in the drug prevention area. We are not saying that we want more money for policing and arresting people. We agree with the current balance. We think that not only crime prevention, but also drug awareness is a vital tool in making a difference. […] We believe, first, that there is a role for police in prevention and awareness as well as in enforcement. We have excellent partnerships with teachers, parents and community groups. Community policing has really started to come together in the last 10 years. […] One of our problems is that some of our programs are dated. Very little effort is put into the prevention aspect. I do not want to be quoted exactly on dollars. However, a report about a year ago indicated that the United States spent about $12 per capita on prevention and awareness. In Canada, the comparative figure was less than $1. I think it was in the area of 20 cents or 30 cents.* [6]

> *Since 1988 and 1989, when we had the Really Me campaign, we have had no federal or, in B.C., provincial campaign speaking about drugs. […] When there was a decrease in consistent prevention messages and the National Drug Strategy ended, I witnessed numerous community coalitions and task forces on drugs that dried up and went away and no provincial funding followed it. I watched in Nakusp, Penticton, the Sunshine Coast, Whistler and many other places as excited people were no longer able to keep going because the attention in the country turned to the population health bandwagon. There was a loss of interest, funding levels and prevention, and at the same time, an increase in messages about hemp, "medical marijuana" and other ideas. […] When you have this going on for years, common sense would tell you we would have some erosion in the gains we had made in consumption. With that, and with some of the changes in drug sentencing and enormous growth in cannabis availability, certainly in British Columbia, it is no wonder we see these changes.* [7]

> [Translation] *Third observation: efforts to prevent substance abuse are clearly inadequate. The task involves budget (increase allocations for prevention in various areas), coordination (provide a better framework for practices in this area) and research (establish clear program evaluation parameters, determine the effectiveness of existing programs, promote winning strategies). There is a particular need for more substance abuse prevention initiatives in the following areas:*

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[6] Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 82-83.

[7] Dr. Colin R. Mangham, Director of Prevention Source B.C., testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, September 17, 2001, Issue 6, pages 74-75.

- *schools (beginning in middle school) and other areas of young people's lives (e.g., streets, parks, youth centres);*
- *workplaces;*
- *front-line services in the health and social services system.* [8]

We had an excellent Canadian program developed in Nova Scotia in conjunction with the Nova Scotia Addictions Foundation known as PACE, the Police Assisted Community Education. We, along with a pharmacist, a doctor, a nurse and some athletes were among the people that went to schools to talk to the students about peer pressure, why some students feel compelled to use drugs, about stealing and different moral ethics, and other subjects relating to drug use. Unfortunately, because of the budget cuts, the programs were cut. The money for evaluations, for increasing the program, or for improving the program no longer exited. [9]

In the 1970s and 1980s, there was support for community-based ongoing prevention efforts. However, in the 1990s, the federal and provincial governments cut a lot of the funding and there has been commensurate rise in drug use. During that same period, multi-faceted prevention efforts such as those directed at tobacco, seat-belts, fire safety, fitness, and dental health, to name a few, made major inroads. [10]

Prevention of social and health problems is often the poor cousin of practice. Whether in health or in justice, the reality is that much more is spent on treatment and intervention after the fact than on prevention. This is true for health issues in general and illegal drugs in particular.

According to the study by Single *et al.*,[11] the direct and indirect cost of illegal drug abuse in 1996 was approximately $1.5 billion. Of that amount, $400 million was spent on law enforcement (police, Customs, courts, correctional services, etc.), and approximately $35 million was spent on prevention, that is, roughly 2% of the total, compared with more than 25% on efforts to fight drugs. Put a different way, the per-capita cost of illegal drugs is roughly $48; by comparison, about $12 is spent on drug control, and about $1 on prevention.[12] **We agree with other stakeholders that spending on prevention is woefully inadequate**.

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[8] Quebec Standing Committee on the Campaign against Drugs (2000), *Consultation 2000. La toxicomanie au Québec : Cap sur une stratégie nationale*, Quebec City: author, page 13.

[9] Chief Superintendent R.G. Lesser, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 8, page 14.

[10] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, November 7, 2002, Issue 10, page 86.

[11] Single, E., *et al.* (1996), *The Costs of Substance Abuse in Canada*, Ottawa: Canadian Centre on Substance Abuse.

[12] These figures do not take into account funds allocated to drug abuse prevention by the National Crime Prevention Strategy that was really implemented beginning in 1998.

Prevention lacks focus

Preventing cannabis use probably requires a different approach than preventing the use of heroin or ecstasy. By the same token, prevention of use by students will not be handled the same way as prevention of use by street kids, and preventive measures aimed at Aboriginal youth will be different from those aimed at white youth. We will see in the next section that the risk factors and protective factors are not the same for all social groups.

However, stakeholders point out that prevention messages and the way they are delivered are often inaccurate. We see either universal messages the real effectiveness of which is hard to measure, or messages that are aimed at specific social groups but are not necessarily geared to the reality of the people being targeted.

> [Translation] *Of particular note are weaknesses in secondary prevention. Programs aimed more specifically at high-risk groups are not enough. There is little effective screening where early intervention might make all the difference in preventing problems from getting worse, and this is true not only of youth, but of client groups of all ages. There is at present a lack of consistency in the messages being conveyed and the initiatives being taken. There is a lack of program stability. And in some areas, a great deal of ground has been lost (e.g., gradual loss of substance abuse prevention educators).* [13]

> *Prevention is not 'one size fits all.' Broad population approaches are needed, but so too are narrow focussed activities that target a specific risk group. Of course, prevention is proactive. It promotes personal responsibility. It is highly cost effective: For the cost of one treatment centre, you can fund prevention initiatives that reach hundreds and, indeed, thousands of kids.* [14]

If the focus is prevention, the objectives have to be clarified: is the goal to prevent use, at-risk behaviour or abuse? The chosen preventive measures will be fundamentally different depending on what objectives are set. This point was made in a recent document produced for Health Canada on best practices in the area of prevention:

> *Clear and realistic goals that logically link program activities to the problems and factors found in a community are necessary to guide implementation. Clear and measurable goals will permit evaluation to determine whether the program achieved its objectives. Goals will vary with the community and the circumstances; however, important considerations for all programs are the points at which use and problematic use of different substances generally begin. […] Accordingly, for youth who are not yet using (i.e., either not considering use or thinking about use) the program aim would be primary prevention. Programs working with a population largely consisting of youth who have initiated use and continue to use, a secondary prevention or harm reduction aim makes most sense. Each of these aims logically lead to*

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[13] Quebec Standing Committee on the Campaign against Drugs, *op. cit.*, page 14.

[14] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, November 7, 2002, Issue 10, page 85.

particular activities and messages (e.g., use of more intensive approaches with those using or preparing to use). [15]

With respect to prevention, there is also a sense that anything and everything is possible by adopting anti-drug rhetoric. However, as we will show in the next section, preventive measures have to zero in more on known risk and protective factors. And because there are many risk factors, preventative action should be multifaceted and involve the community.

There is not enough evaluation of preventive measures

Another reason there is not enough prevention is that no one takes the time or devotes the resources to evaluate programs and demonstrate their effectiveness. As the saying goes, an ounce of prevention is worth a pound of cure. Similarly, one dollar invested in prevention saves five dollars down the road. That may be true, but proving it is something else.

Conducting evaluation studies is not an easy task. If they are to be credible, studies often require a complex methodology. They are also expensive. And most importantly, they cannot – or at least should not – be rushed in order to meet political timelines: to determine, for example, whether a program aimed at preventing drug use among youth is effective, "graduates" have to be monitored for no less than a year (normally at least three years) after they received the program. Canada is not in the habit of doing evaluative research, and, as we saw for Canada's Drug Strategy, we did not set clear objectives or provide the means to evaluate initiatives.

As a result of this situation, prevention – a weak segment if ever there was one – pays the price when even the smallest budget cut is made.

One of the biggest problems is that our programs have never had an evaluation component. Whenever we had the opportunity to implement new programs, it was done "quick and dirty." There was very little money. Our only approach was to pump something out and see if it worked. We have all learned that if you are going to do something, do it properly. We should set up new programs with evaluative components in order to know that we are doing the right things at the right time for the right people. In other words, programs should consider the message, the messenger and effectiveness. [16]

The Committee is of the opinion that any future Canadian drug strategy **will have to include mechanisms and resources to evaluate the various components and in particular to evaluate preventive measures.**

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[15] Roberts, G., *et al.* (2001), *Preventing Substance Abuse Problems Among Young People. A Compendium of Best Practices*, Office of Canada's Drug Strategy, Health Canada, Ottawa: Supply and Services, pages 30-31.

[16] Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 82-83.

Preventive and social messages in contradiction

For some observers, the fact that society has become more tolerant of cannabis in recent years has contributed to increasing levels of use among young people and undermined the prevention efforts.

> *The other important part to remember is acceptability in terms of how drug use is perceived. Even more than availability, acceptability is affected by legal sanctions. When we have sanctions against drugs, it reduces social acceptability and helps hold consumption down. Two aspects of acceptability are perceived risk in using the drug and perceived social acceptance of the drug. Those are two tools we have to keep consumption down.* [17]

> *According to the 1996 Monitoring the Future study by the University of Michigan, today's teens are less likely to consider drug use harmful and risky, are more likely to believe that drug use is widespread and tolerated, and feel more pressure to try illegal drugs than at any other time in the last decade. […]*

> *The implication of these perceptions is that these factors influence an increase or decrease in the levels of drug use. Legalization of illicit drugs would only weaken these perceptions further. It tells our children that adults believe drugs can be used responsibly. It suggests that there is less risk and that drugs are more acceptable to society. […] Another influence is the media and the power of communication. Media coverage of individuals smoking marijuana in cannabis clubs tells kids that drug taking can be fun. Within this atmosphere, it is very difficult, if not impossible, to reach children and convince them that doing drugs is harmful. Increased drug availability and drug use will worsen our crime problems. Increased drug use has terrible consequences for our citizens.* [18]

As one American commentator said, telling children that marijuana is a dangerous drug is one thing, but what happens when they find out in high school that their friends are using it without frying their brains? The message probably has to be adapted to the audience, the context and the objectives. However, it is surely just as necessary to tell children and adolescents the truth in prevention programs about drugs, their real effects and about what we still do not know. If our society engages in contradictory debate over cannabis, it is not because some pot activists are manipulating the media; otherwise we would have to question the ability of our media to remain neutral and keep a critical distance. In light of the epidemiological findings presented in Chapter 6 and the scientific research on the effects of cannabis presented in Chapter 7, we believe that **alarmist rhetoric on the effects of cannabis is probably counterproductive for the very people who legitimately hope to prevent its abuse.**

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[17] Dr. Colin R. Mangham, Director, Prevention Source B.C., testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, September 17, 2001, Issue 6, page 74.

[18] Michael J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, pages 77-78.

That was among the points raised in the recent Health Canada report on best prevention practices.

> *The most important principle for every program, regardless of program goal, is that drug information be scientifically accurate, objective, non-biased and presented without value judgment. […] Even if younger participants initially accept messages that focus solely on the negative aspects of drug use, once they receive more accurate information, there is a danger that all the messages received earlier will lose credibility. […] Fear-arousing messages accompanied by incorrect or exaggerated information are not effective, and can generate scepticism, disrespect and resistance toward any advice on substance use or other risk behaviour. […] Similarly, simplistic messages that young people believe to be unrealistic (e.g., just say 'no') or not feasible (e.g., play sports when there are not facilities readily available) will not be seen as credible.* [19]

There is a body of knowledge on which we have to draw

Without question, there is a widespread preventive practice in Canada that has developed on a trial-and-error basis and is frequently nursed along with limited resources by people who truly believe in it. As we will show in the next section, there is also a body of knowledge on the initiatives that are most likely to have a real effect on risk factors and the processes most likely to support strong preventive measures.

One of the problems is that this "knowledge" all too often remains in the heads of a few people, primarily because few or no evaluative studies are conducted. What studies are done appear in scientific journals and are seen by experts but do not reach practitioners. And there are still few systematic means of disseminating information. This raises the question of how practices proven elsewhere can be adapted to other contexts.

> *We suggest to the Committee that rather than focusing on reforming our drug laws, efforts would be much better spent on examining strategies focused on prevention. Canada's Drug Strategy points out that first and foremost, prevention is the most cost-effective intervention. If we know that to be true, should we not focus our attention on tactics that will ensure greatest possible return on our investment? […] In a compendium of best practices by the Canadian Centre on Substance Abuse, the authors draw attention to the importance of parental influence in high-risk behaviour among youth. […] Numerous studies completed at the Center on Addictions and Substance Abuse at Columbia University which include extensive research into prevention programs, have reached the same conclusion.* [20]

> *Finally, in our years of work and prevention we have come to understand that the real problem is not so much a drug problem as a people problem. That is, all people - especially kids who have suffered abuse, neglect, trauma, and addiction in the home - seek ways to deal with their feelings of anger, despair, hopelessness or powerlessness. Some may have feelings of boredom, curiosity or a desire to belong.*

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[19] Roberts, G., *et al.* (2001), *op. cit.*, page 40.

[20] Brief from the Focus on the Family Association to the Special Senate Committee on Illegal Drugs, May 14, 2002.

Marijuana and other drugs can seem to solve or at least soothe these emotions. […] Alternatively, there is great potential through prevention to foster informed, confident, capable young people, who from the earliest ages learn sound mental health practices that are drug-free ways to manage these pressing and understandable human feelings. [21]

PREVENTING WHAT AND HOW?

Agreeing on the need for prevention is a bit like agreeing on the importance of virtue. Yet, as we saw in the introduction to this chapter, whether we all agree on the very concept of prevention is not all that clear. The United Nations Office for Drug Control and Crime Prevention glossary defines prevention as follows:

Prevention activities may be broad-based efforts directed at the mainstream population(s), such as mass general public information and education campaigns, community-focused initiatives and school-based programs directed at youth or students at large. Prevention interventions may also target vulnerable and at-risk populations, including street children, out-of-school youth, children of drug abusers, offenders within the community or in prison, and so on. Essentially, prevention addresses the following main components:

- *Creating awareness and informing/educating about drugs and the adverse health and social effects of drug use and abuse, and promoting anti-drug norms and pro-social behaviour against drug use;*
- *Enabling individuals and groups to acquire personal and social life skills to develop anti-drug attitudes and avoid engaging in drug-using behaviour;*
- *Promoting supportive environments and alternative healthier, more productive and fulfilling behaviours and lifestyles, free of drug use.* [22]

What this means, then, is taking initiatives that alter the factors leading to drug abuse, where all use is abuse in the case of an illegal substance or a substance controlled by international conventions. The definition identifies as a factor in abuse first-time use of drugs, on the premise that introduction – at least in people considered to be "at risk" – leads to more frequent use or use of other substances. The proposed areas of action indirectly identify other factors: the absence of information on the adverse effects of drug use and social norms that are insufficiently anti-drug, inadequate personal and social skills to resist drug use, and unsatisfactory lifestyles that are not health oriented are other factors in drug abuse.

But what do we know about the reasons why people use drugs, marijuana in particular? We know that men use more alcohol and drugs and that women use more prescription drugs. Do we really know why? We think that there may be more than

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[21] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, November 7, 2002, Issue 10, page 90.

[22] UNDCP (2000), *op. cit.*, page 58.

150 million marijuana users in the world, and we have said that there are approximately 3 million a year in Canada; are we to conclude that those people lacked the personal and social skills needed to resist drugs? When, at what point, does use become a problem? Depending on the answers to those questions, the entire prevention strategy will be different.

Genetic baggage aside, public health factors are a function of:

> [Translation] *[…] environmental factors related to the setting in which the person lives, from conception to death: the social as well as the physical environment. Education, employment, income, family and social relationships, and distribution of wealth are all factors that come into play. There is a close link between socio-economic status and health and well-being: that link is confirmed by data on hospitalization, disability, health problems and mortality in a given population. Other factors of course include lifestyle and behaviour, such as tobacco use and diet. Even though these are factors that can be changed and are often targeted by prevention, they are also largely conditioned by socio-economic factors. The last factor is health services, the level and organization of which vary from community to community and country to country.* [23]

It is true that epidemiological data tend to show that young marijuana users are more likely to be from disadvantaged socio-economic backgrounds, are more likely to smoke tobacco, and probably have parents who smoke or even use marijuana. These are referred to as environmental risk factors. According to some authors, regular or heavy users, those who are at risk, also suffer low self-esteem, are more likely to drop out of school or not finish high school, and do not perform as well academically. These are personal risk factors.

Another term in the vocabulary of prevention besides "risk factor" is "protective factor". The United Nations Office for Drug Control and Crime Prevention defines "protective factor" as follows:

> *A factor that will reduce the probability of an event occurring which is perceived as being undesirable. This term is often used to indicate the characteristics of individuals or their environments, which reduce the likelihood of experimentation with illegal drugs. For example there is some evidence from research in developed countries that each of the following are, statistically at least, protective in relation to illicit drug use: being female; of high socio-economic status; being employed, having high academic attainment; practising a religion; and being a non smoker.* [24]

Epidemiological data show that use is lower among women, non-smokers and people who practise a religion. However, the data are not as clear in terms of the impact of socio-economic status or level of schooling.

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[23] Public Health Directorate, *Les inégalités sociales de la santé. Rapport annuel 1998 sur la santé de la population.* [social inequity in health; 1998 annual report on public health], Montreal: Régie régionale de la santé et des services sociaux de Montréal-Centre.

[24] UNDCP, *op. cit.*, page 60.

One of the key works in the literature on prevention is without question the 1995 research by Hawkins *et al.*[25] The authors give a comprehensive list of risk factors related directly or indirectly to drug abuse, divided into five categories: individual, family, school, peer and community environment. These factors were identified based on a series of longitudinal studies that tracked children and adolescents over long periods.

> *Recent longitudinal research has identified risk and protective factors in the individual and the environment that consistently predict drug involvement. Moreover, the evidence indicates that the likelihood of drug abuse is higher among those exposed to multiple risk factors and that the risk of drug abuse increases exponentially with exposure to more risk factors. The higher rates of drug abuse among criminal and homeless populations are consistent with studies of personal, social and environmental risk factors that are predictive of substance abuse. This line of research suggests that intervention to prevent drug abuse should focus on reducing multiple risk factors in family, school, peer, and community environments.* [26]

1. Individual factors

The authors include among the individual factors identified by the research family history, genetic history, biochemical characteristics, early and persistent behavioural problems, alienation and rebelliousness, attitudes favourable to drug use, and early introduction to drugs.

2. *Family factors*

These factors include parents who use or permit the use of substances, poor parenting, poor parent-child relationships and family conflict.

3. *School factors*

These factors include academic failure and a weak commitment to school; intelligence is not a factor, but the school environment and learning difficulties have a determining effect.

4. Peer factors

Peer rejection in primary school and peers who use drugs are also factors related to substance abuse.

5. *Environmental factors*

The availability of drugs, legal and cultural norms, poverty and an unstable living environment.

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[25] Hawkins, D.J., M.W. Arthur and R.F. Catalano (1995), "Preventing Substance Abuse" in Tonry, M., and D.P. Farrington (eds.), *Building a Safer Society: Strategic Approaches to Crime Prevention*, Chicago: University of Chicago Press.

[26] Hawkins, D., *op. cit.*, page 368.

The authors identify as protective factors individual characteristics (resilience, social and personal skills, intelligence), the quality of childhood relations in the family and especially at school, and individual and social objection to drug use.

These factors must not be confused with causes. They are statistical links that are themselves limited by methodological problems related to measurement of behaviour, evaluation of the impact of intervention, and other considerations.[27]

> *A clear advantage of the protective/risk factor approach is the understanding that many social and health problems are linked by the same root factors – an understanding that can lead to better integration of strategies and economizing of resources. However, because a factor is linked to substance use problems does not necessarily mean that it causes such problems. Consequently, the actual preventive effect of addressing one or another of the protective or risk factors is not very clear and no doubt varies between the factors. Nevertheless, it appears that addressing protective or risk factors in several domains of a young person's life (i.e., individual, school, family and community) can lead to positive outcomes.* [28]

Hawkins *et al.* reviewed a series of initiatives–prenatal and neonatal, and preschool, primary school and secondary school–that were evaluated. They found that the most promising strategies are multidisciplinary approaches involving the community.

> *The evidence suggests that multistrategy approaches that address multiple risks while enhancing protective factors hold the most promise for preventing substance abuse. The current challenge for substance abuse prevention research is to test prevention strategies that empower communities to design and take control of their own efforts to explicitly assess, prioritize, and address risk and protective factors for substance abuse.* [29]

Prevention is not, however, a formula that can be used over and over in the exact same way. The characteristics of local communities, existing social relationships, and the strength of community organizations are among the factors that play a key role in the success of preventive measures. There is growing consensus among authors on a series of steps that are most likely to bring about success. The compendium of best practices published by Health Canada proposes the following:

- Build a strong framework
  - Address protective factors, risk factors and resiliency
  - Seek comprehensiveness
  - Ensure sufficient program duration and intensity
- Strive for accountability
  - Base program on accurate information
  - Set clear and realistic goals

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[27] Hawkins D., *et al.*, *op. cit.*, pp. 363-367.
[28] Roberts, G., *et al.* (2001), *op. cit.*, page 24.
[29] Hawkins, D., *et al.*, *op. cit.*, page 404.

  - Monitor and evaluate the program
  - Address program sustainability from the beginning
- Understand and involve young people
  - Account for the implications of adolescent psychosocial development
  - Recognize youth perceptions of substance use
  - Involve youth in program design and implementation
- Create an effective process
  - Develop credible messages
  - Combine knowledge and skill development
  - Use an interactive group process
  - Give attention to teacher or leader qualities and training

What actions are proven and promising? The compendium lists a number of Canadian intervention programs, but none has really undergone comprehensive evaluation.

A number of people who spoke at our hearings, police officers in particular, mentioned the DARE (Drug Abuse Resistance Education) program.

> *We use a revised, Canadian version of DARE, which is not the program most people have been hearing about for years. We are achieving success and acceptance with it.* [30]

> *We were unable to continue to fund Canadian programs, and to the credit of the RCMP and its members across the divisions, they turned to DARE, the Drug Abuse Resistance Education, from the United States. It was a pre-made, off-the-shelf program. Our budget still does not permit us to develop Canadian programs or to do evaluations. Unfortunately and embarrassing is that of the money that has gone to teaching Canadian police officers to instruct, a total of $750,000 has been paid for by the United States. The Canadian government has not funded any DARE training.* [31]

DARE was introduced in the United States in the early 1980s by the Los Angeles Police Department. In 1996, the program was being used by 70% of school districts and was serving 25 million students. Some 25,000 American police officers were trained to deliver the DARE program in schools. DARE is also used in 44 other countries around the world. It includes a number of modules delivered in different ways depending on the community. Basically, it entails a series of visits from kindergarten to grade four in which the children are given short lessons on personal safety, respect for the law, and drugs. The main 17-week program is designed for students in grades five and six. A 10-week program for middle-school students focuses on resistance to peer pressure, the ability to make personal choices, conflict resolution and anger management. Another 10-week program for high-school students focuses on personal

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[30] Barry King, Chief of the Brockville Police Service, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First Session, 37th Parliament, March 11, 2002, Issue 14, page 83.
[31] Chief Superintendent R.G. Lesser, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 8, page 14.

choices and anger management. Finally, DARE+ is an after-school program for high-school students built around recreational activities. The main 17-week program for grades five and six is the one most frequently used (81% of American school districts). It is delivered by a uniformed police officer and focuses on the ability to resist drugs. It provides information on drugs and their effects, self-esteem, and alternatives to drugs. The program includes lectures, group discussions, audio-visual presentations, exercises and role playing.

A document we received from the RCMP shows that the DARE Program is being taught in 1,811 schools in 584 different communities in Canada outside Quebec. Alberta leads the way with 150 school districts, 583 schools and more than 21,400 students in 2001, followed by Ontario (40 districts, 346 schools, 10,940 students) and British Columbia (60 districts, 289 schools, 10,800 students). All these schools offer the main 17-week program. In 2001, the program served more than 53,000 students. In all, the various components of the DARE program reached more than 65,000 Canadian students in 2001.

We do not know how much the program has been "Canadianized". To our knowledge, there have been no studies to evaluate the program's impact. The document we received is the first phase of an evaluation study that should, in the second phase, provide data on impact. The first phase of the study deals with students', teachers' and parents' opinions, preferences and perceptions.[32] The study looked at all of the grade 5 and grade 7 students in the West Vancouver school district who took the program (500 and 570 students, respectively), as well as their parents and teachers. The findings showed a very high level of satisfaction with the program:

- 97% of the students, 95% of the teachers and between 78% and 94% of the parents, depending on the grade, were in agreement with the program and the program objectives;
- 78% of the teachers agreed with the content of the DARE program for their grade level;
- 72% of the students felt that the information they received was valid and up to date;
- 97% of the teachers were very satisfied with the relationship between the police officer delivering the program and the students;
- 96% of the students said they understood the message;
- 88% of the students said that DARE had helped them resist drugs in middle school; the result was 58% in high school;
- between 82% and 89% said that they had a better understanding of the dangers of drugs.

These are only some of the findings. The data are in line with what can be found on the DARE's U.S. Internet site and in a number of evaluations. However, those evaluations measured opinions, perceptions and attitudes, not behaviour. To some extent, these results, positive though they may be, are not really surprising.

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[32] Curtis, C.K. (1999), *The efficacy of the Drug Abuse Resistance Education program (DARE) in West Vancouver schools. Part 1 – Attitudes toward DARE: An examination of opinions, preferences, and perceptions of students, teachers, and parents*, West Vancouver RCMP.

In contrast, almost all of the evaluations that have endeavoured to measure the impact of the DARE program on behaviour, specifically the prevention or reduction of drug use, have shown that the program had no impact or, at best, very little and very short-term impact.

The compendium of best practices produced for Health Canada contains a separate section on the DARE program which states in part:

> *There have been many D.A.R.E. reviews and evaluations, but few rigorous scientific evaluations. While some evaluations show positive results, studies published in peer reviewed journals, including a 5-year prospective study and a meta-analysis of D.A.R.E outcome evaluations, have been consistent in showing that the program does not prevent or delay drug use, nor does it affect future intentions to use. On the positive side, it does seem to boost anti-drug attitudes, at least in the short-term, increase knowledge about drugs and foster positive police-community relations. Also, acceptance of the program is generally quite high among police presenters, students and their parents.* [33]

Of course, the absence of program impact can be attributed to the requirements of the evaluation. However, these requirements are the same as those used for other program evaluations.

In 1997, a major report on what works, what does not work and what is promising in the area of crime prevention was tabled in the United States Congress; Congress had commissioned the report from a team of prominent researchers at a number of American universities.[34] The report had the following to say about the DARE program:

> *Several evaluations of the original 17-lesson core have been conducted. Many of these are summarized in a meta-analysis of DARE's short-term effects sponsored by NIJ [National Institute of Justice]. This study located 18 evaluations of DARE's core curriculum, of which 8 met the methodological criterion standards for inclusion in the study. The study found:*
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> 1. *Short term effect on drug use are, except for tobacco use, non significant;*
> 2. *The sizes of the effects on drug use are slight. Effect sizes average .06 for drug use and never exceed .11 in any study. The effects on known risk factors for substance use targeted by the program are also small: .11 for attitudes about drug use and .19 for social skills.*
> 3. *Certain other programs targeting the same age group as DARE […] are more effective than DARE. […]*
>
> *Four more recent reports, three of them longitudinal, have also failed to find positive effects for DARE. Lindstrom (1996), in a reasonably rigorous study of approximately 1,800 students in Sweden, found no significant differences on measures of delinquency, substance use, or attitudes favoring substance use between students who did and did not receive the DARE program. Sigler and Talley (1995) found no difference in the substance use of seventh grade students in Los Alamos, New Mexico who had and had not received the DARE program 11 months before. Rosenbaum et coll. (1994) report on a study in*

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[33] Roberts, G., *et al.*, *op. cit.*, page 171.

[34] Sherman, L.W., *et al.* (1997), *Preventing Crime: What Works, What Doesn't, What's Promising.* A Report to the United States Congress, Washington, DC: US Department of Justice.

which 12 pairs of schools (involving nearly 1,600 students) were randomly assigned to receive or not receive DARE. Although some positive effects of the program were observed immediately following the program, by the next school year no statistically significant differences between DARE and non-DARE students were evident on measures of the use of cigarettes or alcohol. […] These studies and recent media reports have criticized DARE for (a) focusing too little on social competency skill development and too much on effective outcomes and drug knowledge; (b) relying on lecture and discussion format rather than more interactive teaching methods; and (c) using uniformed police officers who are relatively inexperienced teachers and may have less rapport with students.
[…]
In summary, using the criteria adopted for this report, DARE does not work to reduce substance use. […] No scientific evidence suggests that the DARE core curriculum, as originally designed or revised in 1993, will reduce substance use in the absence of continued instruction more focused on social competency development. [35]

This information is in the public domain. It has been available for many years. Considering the limited resources available for the prevention of drug abuse in Canada, federal authorities and the RCMP ought to have looked at that information before deciding to implement even a Canadian version of the DARE program. Beyond the rhetoric that may please some, there are in this case–and this is so rare that we must take advantage–comprehensive studies which show that the program is not meeting its stated goals.

The same study identifies other programs that are much more likely to have a positive impact on drug use and abuse, in particular programs that develop social skills. The Canadian compendium also describes a number of programs that have undergone equally comprehensive evaluation and have shown positive results.

Like one of our witnesses, we seriously question the police-led practice used to deliver drug education in schools:

I have a quick aside about police-led drug education. We, personally, have some concerns with police officers teaching many hours of drug education in the classroom. We do not think it is sustainable financially to have paid police officers in at every grade level teaching hours and hours of drug education. Teachers - classroom teachers - are trained to be educators and that includes how to build self-esteem, how to make kids feel more capable. In addition, we know there are good, well-intentioned police officers, but our concern is that some of them do not, in our view, have sufficient training to do the type of education that is required. I am also concerned that the DARE program in the United States is now starting a whole new initiative. […] they still are not addressing a very fundamental question, which is, 'who is the best person to deliver these?'

We have heard concerns from students and teachers that police-led drug education can be more authoritarian and that it can come across not so much as helping kids to make their own carefully thought out choices, but more to lead them into one specific choice. [36]

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[35] *Ibid.*, pages 5-33 to 5-35.

[36] Art Steinmann, Executive Director, Alcohol-Drug Education Service, testimony before the Special Senate Committee on Illegal Drugs, First Session, 37th Parliament, October 29, 2002, Issue 10, page 86.

We believe that there is a need for **education about psychoactive substances, forms of use and the related risks. But we also believe that there is a need to rethink the approaches being used and that police officers, if they must be involved, should neither develop the programs nor deliver them to students.**

Lists of risk and protective factors and of successful programs aside, it is key to have a holistic vision of prevention, because drugs are part of a complex social, cultural and historical environment. Analysis of the debate over prevention and prevention practices shows that one of the risks lies in putting forward a reductionist and mechanistic view of personal and community health. We observed in Chapter 6 that the available data showed an increase in marijuana use among high-school students. We also saw in Chapter 10 that public opinion is perhaps more tolerant than it used to be. And we have seen in this chapter that little has been done in the area of prevention. Does this mean, as the Canadian Centre on Substance Abuse has said, that the increase in use is merely the result of all these factors combined?

> *The resurgence of drug use we are now witnessing is led largely by mainstream youth, indicating that we may have paid a heavy price for changing our focus and neglecting this group in Phase II (*of Canada's drug Strategy*). Ultimately we must aim our prevention messages at all youth. The Centre believes that all young people-drop-outs and A students alike-are vulnerable to drug use and should be viewed as an at-risk population.* [37]

Is it really the effect of the prevention initiatives taken in the first phase of the strategy (1987-1992) that accounts for the relative decline in use during that period? Is it really the absence of debate and prevention practices in the 1990s that accounts for the increase in use? Strictly speaking, no one knows. Not only was there no evaluation of the first phase of the national strategy, but even the most comprehensive evaluation might not have been conclusive. The increase in use in the 1990s could just as easily have been the result of a series of entirely different factors, such as cutbacks in government services, the decline in the youth labour market or even globalization of world markets, which makes people feel powerless to change their living conditions. There might even be other factors of which we are not yet aware.

In the United States, the use of illegal substances decreased between 1982 and 1991, then started to rise again in 1993. Did policies and approaches change? Incarceration rates for drug-related crimes certainly did not drop. At least as much money was spent on prevention and education programs. The rate of alcohol use among youth under 17 also decreased; can that be attributed to the same factors? Inversely, the proportion of smokers in the population hardly changed at all despite equally or more aggressive awareness and prevention campaigns. What do we make of this? The decrease in illegal drug use may be attributable in part to "war on drugs"

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[37] Canadian Centre on Substance Abuse (1996), *Canada's Drug Policy. Brief to the Standing House of Commons Committee on Health,* Ottawa: author.

policies, but that is by no means a completely satisfactory explanation. And we also have to consider the social and economic cost.

> *The U.S. government's 'War on Drugs' resulted in a tremendous expansion of resources applied to supply reduction and interdiction efforts focused on illegal drugs and in increasingly harsh criminal sanctions against users, including those caught in possession of relatively small amounts of illegal drugs. These policies have apparently had little effect on the availability of addictive drugs or on reducing abuse. They have fueled higher costs associated with prison construction and a tremendous increase in the prison population, leading some to call for legalization of currently proscribed drugs such as marijuana and cocaine.* [38]

Through all of this, there is little room for a less mechanistic view of individuals. We were reminded of this by J.F. Malherbe in the paper he wrote at our request:

> *The human experience is always complex and multifactorial, and no statement of risk referring to a single factor has any meaning for an individual subject (even though certain correlations appear to be well established). The future cannot be predicted for a singular individual on the basis of statistical information. We can therefore wonder at times about the level of scientific training (or honesty) of doctors who confuse "statistical correlation" with "risk factors" and "causes". It is true, however, that it is more convenient to "preach" to people about the causes of cancer than to support and inform them in the often chaotic advance of their freedom toward fuller responsibility for themselves, for others and for the fragile biosphere to which we belong.* [39]

Professor Malherbe went on to say:

> *The true harm, the worst of all, the most intolerable, the only one that must absolutely be repressed is wanting to make people happy by deepening their fear of disease and death, without asking each individual to make personal choices and realize his or her preferences. The true, the only harm stems from health ideology, from the* furor sanandi, *which sketches out our happiness without us being able to enjoy it.*
> *Does this mean that everything should be permitted without distinction? Of course not. But the test is still to discover step by step through our trials and errors, and it cannot be imposed on us by experts – doctors or economists – in the name of a prior and death-causing order. The joy of fertile disorder is better for life than the boredom of a type of planning, the arbitrary nature of which equals nothing but sterility.* [40]

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[38] Hawkins, D.J., M.W. Arthur and R.F. Catalano (1995), "Preventing Substance Abuse", in Tonry, M., and D.P. Farrington (eds.), *Building a Safer Society: Strategic Approaches to Crime Prevention, Chicago: University of Chicago Press,* page 344.

[39] Malherbe, J.F. (2002), *The contribution in defining guiding princples for a public policy on drugs.* Document prepared for the Special Senate Committee on Illegal Drugs, Ottawa: Senate of Canada, page 7.

[40] *Ibid.,* page 10.

Moreover, prevention, especially in schools, must provide a forum for open discussion that makes young people accountable and permits the acculturation of substances. Demonization and indoctrination can never take the place of education.

RISK REDUCTION AND HARM REDUCTION

The harm reduction approach has become a preferred tool in preventing AIDS/HIV contamination through intravenous drug use. It was discovered in the late 1980s that IV drug users were a key vector for the transmission of HIV. Needle exchange programs came about as a result.

However, the harm reduction approach creates a number of conceptual and theoretical problems. The first problem is terminology. "Harm reduction" is the term most commonly used in English, but "risk reduction" is also sometimes used. In French, "harm reduction" has been rendered as "*réduction des méfaits*", but also as "*réduction des dommages*" and "*réduction des risques*".

Further, the concept and practice of harm reduction have been criticized by some observers who see them as veiled strategies for legalizing drugs.

> *When I say a 'harm reduction drug policy,' I do not mean as we have already initiated in the response to drugs so far. We have tried many things such as needle exchanges and we have tried a harm reduction approach to drinking and driving. I have developed many programs for youth, which is my specialty. If I were called upon to develop a program to teach youth with any certainty about how to use drugs that are now illegal in a safe and moderate way, I do not think I could do so. Drugs fundamentally have effects. They do affect us. For example, it may be the cleanest heroin in the world, but is the person functioning in the family and at work, and are they able to pay for the habit that they will develop? Those are questions that need to be answered.*
>
> *When I use the term, I mean harm reduction as it has been promoted. The term has become sullied, unfortunately. It began as a noble thing, but has become a key code word for decriminalization or legalization of substances. I would caution you against using the term as it is.* [41]

Granted, harm reduction strategies are often on a collision course with law enforcement strategies: the situation has arisen often in cities across Canada where heroin addicts leaving needle exchange clinics come face to face with police.

The term "harm reduction" refers more specifically to strategies aimed at reducing the adverse effects of drug use on health, economic status and the social environment for users and those around them.[42] In addition to needle exchange, harm

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[41] Dr. Colin Mangham, page 73.

[42] See, for example, the work of D. Riley (1996), *Harm Reduction: Concepts and Practice. A Policy Discussion Paper*, Canadian Centre on Substance Abuse, and the discussion paper Dr. Riley prepared for Senator Nolin.

reduction strategies for drug users include such measures as prescription methadone for heroin addicts, medically supervised prescription heroin programs and "safe injection rooms", or clinics where no prescription is required. Canadian stakeholders agree that these measures are underdeveloped in Canada. Health Canada recently announced that a prescription heroin program would be tested in three major cities. The number of methadone places is said to be insufficient. Moreover, there are no safe injection rooms.

What are the implications of a harm reduction strategy for cannabis? What applications might there be for such a strategy? Harm reduction strategies related to heroin, for example, have been based on knowledge of some of the harmful effects of injecting the drug: HIV and hepatitis C for users (needle exchange programs), unsanitary conditions and risk of violence in places where the drug is injected (safe injection rooms), and petty property crime to get money to buy drugs (prescription heroin). In order to develop harm reduction strategies, we therefore have to know at least something about the ways the drug is used and its direct and indirect harmful effects. What are the harmful effects of cannabis?

We identified some of those harmful effects in Chapters 7 and 8. They include:

- risks for youth under 16 because of their physiological immaturity, in particular the immaturity of their endogenous cannabinoid system;
- risks associated with use that could be described as "occupational" (as opposed to recreational): the person uses marijuana alone, in the morning, to do school work or to carry out a job;
- risks associated with heavy, frequent use over a long period;
- risks associated with inhalation over a long period;
- risks associated with impaired driving, especially when the marijuana is mixed with alcohol.

Based on this knowledge, harm reduction strategies could be developed for cannabis:

- discourage use by youth under 16;
- detect at-risk users, especially among youth;
- provide information on the risks of inhaling and point out that deep inhalation is part of the folklore and is not necessary to obtain the effects;
- use strong measures to discourage impaired driving.

Obviously, like harm reduction strategies for other drugs, these tools are based on recognition of use and an approach that does not call for abstinence. We know full well that these two points may elicit strong reactions from those who believe that cannabis is fundamentally dangerous and may put us at odds with the current legal context.

CONCLUSIONS

Prevention is necessary. Keeping our guiding principles in mind, prevention must be part of a vision of the role of governance as a way of fostering human initiative and a vision of ethics and public health that focus on autonomy. In that sense, it is not an instrument of control, but rather a tool to help set people free. And in the case of cannabis, being set free does not mean not using, but rather having the ability to take a position on and think about the reasons for using and the ability to deal independently with at-risk behaviour.

Conclusions – Chapter 16	
On prevention	➢ **A national drug strategy should include a strong prevention component.** ➢ **Prevention strategies must be able to take into account contemporary knowledge about drugs.** ➢ **Prevention messages must be credible, verifiable and neutral.** ➢ **Prevention strategies must be comprehensive, cover many different factors and involve the community.** ➢ **Prevention strategies in schools should not be led by police services or delivered by police officers.** ➢ **The RCMP should reconsider its choice of the DARE program.**
On evaluation	➢ **Prevention strategies must include comprehensive evaluation of a number of key measurements.** ➢ **A national drug strategy should include mechanisms for widely disseminating the results of research and evaluations.** ➢ **Evaluations must avoid reductionism, involve stakeholders in prevention, be part of the program, and include longitudinal impact assessment.**
On harm reduction	➢ **Harm reduction strategies related to cannabis should be developed in coordination with educators and the social services sector.** ➢ **Harm reduction strategies related to cannabis should include information on the risks associated with heavy chronic use, tools for detecting at-risk and heavy users, and measures to discourage people from driving under the influence of marijuana.**

CHAPTER 17

TREATMENT PRACTICES

With the exception of the treatment given to offenders imprisoned in federal institutions and Aboriginals, the care available to individuals who are substance-dependent is essentially the responsibility of the provinces and territories. This chapter will therefore be brief since we received only a few submissions and heard few witnesses on this question.

In order to place the discussion in context, we should begin by noting certain data concerning dependency induced by cannabis and its derivatives. We shall then examine the various forms of treatment that are available. Finally, we shall take a brief look at the state of knowledge concerning the effectiveness of these treatments.

CANNABIS DEPENDENCY

Let us first clarify the terminology. We saw in Chapter 7 that, while the word addiction is used most often to refer to those who have a problem of dependency on psychoactive substances, the WHO recommended as long ago as 1963 that this expression not be used because of its vagueness. We prefer to use the term dependency for at least two reasons. First, it is more encompassing and may include different types of addictive behaviour: substance-related (food, alcohol, illicit drugs) and activity-related (gambling, sex, extreme sports, etc.). In the cases of substances, it is also more specific, referring to both the physical and psychological components of dependency. We share the distinction made by the WHO between physical and psychological dependency:

> [Translation] … *psychic dependency is a 'state in which a drug produces a feeling of satisfaction and a psychic urge that requires period or ongoing administration of the drug in order to cause pleasure or to avoid discomfort'.*
> *Physical dependency is an 'adaptive state marked by the appearance of intense physical problems when the administration of the drug is delayed or its action is counteracted by a specific antagonist. These*

> *problems, that is the symptoms of withdrawal or abstinence, consist of symptoms and signs of a physical or mental nature that are characteristic of each drug.* [1]

And third, it is a more neutral term. While dependency is described as a state induced by the prolonged and abusive consumption of a substance, addiction has a connotation of mental illness, indeed a moral connotation. Some authorities such as NIDA, for example, do not hesitate to classify addiction as a true illness that has certain genetic components. Seen in this way, drug use triggers biophysiological mechanisms that lead to addiction. Hence the focus on abstinence. Treatment programs in Canada tend to regard dependency as a bio-psychosocial phenomenon; "*[h]owever, support for the various modifications of the disease model continues in some service sectors*".[2] It is interesting to note that more rehabilitation programs for alcoholism (51%) than programs for 'addiction' (47%) accept a harm-reduction strategy and thus objectives other than abstinence.[3]

These precisions made, the Committee noted the ambivalence in the terminology, depending on the language. The English name of the *Centre canadien de lutte contre l'alcoolisme et la toxicomanie* [Canadian centre for the battle against alcoholism and addiction] is the Canadian Centre on Substance Abuse (centre canadien sur l'abus des substances). The French title of the brochure published by the Department of the Solicitor General describing the Department's activities is *La lutte contre la toxicomanie* [the battle against addiction] while the English title is *Countering Substance Abuse* (combattre l'abus de substances). The name of a government organization in Quebec is the *Comité permanent de lutte à la toxicomanie* [standing committee on the battle against addiction]. In addition to projecting a strong moral thrust, the French word "*toxicomanie*" evokes a vocabulary of struggle and combat, whereas the term substance abuse is more neutral and we might even go so far as to say more measured. However, the difference between the two languages cannot be explained by the lack of an appropriate noun in French: *dépendance* is the equivalent of drug addiction, and some in French even use the term addiction. A little rigour and clarity would be beneficial in light of the emotion surrounding the debate about drugs.

Having distinguished between use, at-risk use and excessive use, we feel that we should logically avoid the term drug addiction to refer to dependency induced by excessive use. Moreover, federal government departments and agencies should modify their terminology and ensure that both language versions are in accordance.

How common is cannabis dependency? In Chapter 7 we determined that physical dependency on cannabis was definitely rare and insignificant. Some symptoms of

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[1] WHO (1964), *Comité d'experts des drogues engendrant la dépendance*, Technical Reports Series, No. 273, quoted in Caballero and Bisiou, *op. cit*., pages 5-6.

[2] Roberts, G. and A. Ogborne (1998), *Profile: Substance Abuse Treatment and Rehabilitation in Canada*, Ottawa: Canada's Drug Strategy, Department of Health, page 20.

[3] *Ibid.*

addiction and tolerance can be identified in habitual users but most of them have no problem in quitting and do not generally require a period of withdrawal.

As far as forms of psychological dependency are concerned, the studies are still incomplete but the international data tend to suggest that between 5% and 10% of regular users (at least during the last month) are at risk of becoming dependent on cannabis. If we recall that approximately we estimated that approximately 3% or 600,000 adult Canadians have consumed cannabis in the last month and that approximately 100,000 or 0.5% use it on a daily basis; this indicates that somewhere between 30,000 and 40,000 might be at-risk and 5,000 to 10,000 might make excessive use. For 16 and 17 years old, the numbers were between 50,000 and 70,000 at-risk and 8,000 to 17,000 potentially excessive users. The data also indicated that the peak period for intensive use is between 17 and 25 years. These broad parameters indicate where to look to prevent dependency and offer treatment services for those in need.

What form does cannabis dependency take? Most of the authors agree that psychological dependency on cannabis is also relatively minor. In fact, it cannot be compared in any way with tobacco or alcohol dependency and is even less common than dependency on certain psychotropic medications. Ceasing to consume the substance for two to four weeks, which can be accompanied by certain symptoms similar to those involved in nicotine withdrawal (insomnia, irritability, perspiration, etc.), is usually sufficient to cause the symptoms to disappear. When treatment is necessary, in the case of some people, it does not take as long as and is less difficult than the corresponding treatment for dependency on alcohol or "hard" drugs. It is also worthy of note that those seeking treatment for cannabis dependency are younger than those who receive treatment for dependency on other drugs. A number of factors may explain this situation: consumption of cannabis is more a phenomenon of youth than that of other substances, reaching its peak when young people are in their early twenties and declining significantly when they reach their thirties. Young people who need treatment also display problems of multiple addiction since cannabis is not the only drug they consume.

Overcoming dependency or consumption that the user regards as abusive is often a matter of personal choice and does not necessarily require therapeutic intervention.

> *There is the phenomenon called spontaneous remission. Many people, when they get into their thirties either stop using drugs altogether or tone down their habit. There is an obvious phenomenon of maturity in terms of drug use.*
>
> *Among long-term users, we also see the retirement phenomenon, that is these individuals become fed up of their drug-using lifestyle. These individuals lose interest in the ongoing quest for drugs and for the pleasure that these drugs can provide them. In fact, it can be equated with a type of cost benefit analysis, whereby as the individual gets older, he/she decides that the habit is no longer worth it. The individual considers that the negative impact of his/her habit is no longer worth it.* [4]

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[4] Dr. Céline Mercier, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, Thirty-Seventh Parliament, First Session, December 10, 2001, Issue 12, page 9.

> *While most people who experience substance abuse problems do not receive help, there is good evidence that people exposed to some types of treatment subsequently reduce their use of psychoactive substances and show improvement in other life areas. In general, treatment outcomes are improved when appropriate treatments are also provided for significant life problems (communications problems, lack of assertiveness, unemployment).* [5]

There is every reason to believe that, as far as cannabis is concerned, most problem users do not make use of the various forms of treatment and probably do not need any, firstly because the effects of cannabis are not as marked as those of other drugs and secondly, because cannabis users are more likely to be integrated into society than hard-drug users, which enables them to make use of their natural support groups. The third reason, in our view, why most cannabis users can avoid the trajectory of dependency is the fact that its use is not associated with "degenerate addiction" in the view of society or in the popular imagination, unlike the use of heroin, for example. Furthermore, a Canadian study has indicated that "*few (3%) users of illicit drugs, identified in a population survey, reported seeking any kind of help for drug problems*." [6]

Nevertheless, as in the case of any psychoactive substance, some people opt for or need treatment.

> *It has in fact been observed in groups undergoing treatment - and this is a theory - that there are two groups of people trying to stop using. First, there are people who have mainly used opiates on a regular basis for six or more years. Second, there is the group of users who have been using for two years or less and no longer want to deal with the secondary effects of drugs.* [7]

The decision to seek treatment is determined in particular by the increase in social and personal problems that use of a substance may cause and by the fact that it is often combined with problems of a psychiatric nature.[8] Women systematically make fewer requests for specialized drug and alcohol treatment services; this situation can be explained by the fact that fewer services are available and women are otherwise looked after by traditional psychiatric services.

However, people do not always choose or at least not totally. Family pressures or pressure in the work place and, in some cases, orders made by judges are only some of the factors that lead people to seek treatment. Furthermore, little is known about the trajectories of people who abuse drugs and especially those who seek treatment for the problem. For example, we do not know to what extent the search for treatment is more the result of other earlier problems–family or psychiatric problems–than of the actual use of the substance itself. In the case of drug users who also have problems with the

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[5] Robert, G. and A, Ogborne (1999) *Best Practices: Substance Abuse Treatment and Rehabilitation*, Ottawa: Canada's Drug Strategy, page 9.

[6] Roberts and Ogborne (1999) *op. cit*, page 59.

[7] Dr. Céline Mercier, *ibid.*

[8] Roberts and Ogborne, *op. cit*, page 60.

law and a career of delinquency, deviant and delinquent behaviour often precedes the start of a trajectory of drug dependency, as we saw in Chapter 6. Demand for treatment in these cases will result at least as much from a desire – or indeed obligation – to put an end to a criminal career as from the detrimental effects of using the substance.

Can people be forced to seek treatment? That was one of the questions raised by the introduction in France of a requirement to seek care in the 1970 Law respecting narcotics, which has now taken the form of a therapeutic injunction,[9] and of drug courts in Canada, as we saw in Chapter 15.

Certain sections of the *Criminal Code* deal with the issue of requiring offenders to seek treatment for problems related to alcohol and drugs. For example, where a court is making a probation order, it has the discretion to require, as a condition to the probation order that:

- The offender, if he or she agrees, participate actively in a treatment program approved by the province, subject to the program director's acceptance; and
- The offender visit a treatment facility for assessment and curative treatment in relation to the consumption by the offender of alcohol or drugs that is recommended pursuant to the program (where a program has been established in a province).[10]

In addition, when a court imposes a conditional sentence, one of the optional conditions of the probation order may be that the offender participate in a treatment program approved by the province.[11]

If a person has not been convicted of a criminal offence, it is unlikely that a court will order treatment for alcohol or drug problems, with some exceptions. For example, persons falling under the authority of provincial mental health legislation may be detained because of mental health problems. Such legislation regulates and limits when a person may be confined against their will.

The reluctance of courts to detain a person for substance abuse problems is illustrated in the Supreme Court of Canada decision in *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*.[12] In this case, a young Aboriginal was five months pregnant with her fourth child and was addicted to glue sniffing, a practice which may damage the nervous system of the developing foetus. The Winnipeg Child and Family Services requested assistance from the courts to involuntarily secure the mother in treatment. The case revolved around the issue of the rights of the unborn child, and the Supreme Court of Canada found that neither tort law nor the court's *parens patriae* jurisdiction supported an order for the detention and treatment of a pregnant woman for the purpose of preventing harm to the unborn child.

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[9] We describe the French system in greater detail in Chapter 20.
[10] *Criminal Code*, paragraphs 732.1(3)(g) and (g.1).
[11] *Criminal Code*, paragraph 742.3(2)(e).
[12] [1997] 3 S.C.R. 925.

In France, the therapeutic injunction has been harshly criticized, especially because it involves enforced treatment. The question is still open despite the guarded assessments that have been made of the results of this practice.[13]

> *The therapeutic injunction system has been in place in France since 1970. A study by a colleague at the* Institut national de santé et de recherche médicale, *in France, showed that many people fell through the cracks because of the therapeutic injunction forcing them to follow a treatment program. These people were never treated, because there were not enough places or follow-up. If we want to set up drug courts in Canada, we shall have to plan effectively and organize consultation mechanisms with the treatment systems to ensure that the required treatment services are available. If we fail to do this, setting up drug courts will be nothing more than a sham, if the people requiring treatment fall through the cracks of the system.* [14]

It is estimated that approximately 10% of the offenders imprisoned in federal institutions are there for offences under the *Controlled Drugs and Substances Act.* Moreover and more importantly, it is estimated that at least 50% of all inmates, whether in provincial prisons or federal detention centres, have dependency problems (drugs and alcohol).[15] Generally, few of these inmates receive any kind of treatment. In the United States, studies indicate that fewer than 10% of inmates receive treatment for dependency problems while they are in prison.[16]

In the case of provincial institutions, this situation can be explained by the short duration of the sentences and by the budget cuts made in correction institutions in the early 1990s. In the case of federal institutions, treatment programs are available but they are still very far from meeting the needs. Furthermore, it may be somewhat ironic to offer treatment programs in institutions where drugs circulate freely and where it is not uncommon for the inmates to have access to cannabis in particular.

Nevertheless, the treatment offered to inmates is an essential component of their reintegration into society given the magnitude of the problems caused by dependency on drugs, especially harder drugs, and alcohol.

One final comment: some of the people who appeared before us observed that in certain cases cannabis maintenance could be used in combination with other forms of withdrawal and treatment for dependency on opiates.[17] To the best of our knowledge, there are no studies on the subject–for good reason! However, we should note, as we did in Chapter 5, that cannabinoid and opioid systems engage in complex interactions,

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13 Simmat-Durand, L. (1999), "Les obligations de soins en France", in Faugeron, C., (ed.) *Les drogues en France. Politiques, marchés, usage,* Paris: Georg.

14 Dr Serge Brochu, Professor in the School of Criminology at the Université de Montréal, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, Thirty-Seventh Parliament, First Session, December 10, 2001, Issue 12, page 25.

15 Brochu, S. (1995) *Drogues et criminalité. Une relation complexe.* Montréal : Université de Montréal.

16 Lipton, D.S. (1995) *The effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision.* Washington, DC: National Institute of Justice.

17 Among others at a private meeting with staff of the Vancouver Compassion Club.

and we may be justified in assuming that the consumption of Δ9-THC could cause a dopaminergic response that could reduce opiate withdrawal.

FORMS OF TREATMENT

The 1992 study by Single on the cost of alcohol and drug abuse estimated the cost of specialized treatment for dependency at approximately $290 million. But it would be misleading not to specify that the largest share of treatment dollars is for alcohol: in the case of residential treatment, $180 million was for alcohol and $21 for illicit drugs and in the case of non residential treatment, $82 for alcohol and $8 for drugs.[18]

Most of this money is provided by the provinces and territories. The federal government directly funds rehabilitation for members of the First Nations living on reserves, members of the RCMP and the Armed Forces, inmates in federal institutions and those who have not lived long enough in a province to qualify for the provincial health insurance plan.

This said, the limited resources devoted to treatment of dependency and the growing pressures in terms of the number and diversity of clients, mean that the availability of treatment is limited.

> *Many agencies have received significant cutbacks in recent years. Possibly exacerbating the situation, substance abuse organizations are increasingly being asked to address problem gambling. … Similarly, Bill C-41, which permits court-ordered substance abuse discretion, has an impact on substance abuse treatment at a judge's assessment and treatment resources.* [19]

It is probably not an exaggeration to say that the area of addiction treatment is totally fragmented among the individual practices used by therapists, support and assistance groups, such as addicts anonymous, and therapeutic communities; and among pharmacological, cognitivist and behavioural approaches, psychoanalytic, humanist and systemic approaches; among the proponents of freedom of choice for the user and those who promote enforced treatment. Virtually every possible approach to and form of treatment is available.

Recent reports produced for Health Canada bear witness to this. The Profile of Substance Abuse Treatment programs indicates that in 1998 there were at least 1,200 different treatment programs and approximately 7,200 professional counsellors across the country.[20] Included in these figures are outpatient, day or evening treatment, short-term and long-term reisdential, outreach and crisis treatment programs. The breakdown by province and territory may indicate where priorities are set.

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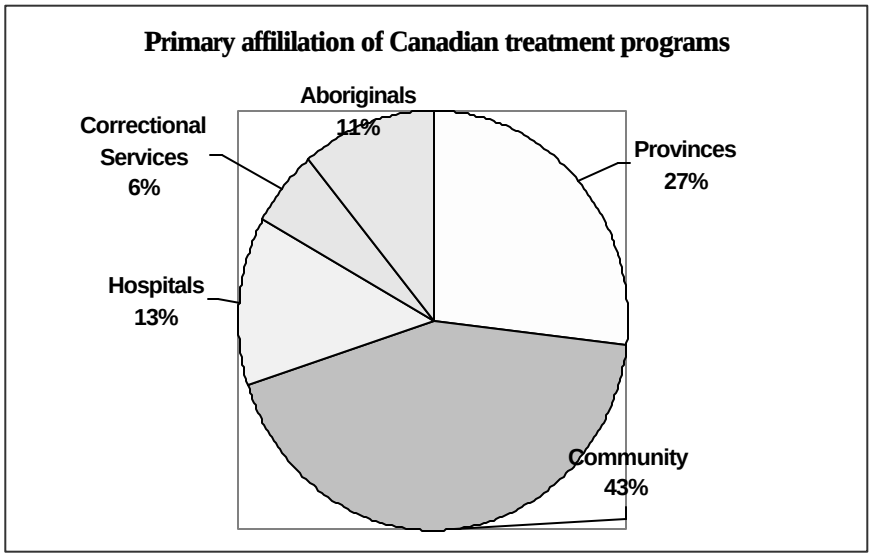
[18] Single, E., et. al., *op. cit*., page 42.
[19] Roberts, G. and A. Ogborne, *op. cit,* page 23.
[20] *Ibid.,* page 6.



Substance abuse treatment services offered across Canada[21]

	Outpatient	Day/Even. Treatment	Short-term residential	Long-term residential	Outreach	Crisis	Total
Nfld	13	2	5	0	2	7	29
NS	9	7	7	6	9	4	42
PEI	2	1	1	1	1	2	8
NB	5	3	3	2	3	5	21
Qc	72	52	59	43	48	44	318
Ont	110	55	43	51	61	64	384
Man	12	5	8	10	8	10	53
Sask	24	9	10	5	14	14	76
Alta	41	22	22	13	14	27	139
BC	128	43	39	28	70	77	385
NWT	7	5	3	2	7	7	31
Yukon	2	1	2	0	0	2	7
TOTAL	425	205	202	161	237	263	1493

The primary affiliation of these programs also gives an indication of their orientation. Fully 43% of existing treatment programs are community-based. One of the implications of this fact is that funding is never secure. Overall, the programs may be broken down as follows:[22]

[21] *Ibid.*, page 8.
[22] *Ibid*, page 14.

In terms of the therapeutic approaches used, 31% make use of confrontation and 40% of psychotherapy, but there are very broad differences between individual provinces and territories and even within a given province.[23]

EFFECTIVENESS OF TREATMENT

Once again we should stress the fact that we are not able to discuss specific treatments for cannabis dependency. To our knowledge, no study assessing the effectiveness of these treatments has been completed. Furthermore, of all the treatment and rehabilitation programs that exist in Canada, approximately 14% have been the subject of independent assessments.[24]

Despite the lack of systematic data, it may be possible to state that approaches to treatments for drug dependency are primarily cognitivist and behaviourist in nature. In the cognitivist approaches, an attempt is made primarily to increase the awareness of the fact that a dependency problem exists: objective information and mechanisms of introspection are used to facilitate this awareness. In the behaviourist approaches, the treatments are designed to facilitate changes in lifestyle. It is known, in fact, that drug taking is part of a way of life revolving around a group of acquaintances and involving the frequentation of specific locations. Changing these patterns will help to create a lifestyle in which these drugs are not used.

How effective is this approach? Most of the authors who have examined dependency treatment programs agree in saying that, beyond the humanistic

[23] *Ibid*, page 22.
[24] *Ibid.*, page 15.

dimensions of the treatment, there is a pool of knowledge indicating that they are relatively effective.

More specifically, most of the studies including those conducted in Quebec show that people who seek assistance in rehabilitation centres show improvement.

> [Translation] … *the people who undertake a rehabilitative approach as part of the services offered in Quebec improve their situation … this improvement is maintained for a period of six months to one year following the treatment. That is a positive and reassuring result. These results are to the same effect as a very large number of other studies conducted for the most part over the last twenty years.* [25]

In technical terms, the studies do not permit the conclusion that one approach is any more effective than another. The report prepared for Canada's Drug Strategy describes two mega-summaries of assessments of 24 different methods of treatment conducted in the United States and shows that, while the two groups of researchers agree on the effectiveness of a number of forms of treatment, they do not, on the other hand, agree entirely on the order in which they should be placed. We reproduce below the part of the table that shows the most effective approaches.[26]

Classification of effective methods of treatment according to two groups of authors

Holder Index	Method	Method	Finney and Monahan Index
18	Social skills training	Community reinforcement approach	59
17	Self-control training	Social skills training	37
13	Brief motivational training	Marital therapy, behavioural	36
12	Marital therapy, behavioural	Disulfiram, implants	34
6	Community reinforcement approach	Marital therapy, non-behavioural	21
6	Stress management training	Stress management training	12
3	Disulfiram, oral	Aversion therapy, chemical	3
3	Aversion therapy, covert sensitization	Psychotropic medication, anti-depressant	2

The studies do not permit us to conclude that the treatment as such makes a difference and, for some of the authors, the decision to register in a treatment program, no matter what form of treatment, would be more conclusive. The studies do not enable us to determine the ideal duration of treatment, but it would appear that the

[25] Michel Landry, *The impact on addicts of the treatments offered in Quebec.* Brief submitted to the Senate Special Committee on Illegal Drugs, November 2001.

[26] Roberts and Ogborne (1999) *op. cit*, page 9. Note that these treatments apply to all forms of dependency while most assessment studies relate to alcoholism.

effects of treatment level off after 9 to 12 months. In addition, it is difficult to determine the impact of the intensity of the treatment (how many hours per day, days per week).

Finally and most importantly, the positive impacts relate primarily to consumption habits and to the person's general psychological state. However, the treatments apparently have little effect on the reintegration of the individuals into society, which is a particularly important factor in the case of offenders.

As a final point, treatment is more effective and certainly less expensive than incarceration. In Canada, it is estimated that the cost of applying the drug court process is approximately $4,500 per person whereas imprisonment costs an average of $47,000. Even with a success rate of 15%, there can be no doubt that treatment both benefits society and better reflects the real needs of offenders who have problems of dependency.

Speaking more generally, cost-benefit ratio of the treatment has been recog ized:

> *Evidence for the economic benefits of treatment for problems with drugs other than alcohol comes from a large study of drug treatment in the United States (Hubbard et al., 1989). This study involved more than 10,000 drug users and 37 treatment programs that represented three main treatment modalities: methadone maintenance treatment, drug-free outpatient counselling and therapeutic community. … Two summary measures of these costs were developed: costs to law-abiding citizens, and costs to society. The cost to law-abiding citizens included those associated with crime-related property loss or damage, reduced productivity because of injury or inconvenience occasioned by drug-related crime, and the costs of criminal justice proceedings. Costs to society included cost to victims of drug-related crime, criminal justice costs and "crime/career/productivity costs" incurred when drug users are not involved in earning a legitimate income. The results showed that, in the population studied, both types of costs were lower after treatment than before and that pre-post differences in costs exceeded the costs of treatment.* [27]

[27] Roberts and Ogborne, (1999) *op. cit.*, page 68.

CONCLUSIONS

Conclusions of Chapter 17	
	➢ **The expression drug addiction should no longer be used and we should talk instead of substance abuse and dependency.** ➢ **Between 5% and 10% of regular cannabis users are at risk of developing a dependency.** ➢ **Physical dependency on cannabis is virtually non-existent.** ➢ **Psychological dependency is moderate and is certainly lower than that for nicotine or alcohol.** ➢ **Most regular users of cannabis are able to diverge from a trajectory of dependency without requiring treatment.** ➢ **There are many forms of treatment but nothing is known about the effectiveness of the different forms of treatment for cannabis dependency specifically.** ➢ **As a rule, treatment is more effective and less costly than a prison sentence.** ➢ **Studies of the treatment programs should be conducted, including treatments programs for people with cannabis dependency.** ➢ **Studies should be conducted of the interaction between the cannabinoid system and the opioid system.**

CHAPTER 18

OBSERVATIONS ON PRACTICES

In previous chapters, we described public action by dividing it up into the major sectors of involvement. Before closing the third part of this report, we would like to make some general observations that cut across the individual areas we have examined. The first concerns difficulties in harmonizing the various levels and sectors of involvement; the second, the difficulty in co-ordinating their various approaches; and the third, the costs of drugs and public policy.

DIFFICULTIES IN HARMONIZING THE PLAYERS

Without reopening the debate on the division of power and responsibilities among the various levels of government, we consider it obvious that any public policy on illegal drugs, and cannabis in particular, applies to all three levels. Drugs affect education and health (primarily provincial jurisdictions), justice (a responsibility shared between the federal and provincial governments), public well-being and public safety (which involve all three levels), international relations (a federal responsibility), and even culture, science and research (essentially provincial). Thus we are attempting to make our way through a field that is at least tangled, if not chaotic.

Co-ordinating mechanisms do exist. On the most formal level, the federal-provincial-territorial Deputy Ministers of Health Working Group is responsible for co-ordinating the drug strategy. But we know almost nothing about their discussions, which are held *in camera*, or any concrete results.

The Canadian Centre on Substance Abuse (CCSA) is another coordinating mechanism, but only a few provinces have equivalent partners (Ontario, Manitoba, Alberta and Quebec, with some reservations). And the Centre has neither the budget, the infrastructure nor even the legitimacy, which it would derive from a clear mandate, needed to initiate a genuine national dialogue on the issue.

Yet another coordinating mechanism is the Health, Education and Enforcement in Partnership (HEP) network.. Established in 1994 by the CCSA, the HEP network is rooted in the balanced approach of Canada's Drug Strategy: seeking an equilibrium between supply reduction and demand reduction. HEP unites key players in the health

and enforcement fields in this common focus and includes other partners, notably in education, social services, correctional services and justice. On a national level, its Steering Committee is composed of representatives of the Addictions Foundation of Manitoba, the Canadian Association of Chiefs of Police (co-chair), the Canadian Centre on Substance Abuse (co-chair), the Correctional Service of Canada, the Canadian Federation of Municipalities, Health Canada, Justice Canada, the National Centre for Crime Prevention, the RCMP and the Solicitor-General. How many readers of this report, even among those actively engaged in the drug field, are aware of this partnership, its achievements, actions and benefits?

In Chapter 14, we examined the disparate response of police services across the country to the application of the law–between regions, provinces and territories and, within provinces and territories, between cities. In Chapter 15, we noted that all the evidence suggests that the same holds true of the judicial response. Chapters 16 and 17, on preventive practices and treatment respectively, described the same unequal or fragmented approaches.

In a federation like Canada, it is to be expected that differences in practice and direction will co-exist. How the issue of cannabis is seen and dealt with will not be the same in the greater Vancouver area, with its explosion of growers, as in Quebec, with its criminal motorcycle gangs, or as in Prince Edward Island, which has almost no problems with production or even with abuse of cannabis. The difficulties experienced in the downtown cores of major cities are not those of smaller urban centres. And First Nations people have their own quite specific problems.

Nevertheless, among other effects, the difficulties in harmonizing the action of different levels of government mean in concrete terms that:

- Results of a successful experiment in prevention conducted in one area of the country will not reach the players in another part.
- Therapeutic practices that have been proven to be ineffective will continue to be used elsewhere because the information is not circulated.
- There is no national knowledge infrastructure on use and use trends; for example, the few studies that have been conducted in school environments are not comparable and are not (all contemporary?).
- Some cities have adopted policies based on the idea of a drug-free society while others are focused on harm reduction.

Notably absent in the development of public policy is the civil society, especially community-based organizations (rehabilitation organizations, for example) and also user self-help support groups (including compassion clubs and groups of users of cannabis for therapeutic purposes).

The hyperbola that would make drugs into a bigger social issue than they actually are aside, it remains that the use of psychoactive substances, legal or illegal, and the resulting problems of dependency that may follow, concern every citizen, every level of

government, throughout the country. This is a *national issue.* That, unquestionably, the future and quality of our health system, the protection of our national interests and security, the quality of education and the protection of the environment are even more important issues does not mean that drugs are not a *national priority.* Or should be, at least. Quite apart from its social and economic consequences, which will be discussed later, the drug issue should be a priority because it concerns the education of children and adolescents, affects the quality and safety of living environments, and causes suffering and wasted lives. Granted that this is not so much the case for cannabis, whose social and economic effects cannot be compared to those of alcohol, but, while agreeing that cannabis calls for a different approach, we cannot isolate it from other psychoactive substances. We need to develop a comprehensive national policy on drugs and addiction, within which cannabis would have a place.

Better harmonization among levels of government and with civil society would allow us to lay the foundations of a shared understanding of the issues presented by psychoactive substances, and above all to develop a common set of indicators for assessing the effectiveness of policies and actions.

INCONGRUITIES OF APPROACH

Some myths are long-lived. Although not supported by the empirical research we have examined, images of cannabis leading to use of hard drugs, damaging brain functions permanently, or causing academic failure, to name but these few, continue to abound.

We are well aware that there is no international consensus among researchers on these issues. But we are equally aware that it is difficult to alter preconceptions. Last year, at an international scientific conference in Europe, whose results we have already cited, some participants concluded that, although a consensus was emerging in the research community, its existence was irrelevant because all the countries represented were signatories of international conventions on drugs. One always finds ways to circumvent reality when it does not fit ideology.

Let there not be finger-pointing. Those who most frequently hold these beliefs about cannabis are also those who are confronted daily with the negative effects of drug abuse: crime and violence for the police officer on the beat; human misery for those in therapeutic practice. Their view of drugs, of cannabis in particular, is naturally coloured by their experience, which puts them in situations of contact with abuse, distress, violence and death. But those users who require treatment are no more representative of the cannabis user population than are the street kids and petty offenders the police see constantly.

Clearly, what is required is a bridge, an intermediary between the worlds of research and the front lines, between decision-makers and field workers and between

them all and civil society. While the research is not perfect, while we deplore the lack of a truly national system of information, the information is, nevertheless, there in quantity, as we have had occasion to observe in the course of our proceedings. But it needs wide circulation, and above all it needs to be the subject of public debate and discussion. The CCSA could disseminate this information and promote discussion, were it given the resources - a role it has never had the means to play.

The researchers themselves must bear some of the responsibility for the situation. They tend not to care whether their work reaches those in positions of power or whether it is distributed in political forums or in the field. Some are still shackled to the idea of "academic freedom," thinking that their involvement in the worlds of decision-making and practice will contaminate the objectivity of their research. It is thus not surprising that knowledge of the players on the ground is limited to what their experience provides; nor are the institutions to which they belong necessarily equipped to systematize and contextualize such knowledge either.

We have observed a serious gulf between the positions taken by the research community and those taken by front-line workers, including the police and the therapeutic community. It would be too easy to reduce the position of the practitioners to "corporate" interests. There is a need for basic discussion and exchange, which is not happening among the various players; and too often the experience-based knowledge derived from practice has no legitimacy in the eyes of the scientific community, though this is the knowledge that attracts the attention of the decision-makers, the media and the general public.

In practice, glaring contradictions arise between the discourse and the approach of the two sides. While young people hear about the potential therapeutic value of cannabis and about decriminalization, they see police operations in the schools and listen to classroom lectures on its dangers. While the primary targets of police action are supposed to be the traffickers, young people read that thousands of people are arrested every year for simple possession of marijuana. While images of junkies destroyed by heroin are flashed in the media, young people also hear that it is available by prescription. And drug users continued to be picked up by the police as they leave needle-exchange clinics. Caught between these contradictory words and actions, how should they know what to think?

These incongruities are exacerbated by the imbalance in power and resources. Non-profit groups that provide cannabis for therapeutic purposes talked about this at length: their credibility with law-enforcement agencies is often hard earned, built over time, with a few individual members of the police. They are well aware that their status is precarious and that they might have to "bail out" at any moment. Public health agencies that attempt to foster discussion and introduce harm-reduction practices are equally aware that they are operating at the outer limits of the law and that their actions are not universally supported. Researchers who wish to study the therapeutic applications of cannabis are restricted by the present system of prohibition.

In the case of alcohol, a decision-making structure exists to give a relatively equal voice to the various players involved. It includes the agencies that regulate production, distribution and sale, the public health organizations that work to reduce at-risk behaviours and clarify the determinants of abuse, the justice system that intervenes to prevent smuggling and arrest those irresponsible people who drive while impaired. The co-operation and dialogue among these players is close and constant, and there are even formal channels for co-operation and dialogue with the distilling and brewing industries. The result, by and large, is uniform practices and views, although this is not to imply that all problems have been solved. But in the field of illegal drugs, there is nothing like this. Dialogue where certain words cannot be spoken or ideas expressed, where certain decisions can never be made and resources are so unequally shared among the players, is merely empty an exercise meant to give the illusion that something is being achieved.

SIGNIFICANT ECONOMIC AND SOCIAL COSTS [1]

In 1996, the Canadian Centre on Substance Abuse published the first study on costs related to alcohol, tobacco and drug abuse in Canada.[2] Estimating costs raises difficult technical questions: what should be included, and how should each element be measured? The very analysis of public drug policies is predicated on the assumption that a number of the associated social costs can be reduced, if not eliminated altogether. These costs are of two major types: those associated with public policy, primarily the cost of prevention and suppression, as well as those of administering the policy; and the costs that would be avoided if the problems stemming from substance abuse were eliminated–the so-called "counter-factual" scenario. In these, the effects of drugs are treated as social costs, that is, as a diminution of the collective well-being. This amounts to saying that all the costs of drug abuse are social costs, or what economists call "externalities" or "spill-overs" – secondary rather than primary consequences.

Moral considerations aside for the moment, there is no doubt that use of drugs can have certain benefits–albeit short-term and to some extent non-rational ones–for the users, and even for those around them. Hyperactive individuals calmed by cannabis, those whose productivity is enhanced by the use of cannabis or whose mental or physical suffering is attenuated, or those who smoke a joint in the evening to relax or

---

[1] For an excellent discussion of these analyses and for some of the best studies on the subject, see the report prepared for this committee by Jackson, A.Y. (2002) *Costs of drugs and drug policy*. Ottawa, Library of Parliament, report produced for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegal-drugs.asp.

[2] Single, E. *et al*, (2002) *The Costs of Substance Abuse in Canada: a cost estimation study*. Ottawa, Canadian Centre on Substance Abuse.

help them sleep and are in better shape to work the next day as a result, are just a few examples. And they are not unusual cases.

From another point of view, the underground drug economy, not trafficking on a major scale, but small-scale neighbourhood supply, whether in poorer or wealthier areas, generates certain economic benefits and even some capacity to integrate socially. Entire families are supported by small-scale dealing. Houses, cars, travel and luxury clothing are financed by drug sales. The amount of the wealth they generate can be illustrated by the example of British Columbia. In this province alone the cannabis-based economy is estimated to be worth $6 billion annually. It can be assumed that a major part of this revenue, let us say half, goes to people who are otherwise well integrated socially and are not part of the criminal culture.

The analysis of social costs based only on externalities does not take into account the drug economy.

Ultimately it rests on another hypothesis, equally difficult to defend, which is that the money saved if the social costs of drug use were reduced could be invested elsewhere; in economic theory these costs are known as "opportunity costs". However, money saved on enforcement of cannabis laws would probably be redistributed within the police organization; other social costs might also arise from the substitution of other substances.

Having set out these caveats, Single's study produced the following table[3].

Total cost of alcohol, tobacco and illegal drugs in Canada, 1992

	Alcohol	Tobacco	Drugs	Total
1. Direct health care costs: total	**$1,300.6**	**$2,675.5**	**$88.0**	**$4,064.1**
1.1 morbidity-general care hospitals	666.0	1,752.9	34.0	2,452.9
-psychiatric hospitals	29.0	--	4.3	33.3
1.2 co-morbidity	72.0	--	4.7	76.7
1.3 ambulance services	21.8	57.2	1.1	80.1
1.4 home care	180.9	--	20.9	201.8
1.5 outpatient treatment	82.1	--	7.9	90.0
1.6 ambulatory care: doctors' fees	127.4	339.6	8.0	475.0
1.7 prescription medications	95.5	457.3	5.8	558.5
1.8 other health care costs	26.0	68.4	1.3	95.8
2. Direct losses in the workplace	**14.2**	**0.4**	**5.5**	**20.1**
2.1 EAP and health promotion programs	14.2	0.4	3.5	18.1
2.2 drug testing in the workplace	N/A	--	2.0	2.0
3. Direct administrative costs for transfer payments	**52.3**	**--**	**1.5**	**53.8**
3.1 social assistance benefits and other programs	3.6	--	N/A	3.6

[3] Single, E. *et al* (1996) *op. cit.*

	Alcohol	Tobacco	Drugs	Total
3.2 workers' compensation	48.7	--	1.5	50.2
3.3 other administrative costs	N/A	N/A	N/A	N/A
4. Direct costs for prevention and research	**141.4**	**48.0**	**41.9**	**231.1**
4.1 research	21.6	34.6	5.0	61.1
4.2 prevention programs	118.9	13.4	36.7	168.9
4.3 training costs for doctors and nurses	0.9	N/A	0.2	1.1
4.4 costs for behavioural modification	N/A	N/A	N/A	N/A
5. Direct costs of law enforcement	**1,359.1**	**--**	**400.3**	**1,759.4**
5.1 police	665.4	N/A	208.3	873.7
5.2 courts	304.4	N/A	59.2	363.6
5.3 correctional services including probation	389.3	N/A	123.8	513.1
5.4 customs and excise	N/A	N/A	9.0	9.0
6. Other direct costs	**518.0**	**17.1**	**10.7**	**545.8**
6.1 damages due to fire	35.2	17.1	N/A	52.3
6.2 damages due to traffic accidents	482.8	--	10.7	493.5
7. Indirect costs: loss of productivity	**4,136.5**	**6,818.8**	**823.1**	**11,778.4**
7.1 loss of productivity due to illness	1,397.7	84.5	275.7	1,757.9
7.2 loss of productivity due to death	2,738.8	6,734.3	547.4	10,020.5
7.3 loss of productivity due to crime	--	--	N/A	N/A
Total	**7,522.1**	**9,559.8**	**1,371.0**	**18,452.9**
Total % of GDP	*1.09%*	*1.39%*	*0.20%*	*2.67%*
Total per capita	*$265*	*$336*	*$48*	*$649*
Total % of all costs related to substances	*40.8%*	*51.8%*	*7.4%*	*100.0%*

An examination of these data indicates:

- In 1992, the costs associated with all illegal drugs were $1.4 billion, compared with $7.5 billion in the case of alcohol and $9.6 billion in the case of tobacco.
- Expressed as a percentage of the gross domestic product, the total costs for all substances was 2.67%. Of this, 0.2% was for illegal drugs, 1.09% for alcohol and 1.39% for tobacco.
- The principal costs of illegal drugs are externalities, that is, loss of productivity ($823 million), health care ($88 million), losses in the workplace ($5.5 million), for a total of about 67% of all costs related to illegal drugs.
- The cost of public policies, or opportunity costs, represent about 33% of what.

- The cost of enforcing the law represents about 29.2% of all costs, or about 88% of all policy costs. The balance goes to prevention, research and administration.

Previous studies conducted in British Columbia (1991), Ontario (1988) and Quebec (1988), using different methodologies, established costs of $388 millions, $1.2 billion and $2 billion respectively, for a total cost of $3.5 billion for these three provinces alone.[4] These figures demonstrate the extent to which such estimates can vary, according to the methodology selected and the availability of data.

Nevertheless, with the CCSA study taken as the standard, two comments must be made. First, loss of productivity–the major cost–is measured in mortality ($547 million) and morbidity ($275 million). Except in the case of traffic fatalities, cannabis is not a cause of death and involves none of this type of social cost. Morbidity corresponds to losses attributed to problems caused by drug use as measured by the difference between the average annual income of users and of the population in general. Here, two further observations about cannabis should be noted. A large proportion of cannabis users are young people who are not yet part of the workforce; and cannabis use involves none of the addiction and attendant problems that follow from heroin or cocaine use. It is, therefore, the costs that can be attributed to cannabis in this regard are likely minimal. If one accepts the methodology of the authors, **cannabis in itself entails few externalities**, which are the main measures of the social cost of illegal drugs.

However, it should also be noted that the study did not calculate the costs of substance-related crime. Alcohol is well known for its frequent association with crimes of violence (at least 30% of all cases), as well as with impaired driving , which results in major social and economic losses. Crime related to illegal drugs is of several types: organized crime, of course; crimes against property committed in order to pay for drugs, true mainly in the case of heroin and cocaine; and crimes of violence committed under the influence of drugs. With the exception of organized crime and driving under the influence, cannabis involves few of the factors that generate criminal behaviour.

Secondly, according to Single's study, the main cost of illegal drugs, after loss of productivity, is the cost of law enforcement, which the study estimates at approximately $400 million. In Chapters 14 and 15, we noted that police and court costs are certainly much higher than this figure, and probably total between $1 billion and $1.5 billion. As Single *et al* state, these are costs that "are incurred as a conscious decision by policy makers, as opposed to those costs imposed on the treatment system and on industry as a result of substance-related morbidity and mortality."[5] The proportion of these costs attributable to cannabis is, obviously, impossible to determine for certain. But, insofar as 77% of all drug-related offences involve cannabis, and of these 50% involve simple possession, and given that about 60% of incidents result in a charge, of which some

[4] Single, E. *et al*, *op.cit.*, page 15.
[5] *Ibid.*, page 57.

10% to 15% of cases the accused receives a prison sentence, it is clear that a considerable proportion of the drug-related activity addressed by the penal justice system is concerned with cannabis. While admitting this to be a very rough estimate, we suggest that about 30% of the activity of the justice system is tied up with cannabis. On the basis of our estimates and the lowest cost of law enforcement, or $1 billion, it costs about $300 million annually to enforce the cannabis laws.

In effect, the main social costs of cannabis are a result of public policy choices, primarily its continued criminalization, while the consequences of its use represent a small fraction of the social costs attributable to the use of illegal drugs.

Next to this, the costs of prevention and research pale into insignificance. Single estimates them at approximately $42 million in 1992, at the height of Canada's Drug Strategy – a strategy that ceased to be funded after 1997. Far from increasing since then, it is probable that expenditures for prevention and research have decreased as a proportion of the total social cost of drugs.

At several points in this report, we have spoken about the Canadian Centre on Substance Abuse, pointing out both its lack of visibility and legitimacy and its lack of resources the two being related. The economic and social costs of illegal drugs alone on the order of $1.5 billion (which in light of our estimate of the costs of suppression alone is certainly the floor), the annual budget of the CCSA represents a mere 0.1% of them! Considering that the CCSA's mandate is to facilitate everything we have just been discussing, and to serve as a clearing-house for information, practical experience and best practices, there is good reason to wonder whether successive governments have not failed to put their money where their mouth is in their approach to the drug issue. The social costs of alcohol, a substance that also falls within the CCSA's purview, have not even been included in this calculation, though they are at least seven times greater than those of illegal drugs! This is why it is imperative to raise the proportion of funding to the CCSA from 0.1% to 1%–a drop in the bucket for the federal government that would produce inestimable benefits.

CONCLUSIONS

Conclusions of Chapter 18	
Harmonization	➢ **The lack of any real national platform for discussion and debate on illegal drugs prevents the development of clear objectives and measurement indicators.** ➢ **The absence of a national platform makes exchange of information and best practices impossible.** ➢ **Practices and approaches vary considerably between and within provinces and territories.**

Co-ordination of approaches	➢ **The conflicting approaches of the various players in the field are a source of confusion.** ➢ **The resources and powers for enforcement are greatly out of balance compared with those of the health and education fields and the civil society.**
Costs of cannabis	➢ **The costs of all illegal drugs had risen to close to $1.4 billion in 1992.** ➢ **Of the total costs of illegal drugs at that time, externalities (social costs) represented 67% and public policy costs 33%.** ➢ **We believe both the social costs of illegal drugs and the public policy costs to be underestimated.** ➢ **We estimate the cost of enforcing the drug laws to be closer to $1-1.5 billion per annum.** ➢ **The principal public policy cost relative to cannabis is law enforcement and the justice system; we estimate this to represent a total of $300-$500 million per annum.** ➢ **The costs of externalities attributable to cannabis are probably minimal (no deaths, few hospitalizations, and very little loss of productivity).** ➢ **The costs of public policy on cannabis are disproportionately high given the drug's social and health consequences.**
Under-funding of the CCSA	➢ **The Canadian Centre on Substance Abuse is seriously under-funded; its annual budget amounts to barely 0.1% of the social costs of illegal drugs alone (alcohol not included). Its budget should be increased to at least 1%; that is, approximately $15 million per annum.**

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME III : PART IV AND CONCLUSIONS

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

TABLE OF CONTENTS

INTRODUCTION 1

PART I - GENERAL ORIENTATION 5

CHAPTER 1 - OUR MANDATE 7
WORDING 7
ORIGINS 9
INTERPRETATION 10

CHAPTER 2 - OUR WORK 13
TWO WORKING PRINCIPLES 14
STATE OF KNOWLEDGE 15
Research Program 18
Expert Witnesses 19
The Challenge of Synthesis 21
TAKING OPINIONS INTO ACCOUNT 22
INTERPRETING IN LIGHT OF PRINCIPLES 23

CHAPTER 3 - OUR GUIDING PRINCIPLES 25
ETHICS, OR THE PRINCIPLE OF RECIPROCAL AUTONOMY 28
GOVERNANCE: MAXIMIZING THE ACTIONS OF INDIVIDUALS 32
Collective governance 34
Governance of the self 35
The role of governance 37
CRIMINAL LAW AND THE LIMITS OF PROHIBITION 38
Requirement for distinctions 38
Criteria for distinction 40
Application to illegal drugs issues 44
SCIENCE OR APPROXIMATE KNOWLEDGE 45
CONCLUSIONS 49

CHAPTER 4 - A CHANGING CONTEXT 51
CHANGES IN THE INTERNATIONAL SPHERE 51
Globalization and Integration 51
Difficulties of the Security Debate 55
From Anti-Drug Policies to Drug Policies 57
CHANGES IN CANADA 58
Judicial Activism 58
A National Crime Prevention Strategy 59
The Fight Against Organized Crime 59
A SOCIETAL DEBATE 60

PART II - CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES 63

CHAPTER 5 - CANNABIS : FROM PLANT TO JOINT 65
ONE PLANT, VARIOUS DRUGS 66
CANNABIS ROADS 69
PROPERTIES OF CANNABIS 77
Δ^9THC Concentrations 78
Pharmacokinetics 83
CONCLUSIONS 87

CHAPTER 6 - USERS AND USES : FORM, PRACTICE, CONTEXT 89
PATTERNS OF USE 90
Consumption by the population as a whole 91
Consumption among young people 94
Use patterns in other countries 101
To summarize 108
PATTERNS AND CIRCUMSTANCES OF USE 111
Cannabis in History 111
Trajectories of Use 113
Factors Related to Use 119
To summarize 124
STEPPING STONE TOWARDS OTHER DRUGS? 125
CANNABIS, VIOLENCE AND CRIME 127
CONCLUSIONS 128

CHAPTER 7 - CANNABIS : EFFECTS AND CONSEQUENCES 131
EFFECTS AND CONSEQUENCES OF CANNABIS: WHAT WE WERE TOLD 134
ACUTE EFFECTS OF CANNABIS 139
CONSEQUENCES OF CHRONIC USE 143
Physiological Consequences of Chronic Use 143
Cognitive and Psychological Consequences 148
Behavioural and Social Consequences 152
TOLERANCE AND DEPENDENCE 152
Cannabis Dependence 154
Severity of Dependence 160
Tolerance 162
To summarize 163
CONCLUSIONS 164

CHAPTER 8 - DRIVING UNDER THE INFLUENCE OF CANNABIS 167
FORMS OF TESTING 170
EPIDEMIOLOGICAL DATA 175
Studies not involving accidents 175
Studies where an accident was involved 176
Epidemiological studies on youth 179

Risk assessment 180
EXPERIMENTAL STUDIES 182
Non-driving activities 183
While driving 184
CONCLUSIONS 188

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES 191
HISTORY 196
CONTEMPORARY KNOWLEDGE 197
Therapeutic uses 198
Marijuana as a drug? 200
CURRENT THERAPEUTIC PRACTICES 203
CONCLUSIONS 205

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES 209
THE MEDIA 210
SURVEYS 215
ATTITUDES AND OPINIONS SHARED WITH THE COMMITTEE 221
CONCLUSIONS 224

PART III - POLICIES AND PRACTICES IN CANADA 225

CHAPTER 11 - A NATIONAL DRUG STRATEGY? 227
PHASE I - DEVELOPMENT AND IMPLEMENTATION 228
Creation of the Canadian Centre on Substance Abuse 233
Creation of Canada's Drug Strategy Secretariat 236
PHASE II - RENEWAL 237
PHASE III – RENEWAL WITHOUT SPECIFIED FUNDING 240
CANADA'S DRUG STRATEGY – A SUCCESS? 241
CONCLUSIONS 243

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT 245
1908-1960: HYSTERIA 248
Opium Act, 1908 252
The Opium and Narcotic Drug Act, 1911 253
Amendments to the Opium and Narcotic Drug Act (1920-1938) 255
Amendments to the Act to Amend the Opium and Narcotic Drug Act in 1954 263
Senate Report of 1955 264
FROM 1960 TO THE LE DAIN COMMISSION: THE SEARCH FOR REASONS 268
Narcotic Control Act (1961) 268
An Act respecting Food and Drugs and Barbiturates (1961) 270
The Le Dain Commission (1969-1973) 272
Bill S-19 and Cannabis 283
AFTER LE DAIN: FORGING AHEAD REGARDLESS 284
Controlled Drugs and Substances Act 286
CONCLUSIONS 295

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS **297**
BACKGROUND TO THE RECENT REGULATIONS 298
Section 56 – Controlled Drugs and Substances Act 298
Charter Challenges – Therapeutic Use of Marijuana 299
Government Reaction 302
MARIHUANA MEDICAL ACCESS REGULATIONS 302
Authorization to Possess 303
Licence to Produce 306
Other Provisions 307
COMPASSIONATE ACCESS? 308
Eligibility 309
Access to cannabis 312
Products 316
Costs 316
RESEARCH PLAN 317
Scientific Research 318
Research-Grade Marijuana 320
CONCLUSIONS 321

CHAPTER 14 - POLICE PRACTICES **323**
ENFORCEMENT AGENCIES 323
RCMP 323
CHARGES UNDER THE CONTROLLED DRUGS AND SUBSTANCES ACT IN 1999 326
TheCanada Customs and Revenue Agency 326
Provincial and Municipal Police 328
COSTS 328
POLICE POWERS 333
Searches and Seizures 335
Entrapment and Illegal Activity 347
Conclusion 352
STATISTICS 353
Reported Incidents 353
Charges 356
Concerns 359
Customs Act - Fines 361
SEIZURES 362
CONCLUSIONS 364

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM **367**
PROSECUTION 367
COURTS 368
Drug Treatment Courts 369
DISPOSITION AND SENTENCING 372
CORRECTIONS 376
CRIMINAL RECORD 379
COURT CHALLENGES 382
CONCLUSIONS 387

CHAPTER 16 - PREVENTION **389**
INITIATIVES THAT FALL SHORT OF THE MARK 393
Not enough prevention 394
Prevention lacks focus 396
There is not enough evaluation of preventive measures 397
Preventive and social messages in contradiction 398
There is a body of knowledge on which we have to draw 399
PREVENTING WHAT AND HOW? 400
RISK REDUCTION AND HARM REDUCTION 410
CONCLUSIONS 412

CHAPTER 17 - TREATMENT PRACTICES **415**
CANNABIS DEPENDENCY 415
FORMS OF TREATMENT 421
EFFECTIVENESS OF TREATMENT 423
CONCLUSIONS 426

CHAPTER 18 - OBSERVATIONS ON PRACTICES **427**
DIFFICULTIES IN HARMONIZING THE PLAYERS 427
INCONGRUITIES OF APPROACH 429
SIGNIFICANT ECONOMIC AND SOCIAL COSTS 431

PART IV - PUBLIC POLICY OPTIONS **437**

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT **439**
A GENEALOGY **440**
The 1909 Shanghai Conference **443**
The 1912 Hague International Opium Convention **444**
The 1925 Geneva Opium Conventions **446**
The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement **447**
The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs **448**
The Second World War **449**
The 1946 Lake Success Protocol **449**
The 1948 Paris Protocol **450**
The 1953 New York Opium Protocol **450**
THE THREE CURRENT CONVENTIONS **451**
The Single Convention on Narcotic Drugs, 1961 **451**
Convention on Psychotropic Substances **455**
Protocol amending the Single Convention on Narcotic Drugs, 1961 **460**
Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances **462**
SOME LEEWAY? **464**
CONCLUSIONS **468**

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES 469
FRANCE 470
Different Forms of Logic 470
An Integrated Public Policy 472
Legislative Framework 474
Key Reports 477
Statistics on Use and Offences 481
Costs 483
THE NETHERLANDS 485
Dutch Pragmatism? 486
Essential Experts Reports 488
Legislation 493
The Coffee Shop System 496
Data on Use 498
UNITED KINGDOM 502
Ten-Year Strategy to Battle Drugs 502
Legislative Framework 503
Other Relevant Legislation in the Field of Drug Misuse 505
Debate in the UK 506
Recent Key Reports and Studies 507
Administration 515
Costs 515
Statistics 516
SWEDEN 518
National Strategy 520
Legislative Framework 523
Debate in Sweden 525
Recent Reports 526
Costs 528
Administration 528
Statistics 529
SWITZERLAND 531
A Harm Reduction Policy 531
The Legal Framework 538
A Bill to Decriminalize Cannabis 539
Administration of Swiss Drug Policy 542
Statistics on Narcotics Use and Offences under the Narcotics Act 544
AUSTRALIA 546
National Drug Strategy 546
Legislative Framework 551
Decriminilization in Australia 554
Administration 556
Statistics 557
UNITED STATES 560
The Federal-State Legislative Framework 560
Current Legislation and Enforcement 563
Federal Drug Policy Goals and Objectives 570
Administration of the Policy 572
Current Issues and Debates 575

Statistics 576

CHAPTER 21 - PUBLIC POLICY OPTIONS 581
INEFFECTIVENESS OF CRIMINAL POLICIES 583
Impact on Consumption 583
Impact on Supply 589
Conclusion 590
GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS 591
COMPONENTS OF A PUBLIC POLICY 593
Strong Decision-making Body 593
Interconnection 594
A Shared Definition of Shared Objectives 594
Information Tools 594
LEGISLATIVE OPTIONS 595
Clarification of criminology 595
Criteria for a Legal Policy on Cannabis 602

CONCLUSIONS AND RECOMMENDATIONS 607

LE DAIN – ALREADY THIRTY YEARS AGO 607
INEFFECTIVENESS OF THE CURRENT APPROACH 609
PUBLIC POLICY BASED ON GUIDING PRINCIPLES 610
A CLEAR AND COHERENT FEDERAL STRATEGY 611
NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESOURCES AND TOOLS 612
A PUBLIC HEALTH POLICY 614
A REGULATORY APPROACH TO CANNABIS 617
A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE 618
PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS 619
RESEARCH 620
CANADA'S INTERNATIONAL POSITION 621

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES 623

BIBLIOGRAPHY 627

GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see chapter 7). In the report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence. (toxicomanie a de l'information additionelle)

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators, THC increasing the liberation of dopamine in nucleus accumbens and cerebral cortex.

At-risk use
Use behaviour which makes users at-risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marihuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic

drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure decriminalization*, which entails an amendment to criminal legislation, and *de facto decriminalization*, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard: other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalisation
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Generally used to refer to illicit rather than licit substances (such as nicotine, alcohol or medicines). In pharmacology, the term refers to any chemical agent that alters the biochemical

or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states objective, reliable and comparable information within the EU on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate quickly the tissues. THC is highly fat-soluble.

Gateway (theory)
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then "hard" drugs. The theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate is from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces on inactive THC metabolites can be detected as many as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant and transformed into a paste.

International Conventions
Various international conventions have been adopted by the international community since 1912, first under the Society of Nations and then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organisation responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems resulting from a substance. Pharmacology generally distinguishes four levels: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC are more difficult, especially in trying to determine the therapeutic benefits of cannabis and to examine its effects on driving.

Legalisation
Regulatory system allowing the culture, production, marketing, sale and use of substances. Although none currently exist in relation to « street-drugs » (as opposed to alcohol or tobacco which are regulated products), a legalisation system could take two forms: without any state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become equivalent for cannabis.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to designate opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of national drug control policy (ONDCP) USA
Created in 1984 under the Reagan presidency, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term designates the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. More neutral than the term "drug" because it does not refer to the legal status of the substance, it is the term we prefer to use.

Psychotropic substance (see also psychoactive)
Much the same as psychoactive substance. More specifically however, the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytic, sedatives, neuroleptics, etc. More specifically, refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
Control system specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Society of Nations (SDN)
International organisation of States until 1938; now the United Nations.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is very fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, leads to higher levels of THC concentration.

Tolerance
Reduced response of the organisms and increased capacity to support its effects after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs, including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Programme works to educate the world about the dangers of drug abuse. The Programme aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programmes. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO)
The World Health Organization, the United Nations specialized agency for health, was established on 7 April 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

PART IV

PUBLIC POLICY OPTIONS

CHAPTER 19

THE INTERNATIONAL LEGAL ENVIRONMENT

This chapter could begin and end with the same words: The international drug control conventions are, with respect to cannabis at least, an utterly irrational restraint that has nothing to do with scientific or public health considerations.

Very useful restraint, to be sure, if one favours prohibition, for when the advocates of such policy run out of scientific and public health arguments, they can simply fall back on the conventions that Canada has signed. More than signed, in fact: owing to the efforts of certain men, police officers and federal public servants, Canada was a leading proponent of those conventions.

Currently, three conventions govern the entire life cycle of drugs, from cultivation of the plants to their consumption: the *Single Convention on Narcotic Drugs, 1961* (Single Convention),[1] the 1971 *Convention on Psychotropic Substances* (Psychotropics Convention)[2] and the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Trafficking Convention).[3] They create not only international law concerning drugs but also control mechanisms and bodies, both political and bureaucratic.

Yet these agreements have a history that began well before the Single Convention, a history that sheds light on the issues that led to their development and on their contemporary significance. That is the subject of the first section. The conventions create obligations, as shown in the second section, detailed obligations that are morally rather than legally binding. And they are a patchwork of compromises that leave states with some leeway, as we shall see in the third section.

[1] Single Convention on Narcotic Drugs, 1961 (RTC 1964/30), amended by the Protocol amending the Single Convention on Narcotic Drugs, 1961 (RTC 1976/48). The Single Convention came into force in Canada in 1964 and the Protocol in 1976.

[2] Convention on Psychotropic Substances, RTC 1988/35. It came into force in Canada in 1988.

[3] Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, RTC 1990/42, which came into force in Canada in 1990.

A GENEALOGY

The genealogy of the international conventions governing drug production and trade is fascinating and unique. The story begins in the mid-19th century, when Britain and China fought two opium wars, both quickly won by the British. In this era, the roles were reversed: the British owned the lucrative opium monopoly of the East India Company and refused to relinquish it, while the Chinese had been trying for decades to stamp out opium use, not so much for health reasons as for economic ones, since this trade was exacting a heavy toll.

> *China had long exercised the upper hand in its economic relations with the Occident. Silks, teas, fine pottery, and other items flowed west. Yet the Middle Kingdom desired little from the outside. (…) Encouraging the China opium trade therefore solved several related problems for colonial governments. Opium production provided a living for numerous peasants, merchants, bankers, and governments officials. Exports to China earned hard currency, thereby reducing specie outflow.* [4]

While Britain balked at introducing control mechanisms that would deprive it of hard currency, the United States realized at the turn of the century that this was a perfect opportunity to assert itself on the international scene.

The drug story's geopolitical ingredients blended with well-known domestic political interests, racist attitudes and economic interests in a complex cocktail. In Chapters 11 and 12, we touched on certain aspects of the anti-Chinese racism that marked the turn of the century in Canada. The same phenomenon existed in the U.S.

> [Translation] *The United States had a number of reasons for acting on this proposal. The official reason was a moral one: at a time when the temperance leagues and the churches were demanding Prohibition, puritan America decided to take the lead in civilization's world crusade. It claimed to be protecting uncivilized races from the ravages of opium and alcohol. But it also had some less virtuous reasons. Under pressure from the trade unions, which feared competition from Chinese labour, it passed the Exclusion Laws, openly xenophobic legislation whose purpose was to control the yellow peril. It therefore spread the myth of the 'unsavoury Chinese opium addict,' devoted to his habit and ready to contaminate American youth.* [5]

Naturally, the Chinese government vigorously protested against the Exclusion Laws, but the Middle Kingdom, a victim of its conflicts and its internal disorganization, lacked the resources to make an impact on the international scene. While continuing to combat opium use within its own territory, China set about promoting poppy cultivation at the local level.

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[4] McAllister, W.B., (1999) *Drug Diplomacy in the Twentieth Century. An international history*, pages 10-11.
[5] Caballero, F., and Y. Bisiou (2000) *Droit de la drogue.* Paris: Dalloz, 2nd edition, page 36.

The pharmaceutical industry, which had been booming since the mid-19th century, was able to produce more and more low-priced medicines, many of which contained extracts of coca or opium.

> *The mid-1880s euphoric reaction of cocaine set off a chain reaction. Pharmaceutical companies rushed to fill orders, but fresh coca leaf was unavailable in sufficient quantity. Consequently, the price skyrocketed. To meet demand and share in the profit, several imperial powers stepped up efforts to develop commercially saleable coca. (…) Within a few years, coca production increased dramatically, coca paste processing became commonplace, coca leaves became a commodity traded on the international market and pharmaceutical manufacturers competed for business on the basis of price, availability, and quality of product. Hardly available in 1885, cocaine became quickly emblematic of the modern, technological, international, political economy. (…) By the early twentieth century, cocaine ranked third in terms of dollar value among drugs. The popularity of the two drugs superseding cocaine, morphine and quinine, resulted from the same constellation of factors – a burgeoning pharmaco-industrial complex.* [6]

The third factor was the growing professionalism and social power of the medical community. The latter was essentially working against a form of popular medicine, ostensibly because it was a source of abuse and charlatanism, but mostly because it was practised outside the medical establishment and thus was less tightly controlled by scholarly medical "authority". Certain of its science, the powerful medical lobby would quickly swing into action and demand the regulation of drugs and sole authority to diagnose and prescribe.

Last but not least, there were moral considerations. The temperance movements fighting the moral and social "vices" of alcohol and drugs were growing rapidly and carried substantial political clout, which the prohibitionists wielded brilliantly.

The last piece of the puzzle was the 1906 decision by Britain's new Liberal government to oppose the forced opium trade between India and China, which made it possible for the Chinese government to launch an extensive campaign against opium consumption and production. In 1907, the British agreed to reduce exports of Indian opium to China by 10 per cent a year, provided that China would permit independent verification of its own production cuts. The accord proved more effective than the two countries expected, until the Manchu (Ch'ing) dynasty fell in 1911. After that, the Chinese warlords began encouraging opium production on a large scale to finance their military spending. Nevertheless, future prohibition advocates would view the 1907 "ten-year agreement" as the first successful opium "treaty"; for the next 60 years. This agreement was to set the tone for international drug control negotiations.[7] The stage was now set for the first in a long series of international conferences, treaties and conventions, as shown in the table below.[8]

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[6] McAllister, *op. cit*., pages 15-16.

[7] McAllister, *op. cit*., pages 24-27.

[8] This table and the text of this section are taken from the excellent report prepared by the Library of Parliament at the Committee's request: Sinha, J. (2001) *The History and Development of the Leading*

Multilateral Agreements on Narcotics and Psychotropic Substances[9]

Date and place signed	*Title of agreement*	*Date of entry into force*
26 February 1909 Shanghai, China	Final Resolutions of the International Opium Commission [1]	Not applicable
23 January 1912 The Hague, Netherlands	International Opium Convention	11 February 1915 / 28 June 1919 [2]
11 February 1925 Geneva, Switzerland	Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium	28 July 1926
19 February 1925 Geneva, Switzerland	International Opium Convention	25 September 1928
13 July 1931 Geneva, Switzerland	Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs [3]	9 July 1933
27 November 1931 Bangkok, Thailand	Agreement for the Control of Opium Smoking in the Far East	22 April 1937
26 June 1936 Geneva, Switzerland	Convention for the Suppression of the Illicit Traffic in Dangerous Drugs	26 October 1939
11 December 1946 Lake Success, New York, USA	Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936	11 December 1946
19 November 1948 Paris, France	Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931, for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946	1 December 1949
23 June 1953 New York, USA	Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium	8 March 1963
30 March 1961 New York, USA.	Single Convention on Narcotic Drugs, 1961	13 December 1964
21 February 1971 Vienna, Austria	Convention on Psychotropic Substances	16 August 1976
25 March 1972 Geneva, Switzerland	Protocol amending the Single Convention on Narcotic Drugs, 1961	8 August 1975
20 December 1988 Vienna, Austria	United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	11 November 1990

[1] This is the only document in the table that is not an enforceable multilateral treaty. It is included because it marks the beginning of substantial international cooperation on drug control.
[2] China, the Netherlands, and the U.S. implemented the Convention in 1915 (Honduras and Norway followed suit later that year). It did not come into force globally until it was incorporated into the Treaty of Versailles in 1919.
[3] As amended by the Protocol signed at Lake Success, New York, on 11 December 1946.

International Drug Control Conventions. Ottawa: Library of Parliament, Parliamentary Research Branch, available on the Committee's Web site at www.parl.gc.ca/illegal-drugs.asp .

[9] Sources: Canadian Treaty Series; Kettil Bruun, Lynn Pan and Ingemar Rexed, (1975) *The Gentlemen's Club: International Control of Drugs and Alcohol*, Chicago: University of Chicago Press; United States, (1972) *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971*, Washington, D.C.: Bureau of Narcotics & Dangerous Drugs.

The 1909 Shanghai Conference

U.S. interest in international drug control grew substantially following the Spanish-American War, which led to its acquisition of the Philippines in 1898.[10] The acquisition brought with it what the American administration perceived as a serious problem: a government-run opium supply monopoly. Under the guidance of the new Episcopal Bishop of the Philippines, Charles Henry Brent, the monopoly was shut down. Yet smuggling continued, and Brent, who regarded the opium issue as a moral question and use of the drug as *"a social vice … a crime,"* persuaded President Theodore Roosevelt to support holding an international meeting in Shanghai to remedy what was clearly a regional problem.[11]

In February 1909, the International Opium Commission[12] met in Shanghai, with Brent as its president. However, because the participants did not have the necessary plenipotentiary powers to conclude a treaty, the result was simply a collection of facts and a set of non-binding recommendations. In the discussions on the Commission's terms of reference, one question that arose was whether drug-related medical issues, such as addiction and its treatment, should be considered; the proposal was defeated (by a majority of one) because it was felt that there was insufficient medical expertise present at the meeting.[13] This set a telling precedent: most subsequent drug meetings would be attended predominantly by diplomats and civil servants, with little significant input from medical experts.

The negotiations during the Commission's meetings laid the groundwork for future conferences. The U.S., aggressively represented by Hamilton Wright, tried to persuade the colonial powers to support a narrow definition of "legitimate use" of opium, under which any non-medical or non-scientific use–by Western medical and scientific standards–would be considered illicit. The colonial powers advocated a softer approach, which would permit "quasi-medical use". In the final wording of Resolution 3, the Commission concluded "that the use of opium in any form otherwise than for medical purposes is *held* by *almost* every participating country to be a matter for prohibition *or for careful regulation*; and that each country in the administration of its system or regulation purports to be aiming, as opportunity offers, at progressively increasing stringency" (emphasis as in original).

The Commission was, in fact, far from "international". The focus was on China's opium problems–five of the nine resolutions mentioned China by name–and the U.S. and Britain dominated the discussions. The U.S. was pushing for prohibition and felt that China needed assistance with its domestic opium problems. Britain worked to

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[10] Lowes, P.D. (1966) *The Genesis of International Narcotics Control*. Geneva: Droz, page 102.

[11] Bewley-Taylor, D.R. (1999) *The United States and International Drug Control.* page 19.

[12] The Commission included all the colonial powers in the region – Britain, France, Germany, Japan, the Netherlands, Portugal and Russia – and China, Siam [now Thailand], Persia [now Iran], Italy and Austria-Hungary. (McAllister (2000), page 28)

[13] Bruun *et al.* (1975), page 11; Lowes (1966), page 187-188.

protect its lucrative Indian opium trade, arguing that curbing such trade would be useless until China brought its domestic production under control.[14]

Underlying the U.S. delegation's hard-line stance at the Shanghai meeting were key domestic political and economic goals that would also colour later negotiations. It was assumed that if other countries controlled their own opium production and exports, the U.S. would not be burdened with the task, because the poppy and the coca leaf had never been grown in appreciable quantities in North America. Furthermore, international agreements calling on countries to take drastic internal measures provided ammunition for Brent and Wright, who were pressuring the U.S. government to develop stringent domestic drug control laws.[15]

The 1912 Hague International Opium Convention

At the Shanghai meeting, the Americans had proposed a future conference to draft an international drug control treaty that would include the Shanghai resolutions in an expanded and more stringent form. This proposal was contested by the other countries and went nowhere. In the years that followed, however, the U.S. lobbied continually and forcefully around the world for a new conference. Addressing the opium problem directly, publicly and internationally was a way for the U.S. to achieve its domestic control objectives, to put an end to the profitable drug trade dominated by the colonial powers, and to curry favour with the Chinese and thereby improve Sino-American economic relations.[16]

Twelve countries agreed to meet at The Hague on 1 December 1911 to draft a treaty.[17] Once again, the meeting was chaired by Brent, and Wright led the U.S. delegation. Most states had demanded amendments to the U.S. draft agenda, which focused on stringent control of opium production, manufacture and distribution in Asia. For example, Britain insisted that manufactured drugs such as morphine, heroin, and cocaine be considered. This was an attempt to dilute the opium agenda and deflect attention from Indian opium production. Britain also hoped that a fair treaty would create a level playing field for British pharmaceutical companies to compete with the dominant German synthetic drug industry.[18]

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[14] Walker III, William O., (1991) *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954*, Chapel Hill, N.C.: University of North Carolina Press, page 16-17; Lowes (1966), page 152-153.

[15] Musto (1999), page 36-37.

[16] William B. McAllister, (1992) "Conflicts of Interest in the International Drug Control System," in William O. Walker III, ed., *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park, Pennsylvania: Pennsylvania State University Press, page 145.

[17] Germany, China, the United States, France, Britain, the Netherlands, Italy, Japan, Persia [now Iran], Portugal, Russia and Siam [now Thailand].

[18] McAllister (2000), page 32-33; Bruun *et al.* (1975), page 11-12.

Chapters I and II of the 1912 *International Opium Convention*[19] (1912 Hague Convention) dealt with raw and prepared opium. For example, Article 1 required parties to "enact effective laws or regulations for the control of the production and distribution of raw opium" unless such laws were already in place. The Convention also recognized the U.S.-initiated principle of restricting opium use to medical and scientific purposes. Chapter IV was aimed at reducing drug trafficking in China.

Chapter III focused on licensing, manufacturing and distribution controls on synthetic drugs, but Germany ensured that the provisions were weak and vague. Article 10 allowed countries to simply make their *"best endeavours"* to implement these controls. Furthermore, Germany refused to sign the treaty until it was agreed that all countries would have to ratify[20] the Convention before it came into force. This was an effective tactic for delaying control measures as it took almost a decade for all countries to ratify the agreement. Germany did so only because ratification was a condition of the Treaty of Versailles that ended the First World War in 1919.[21]

Wright used the 1912 Hague Convention in his campaign for U.S. domestic legislation, arguing that a federal law was necessary for the U.S. to fulfil its obligations under the Convention. In 1916, the U.S. Supreme Court ruled that this was not so, but by then the *Harrison Narcotics Act of 1914* had become the first federal drug control law in the U.S.; it would remain a pillar of U.S. drug policy for the next few decades.[22]

The establishment of the League of Nations in 1919 following the First World War provided the international community with a centralized body for the administration of drug control. In 1920, the League created the Advisory Committee on the Traffic in Opium and other Dangerous Drugs, commonly known as the Opium Advisory Committee (OAC), the precursor to the United Nations (UN) Commission on Narcotic Drugs. The League Health Committee, forerunner of the UN World Health Organization, was also formed. Administration of the 1912 Hague Convention had originally been the responsibility of the Netherlands, but was transferred to the Opium Control Board (OCB) created by the OAC. Enforcement of the Convention was sporadic as the countries on the OCB were the ones profiting most from the drug trade.[23]

The League began to consider demand-side socio-medical issues such as why individuals use drugs, what constitutes drug abuse, and what social factors affect abuse.

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[19] Done 23 January 1912; in force 28 June 1919.

[20] Ratification is the process by which each country enacts national implementing legislation – unless the new international obligations are already met by domestic legislation – and thereby consents to the treaty's application within its territory.

[21] McAllister (2000), page 36-37; Bruun *et al.* (1975), page 12; Lowes (1966), page 182-186.

[22] Musto (1999), page 59-63. Since the U.S. Constitution did not allow a direct federal role in criminalizing drug use, Wright designed the *Harrison Act* as a tax statute; physicians, pharmacists, wholesalers and retailers had to obtain a tax stamp to distribute drugs. The Treasury Department was responsible for enforcing the statute. Thus, the use of drugs was limited through access restrictions. (McAllister (2000), page 35)

[23] McAllister (1992), page 145-146.

However, prohibition and supply-side issues soon regained the ascendancy as preparations began and talks were held, again at the instance of the U.S., for a new treaty in the mid-1920s. In general, the international regime has tended to separate the study of drug-related medical and social problems, including etiological questions, from that of drug control problems.[24]

The 1925 Geneva Opium Conventions

Even though the U.S. had chosen not to join the League of Nations, its influence in international drug control matters remained strong. Worried by the 1912 Hague Convention's limited effect on the smuggling of opium and, increasingly, drugs manufactured in East Asia, the U.S. pressured the League to convene a new conference. The League feared that if it did not comply, the U.S. might act independently.[25]

Between November 1924 and February 1925, two back-to-back conferences were held, and two separate treaties were concluded. The first Geneva Convention[26] focused on opium-producing nations; signatories were permitted to sell opium only through government-run monopolies and were required to end the trade completely within 15 years.

The second Geneva Convention, the *International Opium Convention*[27] (1925 Geneva Convention), was intended to impose global controls over a wider range of drugs, **including, for the first time, cannabis**, which was referred to as "Indian hemp" (marijuana) in Article 11 of the Convention. Articles 21 to 23 required Parties to provide annual statistics on drug stocks and consumption; the production of raw opium and coca; and the manufacture and distribution of heroin, morphine and cocaine. Chapter VI replaced the OCB with an eight-member Permanent Central Opium Board (PCOB).[28] Chapter V of the second Convention set up a PCOB-monitored import certification system to control the international drug trade by limiting the amount that each country could legally import.

While the 1912 Hague Convention had focused on domestic controls, the Geneva Conventions were an attempt to improve transnational control. The U.S. had proposed strict adherence to the principle that drugs should be used only for medical and scientific purposes and that there should be stringent controls on drug production at the source. When these proposals were flatly rejected at the second conference, the U.S.

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[24] McAllister (2000), page 46-50; Lowes (1966), page 188.

[25] McAllister (2000), page 50-51.

[26] *Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium,* done 11 February 1925, in force 28 July 1926.

[27] Done 19 February 1925; in force 25 September 1928.

[28] The PCOB was intended to be impartial and politically disinterested, but its operations remain extremely political to this day (it still exists). Since its inception, its membership has always included a representative from Britain, the U.S. and France. (McAllister (2000), page 83)

delegation walked out of the conference and never signed the treaties. The Chinese delegation withdrew as well, because no agreement could be reached on the suppression of opium smoking.[29] Instead, the two countries concentrated on enforcing the 1912 Hague Convention.

The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement

The import control system put in place following the 1925 Geneva Convention was only partially effective, as drugs were simply transhipped through non-signatory countries. In 1931, the League of Nations convened a further conference in Geneva to place limits on the manufacture of cocaine, heroin and morphine, and to control their distribution. The result of the conference was the *Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*[30] (1931 Limitation Convention).

In 1931, Canada abandoned its policy of simply reacting to international drug control efforts and began playing an active role in supporting U.S. efforts to expand control at the source. Colonel Charles Henry Ludovic Sharman, Chief of the Narcotics Division in the Department of Pensions and National Health, was the principal architect of Canada's domestic and international drug policy until the 1960s. Canada, through Sharman, was heavily involved in the negotiations leading up to the 1931 Limitation Convention.[31]

A new player also emerged from within the U.S. delegation: Harry J. Anslinger, first Commissioner of the newly created Federal Bureau of Narcotics, a position he would hold for 33 years. A firm believer in prohibition and the control of drug supplies at the source, Anslinger is widely recognized as a prime mover in the development of U.S. drug policy and, by extension, international drug control into the early 1970s.[32]

The centrepiece of the 1931 Limitation Convention was the manufacturing limitation system set out in Chapters II and III. Parties were required to provide the PCOB with estimates of their national drug requirements for medical and scientific purposes, and on the basis of those estimates, the PCOB would calculate manufacturing limits for each signatory. A Drug Supervisory Body (DSB) was created to administer the system. The Convention's effectiveness was seriously undermined by Article 26, which absolved states of any responsibilities under the Convention for their

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[29] Bruun *et al.* (1975), page 14.

[30] Done 13 July 1931; in force 9 July 1933.

[31] Giffen *et al.* (2000), page 483.

[32] See, for example, McAllister (2000), page 89-90; Bewley-Taylor (1999), page 102-164; Bruun *et al.* (1975), page 137-141; Inglis (1975), page 181-190. See also Harry J. Anslinger and Will Oursler, "The War against the Murderers," in William O. Walker III, ed., *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict*, Wilmington, Delaware: Scholarly Resources Inc., 1996.

colonies. Article 15 required states to set up a "special administration" for national drug control, modelled to some extent on the U.S. domestic control apparatus.[33]

The Convention came into force quickly because various countries and the League of Nations thought it might provide a useful model for arms control negotiations. The League even prepared a report explaining how the principles set out in the 1925 Geneva Convention and the Limitation Convention could be applied to disarmament issues.[34]

In late 1931, another conference was held in Bangkok to address opium smoking in the Far East. The treaty[35] it produced was weak, primarily because the U.S. attended only as an observer and the European colonial powers were unwilling to implement effective controls on opium use while there was significant opium overproduction and smuggling. The fact that the U.S. strategy of absolute prohibition had made little impact on opium trafficking and use in the Philippines did not strengthen the U.S.'s hand in pushing for the elimination of poppy cultivation. The key result of the Bangkok conference was that it convinced the U.S. that a firmer approach was needed to combat raw material production and illicit drug trafficking.[36]

The 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs

Based on initiatives of the International Police Commission, forerunner of the International Criminal Police Organization (INTERPOL), negotiations had begun in 1930 to develop a treaty to stem illicit drug trafficking and punish traffickers severely through criminal sanctions.[37]

In 1936, the *Convention for the Suppression of the Illicit Traffic in Dangerous Drugs*[38] (1936 Trafficking Convention) was concluded in Geneva. The U.S., led by Anslinger, had attempted to include provisions that would criminalize all activities–cultivation, production, manufacture and distribution–related to the use of opium, coca (and its derivatives) and cannabis for non-medical and non-scientific purposes. Many countries objected to this proposal, and the focus remained on illicit trafficking.[39] Article 2 of the Convention called on signatory countries to use their national criminal law systems to "severely" punish, "particularly by imprisonment or other penalties of deprivation of liberty," acts directly related to drug trafficking.

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[33] Anslinger would use this provision continually in the future as a way of protecting his position and the Federal Bureau of Narcotics from being altered through reorganization. (McAllister (2000), page 98, 108-109)

[34] *Ibid.*, page 110-111.

[35] *Agreement for the Control of Opium Smoking in the Far East*, done 27 November 1931, in force 22 April 1937.

[36] Taylor (1969), page 275-279; McAllister (2000), page 106.

[37] Taylor (1969), page 288-298.

[38] Done 26 June 1936; in force 26 October 1939.

[39] Taylor (1969), page 293-295.

The U.S. refused to sign the final version because it considered the Convention too weak, especially in relation to extradition, extraterritoriality and the confiscation of trafficking revenues. The U.S. was also worried that if it signed, it might have to weaken its domestic criminal control system to comply with the Convention. In fact, the Convention never gained widespread acceptance, as most countries interested in targeting traffickers concluded their own bilateral treaties.

Despite its minimal overall effect, the 1936 Trafficking Convention marked a turning point. All the previous treaties had dealt with the regulation of "legitimate" drug activities, whereas the 1936 Trafficking Convention now made such activities an international crime subject to penal sanctions.

The Second World War

In the late 1930s, the Opium Advisory Committee (OAC) of the League of Nations began to question the international drug control regime's emphasis on prohibition and law enforcement. Some countries proposed combating abuse through public health approaches, including psychological treatment, dispensary clinics and educational programs. Asserting the U.S. belief that addicts could only be cured through institutionalization, Anslinger, supported by Sharman, was able to block all OAC efforts to consider social and etiological approaches to drug problems. Instead, at Anslinger's insistence, the focus remained on developing a new treaty to impose prohibition and supply control worldwide.[40]

Ironically, in anticipation of war, many countries (in particular the U.S.) built up stockpiles of opium and opium products intended for medical purposes.[41] The Second World War put further development of the international drug control apparatus on hold.

The 1946 Lake Success Protocol

Following the war, the drug control bodies and functions of the League of Nations were folded into the newly formed United Nations.[42] The UN Economic and Social Council (ECOSOC) took over primary responsibility through its Commission on Narcotic Drugs (CND), which replaced the OAC. Under the CND, the Division of Narcotic Drugs (DND) was charged with the preparatory work for conferences. The PCOB and the DSB continued under the CND in their respective roles of compiling

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[40] McAllister (2000), page 126-127.

[41] The possibility of war accentuated the hypocrisy and opportunistic nature of the U.S. prohibitionist position. In 1939, Anslinger "was simultaneously pursuing a League-sponsored treaty to curtail agricultural production in far-off lands, a regional agreement that would allow him to commence poppy cultivation at home, and a global acquisition program that amassed the world's largest cache of licit opium yet assembled." (McAllister (2000), page 133)

[42] See Bewley-Taylor (1999), page 54-59; Bruun *et al.* (1975), page 54-65.

statistics for national estimates and administering previous treaties. Canada's Sharman became the first Chair of the CND and also held a seat on the DSB.

All these changes in responsibility and organization meant that the existing international drug control treaties had to be amended. The amendments were made in a Protocol[43] signed at Lake Success, New York, on 110 December 1946.

The 1948 Paris Protocol

Anslinger and Sharman campaigned hard to ensure that the CND would report directly to ECOSOC as an independent organization. They were afraid that if the main drug control apparatus was a larger health or social issues organization, such as the World Health Organization (WHO) or the United Nations Educational, Scientific and Cultural Organization (UNESCO), etiology and treatment issues might take precedence over the prohibition focus. In particular, they wanted to ensure that governments would be represented by law enforcement officials rather than physicians or others with sociology or public health backgrounds. Furthermore, the USSR showed interest in considering the social factors underlying drug abuse. For the Western powers to have agreed with the Soviet Union would have undermined their hard-line stance against Moscow and communism in the looming Cold War.

Although control remained principally with ECOSOC, the World Health Organization (WHO), in particular its Drug Dependence Expert Committee, became responsible for deciding what substances should be regulated.[44] This authority was given to the WHO in an international Protocol[45] signed in Paris in 1948. Article 1 stated that if the WHO found a drug to be *"capable of producing addiction or of conversion into a product capable of producing addiction,"* it would decide how to classify the drug within the international drug control structure. The Protocol also brought under international control specific synthetic opiates not covered by previous treaties.

The 1953 New York Opium Protocol

By the late 1940s, it became clear that the large number of international drug treaties, with their differing types and levels of control, had become confusing and unwieldy. Anslinger, Sharman and their allies had the CND recommend to ECOSOC the idea of consolidating all existing treaties into one document. It would also be an

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[43] *Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936*, done 11 December 1946, in force 11 December 1946.

[44] Bruun *et al.* (1975), page 70.

[45] *Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931, for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946*, done 19 November 1948, in force 1 December 1949.

opportunity to bring in more stringent prohibition-based controls.[46] This plan was sidelined for a decade when the Director of the DND, Leon Steinig, proposed the creation of an "International Opium Monopoly" in an attempt to end the illicit trade and guarantee wholesale licit opium supply.

Throughout the 1950s, Cold War tensions pushed Anslinger to rebuild the U.S. stockpile of opium and opium derivatives, often by making large purchases from Iran through U.S. pharmaceutical companies. Many European countries were also stockpiling. The multinational pharmaceutical companies in Europe and the U.S. feared that a monopoly like the one proposed by Steinig would lead to restrictions and higher prices. Anslinger and Sharman along with the British, Dutch and French killed the monopoly discussions in the CND. The French representative on the CND, Charles Vaille, suggested a new opium protocol as an interim solution until the treaties could be consolidated. ECOSOC approved a plenipotentiary conference, and Anslinger seized the new protocol initiative as an opportunity to impose strict global controls on opium production.[47]

The Protocol[48] (1953 Opium Protocol), finalized in New York in 1953, Article 2 stated bluntly that Parties were required *to "limit the use of opium exclusively to medical and scientific needs."* Various provisions were included to control the cultivation of the poppy and the production and distribution of opium. Article 6 restricted opium production to seven states, and Parties could only import or export opium produced in one of those countries.[49] The Protocol comprised the most stringent international drug control provisions yet, but it never gained the support Anslinger had hoped for. It did not receive sufficient ratifications to bring it into force until 1963, and by then it had been superseded by the 1961 Single Convention.

THE THREE CURRENT CONVENTIONS

The Single Convention on Narcotic Drugs, 1961

The Single Convention has played a central role in the creation of the modern prohibitionist system of international drug control. It is a continuation and expansion of the legal infrastructure developed between 1909 and 1953.

The work of consolidating the existing international drug control treaties into one instrument began in 1948, but it was 1961 before an acceptable third draft was ready to

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[46] ECOSOC approved the recommendation in two resolutions: 159 II D (VII) of 3 August 1948, and 246 D (IX) of 6 July 1949. See also McAllister (2000), page 172; Bewley-Taylor (1999), page 137.

[47] McAllister (2000), page 172-179.

[48] *Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium*, done 23 June 1953, in force 8 March 1963.

[49] The seven producing countries were Bulgaria, Greece, India, Iran, Turkey, the USSR and Yugoslavia.

be presented for discussion at a plenipotentiary conference.[50] The conference began in New York on 24 January 1961, and was attended by 73 countries, each "with an agenda based on its own domestic priorities."[51]

William B. McAllister has divided the participating states into five distinct categories based on their drug control stance and objectives.

- Organic states group: *As producers of the organic raw materials for most of the global drug supply, these countries had been the traditional focus of international drug control efforts. They were open to socio-cultural drug use, having lived with it for centuries. While India, Turkey, Pakistan and Burma took the lead, the group also included the coca-producing states of Indonesia and the Andean region of South America, the opium- and cannabis-producing countries of South and Southeast Asia, and the cannabis-producing states in the Horn of Africa. They favoured weak controls because existing restrictions on production and export had directly affected large segments of their domestic population and industry. They supported national control efforts based on local conditions and were wary of strong international control bodies under the UN. Although essentially powerless to fight the prohibition philosophy directly, they effectively forced a compromise by working together to dilute the treaty language with exceptions, loopholes and deferrals. They also sought development aid to compensate for losses caused by strict controls.*

- Manufacturing states group: *This group included primarily Western industrialized nations, the key players being the U.S., Britain, Canada, Switzerland, the Netherlands, West Germany and Japan. Having no cultural affinity for organic drug use and being faced with the effects that drug abuse was having on their citizens, they advocated very stringent controls on the production of organic raw materials and on illicit trafficking. As the principal manufacturers of synthetic psychotropics, and backed by a determined industry lobby, they forcefully opposed undue restrictions on medical research or the production and distribution of manufactured drugs. They favoured strong supranational control bodies as long as they continued to exercise* de facto *control over such bodies. Their strategy was essentially to "shift as much of the regulatory burden as possible to the raw-material-producing states while retaining as much of their own freedom as possible."*

- Strict control group: *These were essentially non-producing and non-manufacturing states with no direct economic stake in the drug trade. The key members were France, Sweden, Brazil and Nationalist China. Most of the states in this group were culturally opposed to drug use and suffered from abuse problems. They favoured restricting drug use to medical and scientific purposes and were willing to sacrifice a degree of national sovereignty to ensure the effectiveness of supranational control bodies. They were forced to moderate their demands in order to secure the widest possible agreement.*

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[50] One of the Canadian delegates to the CND, National Health and Welfare official Robert Curran, played the leading role in drafting a document that would be acceptable to all countries as a starting point for negotiations (McAllister (2000), page 205). For an analysis of this third draft, see Leland M. Goodrich, "New Trends in Narcotics Control", *International Conciliation*, No. 530, November 1960.

[51] McAllister (1992), page 148.

- Weak control group: *This group was led by the Soviet Union and often included its allies in Europe, Asia and Africa. They considered drug control a purely internal issue and adamantly opposed any intrusion on national sovereignty, such as independent inspections. With little interest in the drug trade and minimal domestic abuse problems, they refused to give any supranational body excessive power, especially over internal decision-making.*

- Neutral group: *This was a diverse group including most of the African countries, Central America, sub-Andean South America, Luxembourg and the Vatican. They had no strong interest in the issue apart from ensuring their own access to sufficient drug supplies. Some voted with political blocs, others were willing to trade votes, and others were truly neutral and could go either way on the control issue depending on the persuasive power of the arguments presented. In general, they supported compromise with a view to obtaining the broadest possible agreement.*

The result of all these competing interests was a document that epitomized compromise. The Single Convention clearly upheld and expanded existing controls and in its breadth was the most prohibitionist document yet concluded, though it was not as stringent as it might have been. It was free of the costly features of the 1953 Opium Protocol, such as the provision restricting opium production to the seven specified countries. Sharman no longer negotiated for Canada, and Anslinger had played a minor role in the conference owing to conflicts with the U.S. State Department. The latter was content with the Convention because U.S. influence was assured within the UN supervisory bodies and the prohibitive framework had been expanded to include tight controls over coca and cannabis. Since the U.S. originated the idea of the Single Convention, walking out of the conference would have meant losing face in the UN and given the impression of weakness vis-à-vis the Soviet Union during a tense Cold War period.[52]

The principal foundations of the previous treaties remained in place in the Single Convention.[53] Parties were still required to submit estimates of their drug requirements and statistical returns on the production, manufacture, use, consumption, import, export, and stockpiling of drugs.[54] The import certification system created by the 1925

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[52] Anslinger was extremely disappointed with the Single Convention because he believed that the opium control provisions were not stringent enough (e.g., Article 25 still allowed any country to produce up to five tons of opium annually, albeit subject to strict controls). He attempted to derail the Convention by lobbying countries to ratify the 1953 Opium Protocol in hopes of obtaining the number of ratifications needed to bring it into force. He failed, and his influence waned after that. (Bewley-Taylor (1999), page 136-161)

[53] Only the 1936 Trafficking Convention was not included in the Single Convention and remained in force separately, because agreement could not be reached on which of its provisions should be included in the Single Convention (McAllister (2000), page 207-208). Article 35 of the Single Convention simply encouraged cooperation between countries to combat illicit trafficking.

[54] Single Convention, Articles 19 and 20.

Geneva Convention was maintained. Parties were required to license all manufacturers, traders and distributors, and all transactions involving drugs had to be documented.[55] The Single Convention built on the trend of requiring Parties to develop increasingly punitive criminal legislation. Subject to their constitutional limitations, Parties were to adopt distinct criminal offences, punishable preferably by imprisonment, for each of the following drug-related activities in contravention of the Convention: cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation.[56] Furthermore, the granting of extradition was described as "desirable."[57]

The Convention assigned substances to one of four schedules based on level of control. Schedules I and IV were the most stringent and covered primarily raw organic materials (opium, coca, cannabis) and their derivatives, such as heroin and cocaine. Schedules II and III were less strict and contained primarily codeine-based synthetic drugs. At the U.S.'s insistence, cannabis was placed under the heaviest control regime in the Convention, Schedule IV. This regime included drugs such as heroin (the WHO considered any medical use of heroin to be "obsolete"). The argument for placing cannabis in this category was that it was widely abused. The WHO later found that cannabis could have medical applications after all, but the structure was already in place and no international action has since been taken to correct this anomaly.

The U.S. was pleased with the Single Convention as it broadened control over cultivation of the opium poppy, coca bush and cannabis plant, though the measures were not as stringent as the ones Anslinger had negotiated in the 1953 Opium Protocol.[58] Articles 23 and 24 of the Convention set up national opium monopolies and put very strict limitations on international trade in opium.

Article 49 of the Convention required Parties to completely eliminate all quasi-medical use of opium,[59] opium smoking, coca leaf chewing, and non-medical cannabis use within 25 years of the coming into force of the Convention. All production or manufacture of these drugs was also to be eradicated within the same period. Only Parties for which such uses were "traditional" could take advantage of delayed implementation; for others, prohibition was immediate. Since the implementation period ended in 1989, these practices are today fully prohibited, and the drugs may be used only for regulated medical and scientific purposes.

Apart from consolidating the previous treaties and expanding control provisions, the Single Convention also streamlined the UN's drug-related supervisory bodies. The PCOB and the DSB were merged in a new body, the International Narcotics Control Board (INCB), responsible for monitoring application of the Convention and

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[55] *Ibid.*, Articles 21 and 29-32.
[56] *Ibid.*, Article 36.
[57] *Ibid.*, Article 36(2).
[58] Single Convention, Articles 22-28.
[59] The limit was 15 years for the quasi-medical use of opium.

administering the system of estimates and statistical returns submitted annually by Parties.[60] The INCB was to have eleven members, three nominated by the WHO and eight by Parties to the Convention and UN members. The manufacturing lobby's effectiveness in the negotiations was evident in the knowledge requirement for WHO nominees: *"medical, pharmacological or pharmaceutical experience."*[61] The INCB was given a limited power of embargo: it could recommend that Parties stop international drug trade with any Party that failed to comply with the provisions of the Convention.[62]

The Convention's emphasis on prohibition was reflected in the minimal attention paid to drug abuse problems. Only Article 38 touched on the social (demand) side of the drug problem by requiring Parties to *"give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts."* Furthermore, it was considered "desirable" that Parties "establish adequate facilities for the effective treatment of drug addicts," but only if the country had *"a serious problem of drug addiction and its economic resources [would] permit."* The inadequate recognition of demand/harm reduction approaches, such as prevention through education, has been one of the key criticisms of both the Single Convention and international drug control treaties in general.[63]

The Single Convention effectively consolidated several decades' worth of assorted drug control machinery into one key document administered by one principal body, the United Nations.

Convention on Psychotropic Substances

In the 1960s, following the signing of the Single Convention, drug use and abuse exploded around the world, especially in developed Western nations.[64] The increase was particularly evident in the pervasive use and availability of synthetic psychotropic substances developed since the Second World War, such as amphetamines, barbiturates and LSD. Most of these drugs were not subject to international control, and because national systems of regulation differed widely, trafficking and smuggling flourished.[65]

Throughout the 1960s, the CND and the WHO debated the issue of control of psychotropic drugs at regular meetings and made various recommendations to member

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[60] Single Convention, Articles 5 and 9-16.

[61] *Ibid.*, Article 9(1)(a).

[62] *Ibid.*, Article 14(2).

[63] See, for example, *Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961*, Toronto, Addiction Research Foundation, 1983, page 10-11; recommendations 4, 5, 15, 19 and 20.

[64] See, for example, Vladimir Kuševic, (1977) "Drug Abuse Control and International Treaties", *Journal of Drug Issues*, Vol. 7, No. 1, page 35-53. See also McAllister (2000), page 218-220; Musto (1999), ch. 11; McAllister (1992), page 153-162; Bruun *et al.* (1975), ch. 16; Inglis (1975), ch. 13.

[65] The U.S. attempted to regulate psychotropic substances through the Bureau of Drug Abuse Control, established under the *Drug Abuse Control Act of 1965*. This statute also shifted the constitutional basis for drug control from the taxing power to interstate and commerce powers, a change that led to the demise of Anslinger's Federal Bureau of Narcotics and the birth of the Bureau of Narcotics and Dangerous Drugs (BNDD) under the federal Department of Justice. (Musto (1999), page 239-240)

states concerning the national control of particular substances, including stimulants, sedatives and LSD. In January 1970, the CND discussed a draft treaty prepared by the UN Division of Narcotic Drugs on the international control of psychotropic drugs. Following some modifications by the CND, this document became the basis for negotiations at a plenipotentiary conference convened in Vienna on 11 July 1971; this conference produced the Psychotropics Convention.[66]

The 1961 Single Convention had been used as a template for the draft Psychotropics Convention, and many of the former's features are found in the latter: CND/INCB administrative authority, schedules establishing different levels of control for different drugs, mandatory transaction documentation and licensing, an import/export control system, illicit trafficking provisions and criminal sanctions. Though superficially quite similar, the two Conventions are in fact extremely different. The Psychotropics Convention imposes much weaker controls. The reason for this becomes apparent when the positions of the negotiating stakeholders are examined and selected parts of the two treaties are carefully compared.[67] The overwhelming influence of the multinational pharmaceutical industry on the Psychotropics Convention was particularly obvious.[68]

In contrast to the five negotiating groups identified by McAllister for the Single Convention, there were only two distinct blocs with conflicting positions at the Vienna conference. One group included mostly developed nations with powerful pharmaceutical industries and active psychotropics markets; this was essentially the "manufacturing group." The other group consisted of developing states, supported by the socialist countries, with few psychotropic manufacturing facilities; this was to a large extent the "organic group." At the 1971 negotiations, however, the positions of the two groups were *completely reversed*. The manufacturing group adopted the traditional arguments of the organic group: weak controls, national as opposed to international controls, and national sovereignty taking precedence over any supranational UN body. The rationale for these positions was that strict controls would be difficult to enforce and would cause financial loss. The organic group, on the other hand, pushed hard for strict controls similar to those it had been forced to accept in the Single Convention.[69]

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[66] Kuševic (1975), page 38.

[67] McAllister (1992), page 154-162; Kuševic (1975), page 38-41. McAllister's comparison is highly detailed, and well worth reading; Kuševic provides useful background and commentary. See also S.K. Chatterjee (1988) *A Guide to the International Drugs Conventions*, London: Commonwealth Secretariat, page 15-33, for a more technical, lower-level comparison of the two Conventions.

[68] The lead author of the preliminary draft, Arthur Lande, had ended his career at the UN shortly before the Vienna conference. He attended the conference as representative of the U.S. Pharmaceutical Manufacturer's Association, one of many industry observers. Another example of the industry's blatant influence involved a group of six small Latin American countries. They uncharacteristically supported weakening the treaty and were all represented by a Swiss national who was not fluent in Spanish and was not a government official, a diplomat or a narcotics expert. He worked for the European pharmaceutical giant Hoffmann-LaRoche. (McAllister (2000), page 232; Kuševic (1975), page 39)

[69] McAllister (1992), page 154; Kuševic (1975), page 39.

A comparison of the Preambles of the two Conventions is revealing. Although the Preamble is not legally binding, it encapsulates the spirit of the instrument. In the Single Convention, addiction is described as *"a serious evil for the individual … fraught with social and economic danger to mankind."* It is recognized, however, that *"the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes."* By contrast, the Psychotropics Convention makes no mention of the "serious evil" of "addiction," but rather notes *"with concern the public health and social problems resulting from the abuse of certain psychotropic substances."* As well, it is recognized that *"the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted."* The overall tone of the Psychotropics Convention Preamble is less harsh, and it implies that *"abuse of certain," not all, psychotropics, is not as serious a problem as "addiction to narcotic drugs"* in general.

The approach to categorizing drugs by means of schedules with varying levels of control also differed between the two Conventions. In the 1961 Single Convention negotiations, when the placement of a drug in a particular schedule was disputed, the drug almost always ended up in a schedule not favoured by the organic group – for example, the placement of cannabis in Schedule IV. The manufacturing group's insistence on this classification method was based on the idea that narcotic drugs should be considered hazardous until proven otherwise. This reasoning did not apply, however, when U.S. economic interests were at stake. In 1971, the U.S. delegation argued forcefully and often successfully that organic raw materials should be assigned to the strictest schedules, while their manufactured derivatives should be placed in the weaker schedules.

The Psychotropics Convention also contains four schedules of control, but they are substantially different in nature and organization from those of the Single Convention. For example, the most stringent schedule in the Single Convention is Schedule IV,[70] which is equivalent to Schedule I[71] in the Psychotropics Convention. In both cases, the drugs included may be used only by authorized persons in government-operated medical or scientific institutions, and their manufacture, import and export are strictly controlled. The weakest schedule in the Psychotropics Convention is Schedule IV, which contains tranquilizers. Some manufacturing states tried to eliminate Schedule IV by arguing that such drugs were sufficiently regulated by national controls and that international control was therefore unnecessary. In the end, Schedule IV was retained, albeit with a much shorter list of drugs. However, the principle on which drugs were classified was completely reversed, in particular by the U.S.: *"unless there was substantial proof that a substance was harmful, it should remain uncontrolled."*[72]

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[70] Which includes cannabis and heroin, for example.
[71] Which includes hallucinogens, such as LSD.
[72] McAllister (1992), page 158.

Another key difference between the two Conventions is revealed by a close comparison of the schedules. Previous treaties, including the Single Convention, not only covered the base substances but also extended control to include their salts, esters, ethers and isomers, i.e., their derivatives. In contrast, derivatives were *completely absent* from the schedules of the Psychotropics Convention. As a result, every substance to be covered under the treaty regime must be specified by name. In practical terms, that is impossible because new derivatives are constantly being produced, and they comprise 95 per cent of the substances developed by pharmaceutical firms. If a general reference to derivatives had been included, new substances would have been covered automatically. This omission was apparently the result of a deal made between political representatives when the technical experts were not present; the derivatives had to be sacrificed in order to get the manufacturing states to sign the treaty.[73]

The system of estimates set out in Article 19 of the Single Convention requires Parties to report annually to the INCB how much of each controlled substance they will need for the next year. This system is one of the pillars of the international drug control regime and dates back to the second Geneva conference, which led to the 1925 International Opium Convention. It was *completely excluded* from the Psychotropics Convention. As McAllister has pointed out, *"[t]his omission was clearly in the interests of the manufacturing states, because without estimates of need it is impossible to calculate whether more of a substance than can legitimately be put to use is being fabricated."*[74] This allowed multinationals to manufacture unlimited quantities of psychotropic substances without being constrained by annual production limits based on licit need.

These omissions–derivatives and estimates–were largely corrected during the 1970s and 1980s through quiet recourse to customary international law by the DND and the INCB. The latter asked Parties to submit psychotropics information and statistics not required by the Convention. The initial positive responses from various organic group states were then used to persuade others to follow suit. Similarly, the CND and the WHO simply announced that derivatives would be included in the schedules. Some governments complied and others were eventually forced by international pressure to do likewise.

Article 3 of the Single Convention gives the WHO the key role in determining whether, on the basis of a medical or scientific analysis, a new drug should be added to a schedule and thus placed under international control. The WHO's recommendation is submitted to the CND, which makes the final decision. However, any Party may appeal the CND's decision to ECOSOC within 90 days. ECOSOC's decision is final. While a decision is being appealed, the CND may still require Parties to place control measures on the substance in question.

Under the Psychotropics Convention, the WHO continues to make recommendations based on medical and scientific criteria. However, Article 2(5)

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[73] McAllister (2000), page 233.
[74] McAllister (1992), page 157.

explicitly directs the CND to bear in mind *"the economic, social, legal, administrative and other factors it may consider relevant"* in coming to its decision. Furthermore, Article 17(2) states that the CND's decision is subject to approval by a two-thirds majority of CND members.[75] The CND's decision may still be appealed to ECOSOC, and Parties have up to 180 days to do so. In addition, ECOSOC's decision is not necessarily final; there is the possibility of continual appeals. Lastly, while a decision is being appealed, Article 2(7) allows a Party to take "exceptional action" and exempt itself from certain control measures ordered by the CND pending the outcome of the appeal. The cumulative effect of all of these additions to the Psychotropics Convention is that it can be much harder for the WHO to bring a new psychotropic drug within the control system than to add a new narcotic drug to the Single Convention.

The criteria for placing a new drug under control also differ between the two Conventions. According to Article 3 of the Single Convention, a narcotic drug will come within the control regime if it is *"liable to similar abuse and productive of similar ill effects as the drugs"* in the relevant schedule. The prerequisites under Article 2(4) of the Psychotropics Convention are significantly more stringent. The WHO must find:

> *(a) that the substance has the capacity to produce*
> *(i) (1) a state of dependence, and*
> *(2) central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood, or*
> *(ii) similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and*
> *that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control.*

Taking the lead for the manufacturing group on this point, the U.S. and Britain were the most adamant about including such highly restrictive criteria.[76]

The Psychotropics Convention is far ahead of the Single Convention's superficial attempt to address the demand side of drug problems (Article 38 described above). Article 20 of the 1971 treaty is a milestone in that it introduced the concepts of public education and abuse prevention into the legal infrastructure of international drug control. In particular, it enjoins Parties to *"take all practical measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, and [to] coordinate their efforts to these ends."* Parties are also required to promote "as far as possible" the training of personnel to carry out these tasks and encouraged to further the study and public awareness of etiological issues related to abuse. Although these provisions leave plenty of room for countries to avoid taking measures, they are a definite improvement over the Single Convention.

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[75] The U.S. tried to increase it to a three-quarters majority. (McAllister, 2000, page 161)
[76] *Ibid.*, page 159.

The penal provisions in Article 22 of the Psychotropics Convention allow states to use treatment, education, after-care, rehabilitation and social reintegration instead of just conviction or punishment in dealing with abusers who commit offences under the Convention. While the acknowledgement of treatment and rehabilitation is an improvement over previous strictly penal provisions, such measures are intended as a supplement to imprisonment rather than as an alternative.[77]

On the whole, the 1971 negotiations resulted in a treaty that was significantly weaker than the Single Convention. Furthermore, any possibility of revisiting the provisions of the Psychotropics Convention was not realistic in the early 1970s, as a new chapter in the U.S. "war on drugs" was beginning.[78]

Protocol amending the Single Convention on Narcotic Drugs, 1961

In the early 1970s, U.S. President Richard Nixon officially declared "war on drugs" in response to the massive drug abuse in the U.S. and the social damage it was causing. This announcement had global repercussions.[79]

In 1971, as part of the Nixon administration's international anti-narcotics campaign, U.S. officials suggested creating a government-funded, UN-administered fund to combat drug abuse.[80] The United Nations Fund for Drug Abuse Control (UNFDAC) was launched in 1971 with an initial $2 million donation from the U.S. Other governments were reluctant to contribute because of the motives behind the Fund. This reluctance was well founded as UNFDAC essentially became a U.S. tool.

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[77] United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, page 353-354.

[78] The U.S. war on drugs is considered to have begun with the enactment of a federal drug control law known as the *Harrison Narcotics Act of 1914*, and has continued ever since at varying levels of intensity. The most recent supporters of the war on drugs include President Nixon in the late 1960s and early 1970s, President Ronald Reagan in the 1980s, President George Bush in the late 1980s and early 1990s, President Bill Clinton in the 1990s and now President George W. Bush. A great deal has been written about the war on drugs. See, for example, Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport, Connecticut: Greenwood Press, 2000; H. Richard Friman, *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca, New York: Cornell University Press, 1996; James A. Inciardi, *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*, Palo Alto, California: Mayfield Publishing Company, 1986; Kenneth J. Meier, *The Politics of Sin: Drugs, Alcohol and Public Policy*, Armonk, New York: M.E. Sharpe, 1994; Musto (1999); William O. Walker III, *Drug Control in the Americas*, revised edition, Albuquerque, New Mexico: University of New Mexico Press, 1989; Steven Wisotsky, *Beyond the War on Drugs: Overcoming a Failed Public Policy*, Buffalo, New York: Prometheus Books, 1990.

[79] Musto (1999), page 248-259; Bruun *et al.* (1975), ch. 10.

[80] The U.S. campaign included massive international funding for crop substitution, technical assistance to improve the administration and law enforcement, initiatives to combat smuggling, and coordination of educational programs. However, many developing countries were wary of U.S. money with strings attached. The Americans saw the Fund as a way to get around that reluctance. (McAllister (2000), page 236-237)

The emphasis was on law enforcement and crop substitution rather than abuse and demand-oriented strategies. Money went primarily to projects that involved U.S. allies and focused on countries where the U.S. had been unable to stop opium production.[81]

The Fund was also sharply criticized for succumbing to the inefficiency of the UN's bureaucratic machinery: *"A large proportion of the money allocated to the Fund's various programs is in fact spent on supporting an ever-expanding bureaucracy to administer the programs. Indeed many of the Programs appear to serve no purpose other than to provide occupation for the enlarged secretariats."*[82] It was also argued that the UNFDAC should be transferred from the drug control bodies under ECOSOC to the United Nations Development Program, which was better able to assess the development and aid needs of recipient countries.[83]

Another key initiative of the Nixon administration was to strengthen the Single Convention. As a result of heavy U.S. lobbying, a UN plenipotentiary conference was convened in March 1972 to amend the Convention.[84] What came out of the conference was the Single Convention Protocol. The main goal of the amendments was to expand the INCB's role in controlling licit and illicit opium production and illicit drug trafficking in general. The U.S. wanted to revive certain aspects of the 1953 Opium Protocol by attempting to reduce licit opium production. However, in 1972, licit production was just meeting licit demand, and few countries were willing to risk a global shortage of opium for medical use.[85] Consequently, the U.S. proposals were significantly diluted.

The backbone of the Single Convention Protocol consists of provisions that enhance the INCB's powers, especially in relation to illicit trafficking. In Article 2 of the Single Convention, the definition of the INCB's functions now includes an explicit reference to the prevention of *"illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs."* Article 35 encourages Parties to supply the INCB and the CND with information on the illicit drug activity in their territory; as well, the INCB is empowered to advise Parties on their efforts to reduce illicit drug trafficking. When Parties conclude extradition treaties with one another, such agreements are now deemed to automatically include the drug-related offences set out in the Single Convention, including trafficking.[86] Article 22(2) of the Psychotropics Convention says only that it is "desirable" that such offences be made extraditable.

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[81] *Ibid.*, page 238.

[82] Bruun *et al.* (1975), page 281.

[83] *Ibid.*, page 282; Kuševic (1975), page 51.

[84] U.S. ambassadors were selected specifically for the purpose of visiting signatory countries to persuade their leaders to support the amendments proposed by the U.S. It is widely believed that the conference was largely an instrument that Nixon planned to use in the approaching presidential election. (Kuševic (1975), page 47)

[85] Kuševic (1975), page 48. According to Kuševic, it would have been better to try to reduce the *diversion* of licit demand into the illicit market.

[86] Single Convention, Article 36, as amended by the Single Convention Protocol, Article 14.

The Protocol amended the Single Convention's abuse prevention provisions to bring them into line with Article 20 of the Psychotropics Convention.[87] The amended Single Convention also echoes the Psychotropics Convention by now allowing countries to use *"treatment, education, after-care, rehabilitation and social reintegration"* either as an alternative to or in addition to conviction or punishment.[88]

Although not as stringent as originally intended by the U.S., the Single Convention Protocol continued the prohibitive tradition of the international drug control regime, especially against opium, and stepped up the war on illicit trafficking.

Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

Numerous national and regional drug control initiatives were launched in the 1970s and 1980s.[89] In Europe, the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, also known as the "Pompidou Group," was created to facilitate discussions between countries. In addition, the Heads of National Law Enforcement Agencies (HONLEA) met regionally - in Asia and the Pacific in the 1970s, and in Africa, Latin America and Europe in the 1980s - to improve police and customs drug enforcement cooperation. INTERPOL expanded its operations and became "an important clearinghouse for information and a sponsor of local, regional, and global drug enforcement meetings."[90]

Meanwhile, concerns arose within the UN and among its main control-oriented members that the anti-trafficking efforts of the international drug control system were being compromised by the fact that certain nations were not Parties to the Conventions or did not have domestic law enforcement systems capable of properly combating illicit trafficking.[91] In 1984, the UN General Assembly adopted resolution 39/141, which called on ECOSOC to instruct the CND to prepare "as a matter of priority" a draft convention considering *"the various aspects of the problem [of illicit drug trafficking] as a whole and, in particular, those not envisaged in existing international instruments."* Thus, the goal was to add an additional, trafficking-specific layer to the drug control system to complement the two existing Conventions.

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[87] *Ibid.*, Article 38, as amended by the Single Convention Protocol, Article 15.

[88] *Ibid.*, Article 36, as amended by the Single Convention Protocol, Article 14.

[89] In the U.S., the war on drugs lost some momentum in the 1970s during the administrations of Presidents Gerald Ford and Jimmy Carter. Eleven U.S. states decriminalized certain aspects of marijuana regulation and were supported by well-known organizations such as the American Medical Association, the American Bar Association, the American Public Health Association and the National Council of Churches. President Ronald Reagan reversed this trend in the early 1980s. (Wisotsky (1990), page xviii)

[90] McAllister (2000), page 242-243.

[91] Bewley-Taylor (1999), page 167; David P. Stewart, "Internationalizing the War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances," *Denver Journal of International Law and Policy*, Vol. 18, No. 3, Spring 1990, page 387-404.

The draft treaty was finalized at the 1987 UN Conference on Drug Abuse and Illicit Trafficking. Also at this Conference, a Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control[92] (CMO) was adopted to encourage states to fulfil their existing treaty obligations. The CMO focused on four areas: (1) prevention and reduction of illicit demand; (2) control of supply; (3) suppression of illicit trafficking; and (4) treatment and rehabilitation. Many of the objectives described in the CMO were reflected in the draft treaty. Between 25 November and 20 December 1988, representatives of 106 states met in Vienna to negotiate a final text. The result was the Trafficking Convention.

The Trafficking Convention is essentially an instrument of international criminal law. Its aim is to harmonize criminal legislation and enforcement activities worldwide with a view to curbing illicit drug trafficking through criminalization and punishment. Under the Convention, Parties are required to enact and implement very specific criminal laws aimed at suppressing illicit trafficking. These laws relate to such aspects of the problem as money laundering, confiscation of assets, extradition, mutual legal assistance, illicit cultivation, and trade in chemicals, materials and equipment used in the manufacture of controlled substances. As with the other two Conventions, the CND and the INCB are charged with administration of the Convention. Furthermore, for minor offences, the Trafficking Convention allows demand-side measures to be used as an alternative to conviction or punishment.[93]

The Preamble describes illicit trafficking as *"an international criminal activity"* and points out the *"links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States."* It also stresses *"the importance of strengthening and enhancing effective legal means for international co-operation in criminal matters for suppressing the international criminal activities of illicit traffic."* Even the single reference in the Preamble to demand-side issues is couched in terms specific to criminal law: *"Desiring to eliminate the root causes of the problem of abuse of narcotic drugs and psychotropic substances, including the* ***illicit demand*** *for such drugs and substances and the enormous profits derived from illicit traffic"* (emphasis added). The implication is that drug users also are to be considered criminals. The Preamble clearly reflects its prohibitionist roots, even explicitly reaffirming *"the guiding principles of existing treaties in the field of narcotic drugs and psychotropic substances and the system of control which they embody."*

Accordingly, the cornerstone of the Trafficking Convention is Article 3: "Offences and Sanctions." Here the treaty breaks new ground by *requiring* that Parties "legislate as necessary to establish a modern code of criminal offences relating to the

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[92] *Declaration of the Conference on Drug Abuse and Illicit Trafficking, and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control*, UN document ST/NAR/14, 1988.

[93] For a detailed description of the provisions of the Trafficking Convention, see William Gilmore, *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, London: Commonwealth Secretariat, 1991; Stewart (1990). Since Stewart was a member of the U.S. delegation that took part in the negotiations, his article presents the U.S. perspective on the treaty.

various aspects of illicit trafficking and to ensure that such illicit activities are dealt with as serious offences by each State's judiciary and prosecutorial authorities."[94] The mandatory offences, set out in Article 3(1), include the following:

- The production, manufacture, distribution or sale of any narcotic drug or psychotropic substance in violation of the provisions of the Single Convention or the Psychotropics Convention;
- The cultivation of the opium poppy, coca bush or cannabis plant in violation of the above Conventions;
- The possession or purchase of any narcotic drug or psychotropic substance for the purpose of illicit trafficking;
- The manufacture, transport or distribution of materials, equipment and substances for the purpose of illicit cultivation, production or manufacture of narcotic drugs or psychotropic substances;
- The organization, management or financing of any of the above offences.[95]

Furthermore, Article 3(2) of the Trafficking Convention requires each Party, subject to its constitutional principles and the fundamental principles of its legal system, to establish criminal offences for the possession, purchase or cultivation of drugs for personal consumption.

SOME LEEWAY?

Three points bear making concerning the substance of the current conventions.

The first has to do with the absence of definitions. The terms drugs, narcotics and psychotropics are not defined in any way except as lists of products included in schedules. It follows that any natural or synthetic substance on the list of narcotics is, for the purposes of international law, a narcotic, and that a psychotropic is defined in international law by its inclusion in the list of psychotropics.[96] The only thing that the 1961 Convention tells us about the substances to which it applies is that they can be abused. The 1971 Psychotropics Convention, which, as noted earlier, reversed the roles in that the synthetic drug producing countries wanted narrower criteria, indicates that the substances concerned may cause dependence or central nervous system stimulation or depression and may give rise to such abuse as to *"constitute a public health problem or a social problem that warrants international control."*

The second point, following from the first, relates to the arbitrary nature of the classifications. While cannabis is included, along with heroin and cocaine, in Schedules

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[94] United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, page 48.

[95] See Stewart (1990), page 392; Gilmore (1991), page 5.

[96] Caballero and Bisiou, *op. cit.*, page 26.

I and IV of the 1961 Convention, which carry the most stringent controls, it is not even mentioned by name in the 1971 Convention, though THC is listed as a Schedule I psychotropic along with mescaline, LSD and so on. The only apparent criterion is medical and scientific use, which explains why barbiturates are in Schedule III of the 1971 Convention and therefore subject to less stringent controls than natural hallucinogens. These classifications are not just arbitrary, but also inconsistent with the substances' pharmacological classifications and their danger to society.

Third, if there was so much concern about public health based on how dangerous "drugs" are, one has to wonder why tobacco and alcohol are not on the list of controlled substances.

We conclude from these observations that the international regime for the control of psychoactive substances, beyond any moral or even racist roots it may initially have had, **is first and foremost a system that reflects the geopolitics of North-South relations in the 20th century**. Indeed, the strictest controls were placed on organic substances - the coca bush, the poppy and the cannabis plant - which are often part of the ancestral traditions of the countries where these plants originate, whereas the North's cultural products, tobacco and alcohol, were ignored and the synthetic substances produced by the North's pharmaceutical industry were subject to regulation rather than prohibition. It is in this context that the demand made by Mexico, on behalf of a group of Latin American countries, during the negotiations leading up to the 1988 Convention, that their use be banned must be understood. It was a demand that restored the balance to a degree, as the countries of the South had been forced to bear the full brunt of the controls and their effects on **their own** people since the inception of drug prohibition. The result may be unfortunate, since it reinforces a prohibitionist regime that history has shown to be a failure, but it may have been the only way, given the mood of the major Western powers, to demonstrate the irrationality of the entire system in the longer term. In any case, it is a short step from there to questioning the legitimacy of instruments that help to maintain the North-South disparity yet fail miserably to reduce drug supply and demand.

Putting aside such questions of substance, we will now examine how much leeway countries have within the current conventions to adopt less prohibitionist policies.

Several states have adjusted their criminal enforcement systems to allow *de facto* possession of small amounts of certain soft drugs, such as cannabis and its derivatives, for personal consumption while remaining within the legal bounds of the Conventions.[97] Although the Conventions do not permit legalization or even decriminalization of possession, those countries have circumvented the limitations by criminalizing possession, as required by the treaties, but not strictly enforcing the

[97] For example, Belgium, Denmark, Germany, the Netherlands, Poland and some Australian states. Switzerland is currently considering a bill to legalize cannabis. The next chapter provides more detail on the Australian, Dutch and Swiss approaches in particular.

legislation, or they have effectively "depenalized" the offences by exempting them from punishment.[98]

According to some observers, such approaches clearly violate the spirit of the Conventions, especially the Trafficking Convention, which seems to use the term "trafficking" very broadly to include demand-side activities within a supply-oriented control regime. Yet there is a legal basis for these "softer" approaches because the treaties do not explicitly forbid them.

The hard-nosed criminal law approach adopted by the international drug control system has drawn criticism from human rights activists. Some maintain that the imprisonment penalties are excessive for soft-drug offences such as possession of a small amount of cannabis for personal consumption.[99] It is argued that imprisonment in such circumstances is disproportionate to the offence and therefore violates the inherent dignity of persons, the right to be free from cruel and degrading punishment, and the right to liberty, as set out in such instruments as the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights*, and the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*[100] It has also been argued that drug use is a human right and should be recognized as such in the *Universal Declaration of Human Rights*.[101]

The Trafficking Convention is the only one of the three Conventions that mentions human rights. Article 14(2) of the Trafficking Convention explicitly requires Parties "to respect fundamental human rights" when they take measures to prevent and eradicate the illicit cultivation of plants containing narcotic or psychotropic substances, such as opium, cannabis and coca. The same provision also requires states to take into account traditional licit uses, where there is historical evidence of such use, and protection of the environment.

There are three factors that provide states, including Canada, with some leeway. The first is the fact that the conventions recognize the primacy of national legal systems. Indeed, the international drug agreements have no direct application in

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[98] See Krzysztof Krajewski, "How flexible are the United Nations drug conventions?" *International Journal of Drug Policy*, No. 10, 1999, page 329-338. Krajewski provides an excellent overview of the conventions' legal limits in the area of legalization and prohibition. He concludes that legalization or decriminalization would probably require amendment of Article 3(2) of the Trafficking Convention. See also the discussion on legalization in Dupras (1998), page 24-33; and Alfons Noll, "Drug abuse and penal provisions of the international drug control treaties," *Bulletin on Narcotics*, Vol. XXIX, No. 4, October/December 1977, page 41-57.

[99] See, for example, the following pages on the Web site of Human Rights Watch, a human rights non-governmental organization: http://www.hrw.org/campaigns/drugs/ and http://www.hrw.org/worldreport99/special/drugs.html.

[100] The full text of these international instruments is available on the Web site of the Office of the UN High Commissioner for Human Rights: http://www.unhchr.ch/html/intlinst.htm.

[101] See Erik Van Ree, "Drugs as a Human Right," *International Journal of Drug Policy*, Vol. 10, 1999, page 89-98. Van Ree proposes the addition of a new Article 31 to the *Universal Declaration of Human Rights*: Everyone has the right to use psychotropic substances of one's own choice.

national law. To make them enforceable within its territory, the state must enact a law; in Canada, that law is the *Controlled Drugs and Substances Act.* Specifically, the conventions variously state that the proposed penalties are to be imposed "subject to [the Parties'] constitutional provisions" or *"having due regard to their constitutional, legal and administrative systems."* In Canada, the provisions of the *Canadian Charter of Rights and Freedoms* and the interpretations given to them by the Supreme Court are the framework for interpreting the international conventions on drugs.

The second, slightly more technical point suggests that sanctions for possession apply only to possession for the purposes of trafficking, especially in view of this provision's position between two articles on trafficking and of its earlier wording.[102] Failing to punish people for possession for personal use would not be, strictly speaking, prohibited. That is the legal opinion of an expert asked by Switzerland's Federal Office of Public Health to comment on its draft legislation to legalize cannabis: [Translation] *"The statute's general depenalization of the consumption and small-scale cultivation of cannabis would be compatible with the conventions."*[103] With regard to cannabis trade and supply, the author writes: [Translation] *"Even though regulating cannabis trade with a licensing system does not appear to be out of the question, some practical problems remain, partly because of the control mechanisms required by the 1961 Convention, and partly because the international community interprets the 1988 Convention as an obligation to punish the buying and selling of cannabis."*[104]

The third factor is that the conventions impose moral obligations on states and not legal obligations, much less penalties or sanctions for violating them, and that they also include review or amendment mechanisms.

CONCLUSIONS

As we have seen in Chapters 5, 6 and 7, cannabis is widely used in every part of the world, does not have the harmful effects ascribed to it, and poses little risk to public health. Consequently, it in no way deserves to be included in the convention schedules that list what are supposed to be the most dangerous drugs. Cannabis even has therapeutic uses recognized by Canadian courts. For the above reasons, **we recommend that Canada notify the international community of its intent to seek**

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[102] See Daniel Dupras (1998) *Canada's International Obligations under the Leading International Conventions on the Control of Narcotic Drugs.* Ottawa: Library of Parliament, available on the Committee's Web site at www.parl.gc.ca/illegal-drugs.asp .

[103] Peith, M., (2001) "Compatibilité de différents modèles de dépénalisation partielle du cannabis avec les conventions internationales sur les stupéfiants" [Compatibility of various models of partial depenalization of cannabis with international narcotics conventions]. Legal opinion requested by the Federal Office of Public Health of the Swiss Confederation, page 14.

[104] *Ibid.*, page 15.

the declassification of cannabis as part of a public health approach that would include stringent monitoring and evaluation.

Conclusions of Chapter 19	
	➢ **The series of international agreements concluded since 1912 have failed to achieve their ostensible aim of reducing the supply of drugs.** ➢ **The international conventions constitute a two-tier system that regulates the synthetic substances produced by the North and prohibits the organic substances produced by the South, while ignoring the real danger which those substances represent to public health.** ➢ **When cannabis was included in the international conventions in 1925, there was no knowledge of its effects.** ➢ **The international classifications of drugs are arbitrary and do not reflect the level of danger those substances represent to health or to society.** ➢ **Canada should inform the international community of the conclusions of our report and officially request the declassification of cannabis and its derivatives.**

CHAPTER 20

PUBLIC POLICIES IN OTHER COUNTRIES

As just seen, the international conventions provide the framework for the criminal policy approaches the signatory states may adopt. We have also seen that interpretations vary as to the nature of the obligations they create, specifically with regard to use, and thus possession, for personal purposes. Some interpretations go so far as to suggest that, with regard to cannabis, certain forms of regulation of production could be possible, without violating the provisions of the conventions, as long as the State took the necessary steps to penalize illegal trafficking.

The vast majority of Canadians have heard about the "war on drugs" which the USA is conducting and about its prohibitionist approach, but many would be surprised to see the major variations between states, indeed between cities, within that country. Even fewer know that Sweden enforces a prohibitionist policy at least as strict as that of the US, but through other means. Many of us have, in one way or another, heard about the "liberal" approach introduced in the Netherlands in 1976. Fewer people know of the Spanish, Italian, Luxembourg or Swiss approaches, which are even more liberal in certain respects. More recently, Canadians learned of the decision by the UK's Minister of the Interior to reclassify cannabis as a Class C drugs, but it is not clear that we know precisely what that means. In view of the preconceptions that many may have in relation to France with regard to wine, many may be surprised to learn that its policy on cannabis appears more "conservative" than that of neighbouring Belgium, for example.

As may be seen, once the overall framework of the puzzle has been established by the international community, ways of putting the pieces together vary widely between states, and at times among the regions of a single state. That is why, in order to learn about the experience and approaches of other countries, the Committee commissioned a number of research reports on the situations in other countries[1] and heard representatives of some of those countries in person.[2]

We of course had to make some choices, limiting ourselves to the western countries of the northern hemisphere. This is a weak point, we agree, but our resources

[1] Those reports, prepared by the Parliamentary Research Branch staff, concern Australia, the United States, France, the Netherlands, the United Kingdom, Sweden and Switzerland. Exact references appear in Appendix B.

[2] We heard representatives of the United States, France, the Netherlands and Switzerland.

were limited. In addition, as we wanted to compare public policies with data on use trends and judicial practices, we were forced to choose countries with an information base. In our hearings of representatives of those countries, we were mainly limited by time.

In this chapter, we describe the situations in five European countries – France, the Netherlands, the United Kingdom, Sweden and Switzerland – and in Australia and the United States.

FRANCE[3]

Different forms of logic

The new direction taken by the Law of 1970,[4] currently in effect, which penalizes drug use, is, in some respects, more apparent than real. Internal public policy had begun to change in the late nineteenth century, leading to the adoption of the great law on narcotics in 1916, providing criminal penalties for importing, trafficking, possession and use. That legislation, which was particularly strictly enforced for the time (up to three years in prison for narcotics offences) introduced the offence of "use in society". Its passage had been preceded by an intensive "public health campaign" in which narcotics were [translation] "*accused by their detractors of being the root of most of society's ills, that is to say of comprehensively promoting depopulation, moral decadence and, even worse, violent and criminal acts*".[5]

That law was supplemented by the Law of 1922 and the Executive Order of 1939, which stepped up and reinforced its prescriptions. The Law of 1922 required judges to order out of the country persons convicted of trafficking or facilitating use, while the Executive Order increased prison terms to five years. The Law of 1922 also authorized the police to enter homes without prior legal authorization. In Charras' view, "*these various provisions made the French legislation one of the most draconian in Europe*."[6]

The "therapeutic injunction", another factor causing tension in the 1970 legislation, is in some instances considered the very core of France's drug legislation. Under that provision, [translation] "*an obligation of care may be imposed on every drug user at three points in the penal process:*

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[3] In this section, we have drawn on a study report prepared by the Library of Parliament: C. Collin, *National Drug Policy: France*, Ottawa: Library of Parliament, 2001, report prepared for the Senate Special Committee on Illegal Drugs.

[4] Law No. 70-1320 of December 31, 1970, respecting health measures in the fight against substance abuse and repression of the trafficking in and use of poisonous substances.

[5] I. Charras, "L'État et les 'stupéfiants'" : archéologie d'une politique publique répressive", in *Drogue. Du bon usage des politiques publiques.* Les cahiers de la sécurité intérieure, page 13.

[6] I. Charras, *op. cit.*, pages 15-16.

- *upon entry into the judicial process, the prosecution may propose an alternative to trial*;
- *during trial, the trial judge or juvenile court judge may impose medical supervision;*
- *at sentencing, the court may impose a health measure either because the user has previously refused it or, on the contrary, to extend it if it commenced under the previous article*." [7]

Characterized as a [translation] "*humanist counterweight to a repressive policy*",[8] the therapeutic injunction has often been considered by various French observers as an awkward compromise between police powers on the one hand and medical powers on the other.[9]

However, in characterizing the French system as falling between repressing the user as an "offender" and treating him as a "patient", there is a risk of disregarding another aspect of the French approach to drugs at least until the 1970s: the country's foreign policy and the logic of its tax system.

> [Translation] "*The prohibition against drugs is a recent phenomenon. Unlike China, which, since the eighteenth century, has sought to prohibit the use of opium, European countries did not discuss prohibition until the twentieth century. Furthermore, prohibition did not actually become effective until after the 1950s, and there has been no real desire to provide medical care to users until the past 20 years. Before being prohibited or prescribed, narcotic use was taxed through opium and cannabis tax monopolies.*" [10]

Bisiou identifies five known monopolies in the history of colonial France: India from 1864 to 1954, Indochina from 1864 until 1975, in Laos; Oceania from 1877 to 1922 and two cannabis monopolies operated concurrently with tobacco monopolies, one in Tunisia between 1881 and 1954 and the other in Morocco between 1914 and 1952. Another monopoly, the existence of which has not been confirmed, purportedly existed in Lebanon.[11]

These monopolies offered various advantages from a tax and policy standpoint. For tax purposes, they generated significant cash flows, making it possible to finance colonization; from a policy perspective, they were well accepted by the colonies to the extent they pre-existed French colonization and were already well accepted by local populations. What is interesting is the moral character of the "vicious substances" which justified the system for the taxation of luxury products whose consumption

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[7] L. Simmat-Durand, "Les obligations de soins en France." in C. Faugeron, ed., *Les drogues en France. Politiques, marchés, usages*. Paris: Georg éditeur, 1999, page 111.

[8] M. Setbon, *L'injonction thérapeutique. Évaluation du dispositif légal de prise en charge sanitaire des usagers de drogues interpellés.* Paris: Observatoire français des drogues et des toxicomanies, 2000, page 11.

[9] See *inter alia* L. Simmat-Durand, *La lutte contre la toxicomanie. De la législation à la réglementation.* Paris: L'Harmattan, 2000; J. Bernat de Celis, *Drogues : Consommation interdite.* Paris: L'Harmattan, 1996; and H. Bergeron, *Soigner la toxicomanie. Les dispositifs de soins entre idéologie et action.* Paris: L'Harmattan, 1996.

[10] Y. Bisiou, "Histoire des politiques criminelles. Le cas des régies françaises des stupéfiants.", in C. Faugeron, ed., *Les drogues en France. Politiques, marchés, usages.* Paris: Georg éditeur, 1999, page 89.

[11] Bisiou, *op. cit.*, page 90.

authorities did not wish to encourage. Although abolished at decolonization and characterized by certain internal contradictions between the economic imperatives of profitability and health objectives, this policy, starting in the 1930s, also came under extensive criticism from the international community, whose orientations, as noted above, were increasingly prohibitionist. The history of state drug monopolies has nevertheless marked French history (as it did Dutch, British and Portuguese history) and was another factor in addition to domestic policy.

Thus it was not one single drug policy that France had in the twentieth century, but three often competing forms of logic on the issue. But it was not until the *Mission interministérielle de lutte à la drogue et à la toxicomanie* [Interministerial Mission on Anti-Drug and Addiction Activities] (MILDT) was reinforced in the mid-1990s that a trend emerged toward a more integrated and coherent overall policy.

An integrated public policy

MILDT was established in the early 1980s during the first seven-year term of French President François Mitterrand. Over the years, however, it either lacked leadership or did not have the resources to achieve its ambitions. It was not until Nicole Maestracci was appointed in 1995, under the socialist government of Prime Minister Jospin, that MILDT began to become more visible and take stronger public action. Its activities were directed in particular by the strong controversies and demonstrations conducted by stakeholders of various types (hospital physicians concerned by AIDS, members of NGOs, drug addicts, specialists and others) who criticized the scientific bases of the main objectives of France's drug policy. At the centre of the debate was a need for a harm reduction approach, focusing on reducing AIDS transmission by intravenous drug users and methadone treatment for drug addicts.[12]

In February 1994, only one small group of 77 addicts had access to methadone treatment, whereas there were 160,000 heroin addicts in France at the time. In 1998, medication substitution treatments were offered in France to a group of up to 70,000 addicts, the vast majority of whom received Subutex and methadone replacements.[13] This new development clearly shows that public authorities now consider harm reduction a fundamental component of France's drug policy.[14]

On June 16, 1999, the French government introduced a three-year plan clearly reflecting this paradigm shift since palliative and preventive measures became legitimate

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[12] See Ms. Nicole Maestracci, President, Mission interministérielle de lutte à la drogue et à la toxicomanie [Interministerial Mission for the Fight Against Drugs and Drug Addiction], testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, October 1, 2001, Issue no. 7, page 9-10.

[13] Michel Kokoreff, "Politique des drogues en France, entre loi pénale et réduction des risques", presentation to the Senate Special Committee on Illegal Drugs, 2001.

[14] Henri Bergeron, "Comment soigner les toxicomanes?" *Sociétal*, June-July 1998, pages 45-49.

goals in the French policy context. As to criminal policy, the main legislative framework – the law of 1970–has not been amended and drug use is still considered an offence. However, in a circular, the Minister of Justice has asked prosecutors not to seek prison terms and to promote treatment in drug cases.

The plan is based on European and international data and on recent reports, interdepartmental consultations and scientific studies providing fundamental observations on France's policy on drugs and drug abuse. The emergence of new use profiles such as the use of numerous drugs (both legal and illegal), increased cannabis and alcohol use among young people and greater availability of synthetic drugs were the main concerns expressed. Information bases and systems have also come under criticism from various quarters concerning:

- the lack of coordination among prevention programs and their limited accessibility (e.g., school drug prevention programs are offered to less than 40 per cent of students and those concerning alcohol and tobacco to less than 20 per cent);
- the lack of social and professional support;
- the fact that there is no ground for agreement among the various stakeholders (law enforcement, social welfare, education and public health);
- the excessive importance attached to heroin addicts in the administration of specialized treatment at a time when use among the members of this addicted group has stabilized;
- the difficulty in reconciling law enforcement with the public health strategy.[15]

Criminal law enforcement with respect to drug users has been constantly marked by the difficulties inherent in reconciling suppressive activities with public health imperatives. The number of users who have been questioned by authorities has doubled over the last five years, without the judicial system having permitted adequate and effective cooperation with physicians and social workers.[16]

Furthermore, observing the declining number of trafficking arrests at the local level since 1996, elected representatives and the general public find this hard to understand in view of the importance they feel should be attached to monitoring drug

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[15] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), *Three-Year Plan to Combat Drug Use and Prevent Dependence 1999-2001*. Available online at: http://www.drogues.gouv.fr/uk/what_you_need/whatyouneed_intro.html.

[16] Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT), "An Information Booklet Summarising the Government's Plan for the Fight Against Drugs and the Prevention of Addiction 1999-2000-2001", *Drugs: No More, Risk Less*, MILDT, December 1999, page 7. Available online at: http://www.drogues.gouv.fr/fr/index.html.

supply. Lastly, the shortage of reliable indicators has prevented any in-depth, or even comprehensible, assessment of existing programs.

Based on these observations, the government has developed a three-year plan defining action priorities, objectives and measures that should be taken. Two key factors – integration and knowledge – are the watchwords of this effort. Integration is viewed from two standpoints: for the first time, France will have an integrated policy on all psychoactive substances, drugs, medications, alcohol and tobacco.

> *The fact that we were talking about alcohol, tobacco and medication at the same time as we were talking about drugs no doubt made everyone feel closer to the situation because everyone had the experience of consuming a product, be it legal or illegal. This was an important aspect that did not result in our saying that all of the products should come under the same legislative regime, but [that made it possible, regardless of the product used] to distinguish between occasional use and problem use.* [17]

The other aspect of integration is a reinforced effort among the 19 departments that form the MILDT under the chairmanship of the Prime Minister.

The second watchword of this French effort is knowledge. As noted above, a certain number of observers had noted weaknesses in the knowledge apparatus, including reports commissioned by various authorities (discussed below). In the wake of the impetus given by President François Mitterrand to the creation of the European Monitoring Agency for Drugs and Drug Addictions, France, in 1993, established the French Monitoring Centre for Drugs and Drug Addictions. The mission of the French Centre, which is an "independent" agency, is to "develop the observation network in order to monitor recent trends in drug use, conduct regular epidemiological surveys on the public and implement a comprehensive public policy evaluation framework".[18] To do so, it organizes its work along three main lines: observation and improvement of indicators, monitoring of recent trends and policy evaluation. The Centre has a staff of 25 persons and a budget of 18 million French francs (approximately Cdn $3.5 million). It is also the national focal point in the network of the European Monitoring Centre for Drugs and Drug Addictions.

Legislative framework

French law related to illicit drugs is drawn from many sources including four codes: the Code of Public Health (code de la santé publique), the Penal Code, the Code of Penal Procedure, and the Customs Code. The main legislative framework is the law of 31 December 1970, which amended the Code of Public Health and created a legislative framework based on both the application of repressive measures and health-related dispositions. The objectives of the Law of 1970 were to severely repress

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[17] Nicole Maestracci, testimony before the Senate Special Committee on Illegal Drugs, page 13.

[18] Observatoire français des drogues et des toxicomanies, *Drogues et dépendances. Indicateurs et tendances 2002.* Paris: author, 2002, page 291.

trafficking, prohibit the use of narcotics, and yet propose alternatives to the repression of use, as well as to ensure free and anonymous care for users seeking treatment. [19] It must be noted that most articles of the Law of 1970 (originally written into the Public Health Code) have since been integrated into the new penal code that came into force in 1994 except for infractions related to drug use, which are still sanctioned through the Public Health Code. French law is also governed by international law since France has ratified the UN conventions related to drugs.

Classes of drugs

French law does not distinguish between illicit substances and thus, an offence such as drug use is prosecuted and judged in the same way regardless of the illicit substance involved. However, judicial authorities may take into consideration the nature of the substance, the quantity and any prior criminal records in their decision to prosecute, reduce the charges or not prosecute an offender. Illicit substances are listed in an annex to Decree Law of 22 February 1990 and include the following:

List I: narcotic substances such as heroin, cocaine, cannabis, methadone, opium, etc.;
List II: substances such as codeine, propiram, etc.;
List III: psychotropic substances such as amphetamines, Ecstasy, LSD, etc.; and
List IV: synthetic drugs such as MBDB, 4-MTA, Ketamine, Nabilone, THC, etc.[20]

Offences and penalties

Public or private drug use in France is prohibited and criminalized by the Law of 1970 (article L3421-1 of the Code of Public Health). The penalty for illicit drug use is up to one year in prison or a fine of 25,000 French Francs, or diversion to a court-ordered treatment program (therapeutic injunction–in French, "*injonction thérapeutique*"). This article of the Code of Public Health applies to all users without any distinction as to the type of illicit substance used.

The Code of Public Health also provides for the monitoring of drugs users by health authorities (article L3411-1). Prosecutors may not undertake legal action against an offender if that person can provide medical certification that he has undertaken some form of therapy or has submitted himself to medical supervision since the commission of the infraction. However, if the offender does not supply a medical certificate to that effect, prosecutors may request that an individual who has made use of illicit drugs follow a drug addiction treatment program or be placed under medical monitoring (article L3423-1). The involvement in a court-ordered treatment program

[19] Observatoire français des drogues et des toxicomanies (OFDT), *Drogues et toxicomanies : indicateurs et tendances*, 1999 Edition, page 20. Available online at: http://www.drogues.gouv.fr/fr/index.html.
[20] Observatoire européen des drogues et des toxicomanies (OEDT)/ *European Legal Database on Drugs (ELDD), France Country Profile, French Drug Legislation*. Available online at: http://eldd.emcdda.org/databases/eldd_national_reviews.cfm?country=FR.

suspends legal proceedings and these will not be pursued if the individual completes the detoxification program.[21] It is not uncommon for a repeat offender to be subjected to more than one court-ordered treatment program as more repressive measures are rarely used for simple drug use, particularly cannabis use.

As mentioned above, the Ministry of Justice – in a directive dated June 1999 – asked prosecutors to prioritize treatment over incarceration for small-time offenders and problematic drug users. Practice has shown that therapeutic alternatives are used mainly for simple users and that most cases of simple drug use receive a warning with the request to contact a social or health service. When legal proceedings are undertaken, the magistrate may also force, and not simply order, the accused to undertake a detoxification program but in this case, judicial authorities take charge of the case rather than health authorities. In these cases, if the user completes the treatment, no penalties may be imposed on the individual but the use of such measures are extremely rare. [22] As well, a detoxification treatment may be a condition attached to a conditional prison sentence, parole or judicial supervision. In France, the delinquent user is thus seen mostly as a sick person to whom therapy must be offered. [23]

On the drug trafficking side, the Law of 1970 has been modified on several occasions, creating new offences such as the selling or supplying drugs for personal use (17 January 1986) and drug-related money laundering (31 December 1987), or enacting new procedures such as the confiscation of drug trafficking profits (14 November 1990) to comply with Article 5 of the United Nations Convention (19 December 1988).[24] Currently, trafficking offences include selling or supplying drugs for personal use with a penalty of up to five years and a fine of up to 500,000 F (articles 222-39 of the Penal Code) and a more serious offence for transportation, possession of, supply, sale and illicit purchase of narcotics with a penalty of up to 10 years and a fine up to 50 million F (article 222-37). Illicit imports and exports of narcotics are also punishable by 10 years' imprisonment and a fine up to 50 million F but when the offence is committed by a criminal organization, the penalty increases to 30 years of imprisonment (article 222-36). Furthermore, trafficking in narcotics might also be punishable as a customs offence (contraband and similar offences) with a maximum sentence of three years' imprisonment and fines equalling two-and-one-half times the value of the illegal merchandise. Prosecutions under the Customs Code do

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[21] Comité consultatif national d'éthique, *Rapports sur les toxicomanies*, rapport nº 43, November 23, 1994, page 19. See: http://www.ccne-ethique.org/français/start.htm.

[22] OEDT/ELDD, *France Country Profile*, 2001.

[23] Comité consultatif national d'éthique, 1994.

[24] United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, December 19, 1988: Article 5, Confiscation 1. Each Party shall adopt such measures as may be necessary to enable confiscation of: (a) Proceeds derived from offences established in accordance with article 3, paragraph 1, or property the value of which corresponds to that of such proceeds; (b) Narcotic drugs and psychotropic substances, materials and equipment or other instrumentalities used in or intended for use in any manner in offences established in accordance with article 3, paragraph 1.

not exclude penal prosecution, and customs sanctions can be added to penal sanctions.[25]

Other offences include the illegal production or manufacturing of narcotics punishable by 20 years in prison and a fine of 50 million F. Here again, when a criminal organization commits the offence, the penalty increases to 30 years' imprisonment (article 222-35). Drug-related money laundering defined as "*facilitating by any means, false justification of the source of assets or revenues of the author of an infraction to narcotics legislation*" is punishable by 10 years imprisonment and a fine of 5 million F (article 222-38). Incitement to drug use or to commit any offence sanctioned by articles 222-234 to 222-239 of the Penal Code or to present these offences in a favourable light is punishable by five years in prison and a fine of 500,000 F (article L3421-4 of the Code of Public Health). This offence is aimed at the media and literary or artistic works. Inciting a minor to use narcotics is punishable by five years' imprisonment and a fine of 700,000 F and in the case of a minor under the age of 15 years or if the offence is committed in or around an educational establishment, the penalty increases to 7 years in prison and a fine of 1 million F (article 227-18). Finally, heading or organizing a group engaged in the production, manufacturing, import and export, transportation, possession, supply, sale, purchase or use of narcotics can lead to a life sentence and a fine of 50 million F (article 222-34).

Key reports

The Pelletier Report

The first assessment of the Law of 1970 and of the French policies with respect to drugs and drug addiction was completed in 1978 by a commission presided by Monique Pelletier, who studied the issue at the request of French President Giscard d'Estaing.[26]

The Pelletier report stated that the difficulties encountered in the implementation of the Law of 1970 were the result of inequalities in handling drug users due in part to the fact that the law did not include an intermediate category between a drug user and a trafficker. The report also attributed the implementation problems to the difficulties encountered in getting legal and health authorities to work together.[27] Doctors were particularly sceptical about the principle of court-ordered treatment and of forcing an individual into treatment. The Pelletier Commission noted as well that legal sanctions were used more often than treatment alternatives. Members of the Pelletier Commission believed that the Law of 1970 deserved a second chance. They suggested

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[25] OEDT/ELDD, *France Country Profile*, 2001.

[26] M. Pelletier, *Rapport de la mission d'étude sur l'ensemble des problèmes de la drogue*, Paris: La Documentation française, 1978.

[27] Centre d'aide et d'accueil en toxicomanie (CAAT), *La mise en application de la loi*. See: http://caat.multimania.com/info/app_loi.htm.

that it could benefit from the institution of clear implementation guidelines (circular letters) and the establishment of structural and financial resources to ensure the successful implementation of therapeutic alternatives, both at the judicial and medical level. The report proposed, among other suggestions, that drug users should be differentiated according to the type of illicit substance they use.[28]

Officially today, the law still does not distinguish between illicit substances but in practice many circular letters over the past 20 years have invited prosecutors and judges to differentiate between cannabis use and use of other drugs such as heroin and cocaine. For example, a circular letter (7 May 1978) suggested that cannabis users should not be considered "true" drug addicts, that detoxification treatment may not be the appropriate measure for this type of user, and that they should receive a simple warning. It also invited judges to encourage drug users to contact a drug addiction centre and to only use court-ordered treatment for repeat offenders. This circular letter has been perceived by many as a decriminalization of cannabis use. However, it must be noted that circular letters express the intentions of the Ministry of Justice but can be enforced diversely by prosecutors.[29]

The 1978 circular letter was a point of reference until 12 May 1987 at which time a Justice-Health circular repealed preceding letters and introduced a new distinction for drug use based on the frequency of use.

> [Translation] *For all cases involving drug use, a report had to be sent to the prosecution and dealt with by a specialized judge. "Occasional" users, who were well integrated into society were to be given a simple warning. The letter recommended court-ordered treatment or prosecution for "habitual" users. Illegal foreign users were to be immediately tried and banned from the French territory. Lastly, user-dealers or delinquent users were to be prosecuted as a head dealer or for harming others or goods. This letter also marked a will to revive court-ordered treatment and clarified how it should be enforced.* [30]

This circular letter was a turning point towards more repressive measures for habitual users and user-dealers[31] and the basis of the orientation of legal policy between 1990 and 1995, which focused on reviving court-ordered treatment and distinguishing between occasional users, habitual users, and user-dealers.[32]

The Trautmann Report

The second report was commissioned in 1989 from Catherine Trautmann who, at the time, was the president of the Interministerial Mission for the Fight against Drugs and Drug Addiction. The Trautmann report, submitted in 1990, included a review of

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28 OFDT, 1999, page 25.
29 *Ibid.*
30 *Ibid.*, page 26.
31 CAAT, 2001, page 3.
32 OFDT, 1999, pages 26-27.

available data on drug use and drug addiction, the main difficulties in the fight against drugs, and the drug policy in France from 1978 to 1988.[33]

The report did not recommend any changes to the Law of 1970. Rather, it highlighted the need for more effective actions against drug trafficking, with a particular focus on developing better cooperation between the three main national services involved in the fight against drug trafficking: the police, the gendarmerie, and customs – each of which have a different jurisdiction (urban areas for the police, rural areas for the gendarmerie, borders for customs). It suggested that the policing of French outer borders should be reinforced. The report further proposed that more should be done to deal with the demand side of the drug issue by developing strategies aimed at preventing drug use and drug addiction, particularly among young people. Suggestions related to the care of drug addicts and their integration and reintegration into the community revolved around three main axes: improving health and social services; taking into consideration problems associated with AIDS; and establishing a solid financial management system to support specialized units providing services to drug addicts.

Finally, with respect to the issue of decriminalization or legalization of drugs, in particular cannabis, the Trautmann report was clearly against such propositions. The report stated that the issue is one of preventing drug use and caring for drug addicts, and that decriminalization of cannabis would trivialize drug use and promote earlier and more frequent use of hard drugs.[34]

The Henrion Report

The Henrion Commission produced in 1995 a third report on the drug situation in France.[35] It is interesting to note that the Commission comes to similar conclusions as the two previous reports with respect to the lack of coordination and cooperation between judicial and health authorities and the difficulties in implementing a policy based on both repressive and public health measures. The Commission made note of the limited use of court-ordered treatment and the increasing number of arrests for simple drug use. It recommended first and foremost the development of an evaluation policy to assess the drug situation in France and suggested that French drug policy should give priority to preventing drug use. As well, the report criticized the lack of consistency in law enforcement and inequalities in handling drug users throughout France and recommended that the existing agencies and structures involved in the repression of drug trafficking be given the necessary financial and human resources to successfully achieve their mandate.

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[33] C. Trautmann, *Lutte contre la toxicomanie et le trafic de stupéfiants*. Report to the Prime Minister, Paris: La Documentation française, 1990.

[34] *Ibid.*, Annexe 10, pages 252 and 253.

[35] R. Henrion, *Rapport de la Commission de réflexion sur la drogue et la toxicomanie*. Report to the Minister of Social Affairs, Health and Cities, Paris: La Documentation française, 1995.

However, the Henrion Commission distinguished itself in proposing a reform of the Law of 1970. Members of the Commission debated the issue of decriminalizing cannabis, expressing diverging opinions on the issue. A minority of members (8 out of 17) opposed the idea of decriminalizing the use of cannabis mainly because they thought it would be difficult to maintain a moral interdiction without a legal prohibition. However, a small majority of members (9 out of 17) were in favour of decriminalizing the use of cannabis and possession of small quantities of such substance. They suggested proceeding gradually without effecting any changes to the existing measures sanctioning the supply of cannabis in the hope of better controlling and assessing the consequences of decriminalizing drug use. They also recommended that decriminalization should be accompanied by the enactment of regulations limiting use of cannabis to certain locations and forbidding its use by young people under the age of 16. Regulations would also repress being intoxicated in public places, create an offence of driving under the influence of cannabis, and would prohibit the use of cannabis by certain professionals for safety reasons (i.e., air traffic controllers; pilots, drivers of public transit, etc.). All these measures had to be accompanied by a prevention campaign focusing on the potential negative consequences of using cannabis, an ongoing evaluation not only of cannabis use but of opiates, cocaine and crack as well, and ongoing neurobiological research on the effects of cannabis use. Finally, the offence of incitement to drug use was to be maintained and applied.[36]

The Commission suggested that, if such a reform was applied and there was no deterioration of the situation within two years, the government should then consider a regulation of the commerce of cannabis under the strict control of the state. It should be noted, however, that some members of the Commission thought that such a regulation should be implemented concurrently with the decriminalization of cannabis and that there should not be any trial period.[37] These recommendations have yet to be implemented.

The Henrion Commission also recommended the adoption of a harm reduction policy that would not limit itself to minimizing the health risks related to drug use, but would be grounded in a public health perspective that would rigorously crack down on specific problem behaviours such as discarding needles in a public place.[38]

Expert reports

In Chapters 5, 6 and 7, we have more fully discussed the scientific data from three recent expert reports, the Roques report on the dangerousness of drugs (1995),[39] the Parquet and Reynaud report on addictive practices (1997)[40] and the INSERM expert

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36 *Ibid*., pages 82-83.
37 *Ibid*., page 83.
38 *Ibid.*, page 89.
39 B. Roques, *La dangerosité des drogues.* Paris: Odile Jacob, 1995.
40 Reynaud, M. et al., (1999) *Les pratiques addictives. Usage, usage nocif et dépendance aux substances psychoactives.* Paris : Secrétariat d'État à la Santé et aux Affaires sociales.

report on cannabis (2001).[41] Those three reports, which supplement each other and are largely consistent in their main conclusions, constitute one of the most rigorous international scientific information bases, and certainly the least ideological, that we consulted. As they were not associated with a commission established to study the public policy aspects of the issue, the three commissions were thus likely in a slightly better position to escape the potential contamination of teleological interpretations of research data.

Statistics on use and offences

Use

The following is from a 1999 document entitled *Drugs and Drug Addictions: Indicators and Trends* prepared by the French Monitoring Centre for Drugs and Drug Addictions, which synthesized available data and analyzed drugs and drug addiction in France.[42]

The current trends observed in that report were as follows:

- a strong decrease in overdose-related deaths (554 in 1994, 143 in 1998) and AIDS deaths associated with injection drug use (1,037 in 1994, 267 in 1997);
- an important drop in heroin use since 1996 possibly attributable to an increase in use of substitution treatments;
- normalization of the use of cannabis as its use is becoming more and more commonplace particularly amongst young people;
- cultivating cannabis is a developing phenomenon;
- synthetic drugs have become much more widely available although these drugs still represent a very small percentage of drug consumption;
- cocaine use is increasing; and
- multiple drug use including licit substances such as alcohol, is an emerging phenomenon especially among youth–54% of young people in care in rehabilitation units are users of at least two products.

Surveys conducted in 1995 amongst a representative cross-section of French adults revealed that almost 25% of 18- to 44-year-olds declared having experimented with cannabis and 7.7% stated that they used it on an occasional or regular basis. Surveys conducted amongst conscripts in army selection centres in 1996 also showed that a large percentage (40%) of young men 18-23 years old had experimented with cannabis and 14.5% had used it during the past month.[43] Whereas adolescents are

[41] INSERM, *Cannabis : Quels effets sur le comportement et la santé?* Paris: author, 2001.

[42] Observatoire français des drogues et des toxicomanies, *Drogues et toxicomanies : indicateurs et tendances*, 1999 Edition. Available online at: http://www.drogues.gouv.fr/fr/index.html.

[43] OFDT, 1999, pages 62 and 63.

concerned, it is estimated that in the second half of the 1990s more than one-third of all 15- to 19-year-olds had experimented with drugs, mostly cannabis. Surveys also showed an important increase in the frequency of use of cannabis as "the share of young people who had used cannabis at least ten times during the year increased by over one-half from 1993 to 1997."[44] It was further found that boys are more likely than girls to use illicit substances and at much higher risk of repeated use. A 1998 survey indicated that 33% of the boys declared that they had experimented with cannabis, compared to 23% of the girls.[45] The 2002 report of the French Monitoring Centre for Drugs and Drug Addictions also notes an increase in the number of new health and social cases involving cannabis use: approximately 15 per cent of cases involved cannabis use. Those persons were generally younger than those involved in opiate use, more of them were entering the system for the first time and more had been referred by the courts.[46]

During the second half of the 1990s, the number of "problem" opiate users (drug use that may result in treatment in the health and social system and/or contact with law enforcement agencies) was estimated between 142,000 and 176,000.[47]

Offences

The report from the French Monitoring Centre indicates that the number of arrests for drug-related offences increased from 45,206 to 85,507 over the period 1993-1998. The most important increase was in the number of individuals arrested for cannabis use (30,344 in 1993 compared to 72,281 in 1998) whereas the number of arrests for heroin use had actually decreased (14,959 in 1993, 7,469 in 1998, following a peak at 17,356 in 1995). Cannabis, in fact, accounted for 85% of drug-related arrests in France in 1998 compared to 63% in 1993. However, it must be noted that a little less than half of the individuals arrested for using drugs (45%) were retained for questioning and the vast majority of persons (97.2%) held for questioning were freed in 1997.[48]

Studies in France have emphasized that the statistics on arrests of drug users should be used with caution as it is difficult to ascertain how much of noted changes reflect variations in the population of drug users and how much of these changes are linked to modifications of police and gendarmerie services. For example, data on arrests for use between 1993 and 1998 indicated a significant growth of 30% in use-related arrests in 1997 and 9% in 1998.[49] Many factors may explain such an increase including changes in the behaviour of police and gendarmerie services, the reorganization of

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[44] *Ibid.*, page 83.
[45] *Ibid.*, page 82-84.
[46] OFDT, 2002, page 96.
[47] OFDT, 1999, page 64.
[48] *Ibid.*, page 112 and 113. It should be noted that release refers to many situations and does not imply that prosecution does not go forward. Some may subsequently be convicted upon being summoned to court.
[49] *Ibid.*, page 112.

police departments, and the normalization of cannabis use. One explanation suggests that a circular letter on court-ordered treatment issued in 1995 by the Ministry of Justice has led public prosecutors to instruct the police and gendarmerie to "systematically report users." [50] It may be assumed that such instructions may have led to the notable increase in drug use-related arrests recorded in 1997.

With respect to trafficking, the number of arrests decreased between 1996 and 1998 from 8,412 to 5,541. Slightly more than half of dealers (52%) arrested in 1998 were trafficking cannabis, 24% were involved in dealing heroin, and 17% trafficked cocaine and crack. The main development was observed in the number of arrests of heroin traffickers which decreased from 3,395 in 1993 to 1,356 in 1998. Arrests for trafficking cocaine increased from 383 to 972 during the same period whereas arrest related to cannabis trafficking increased slightly from 2,456 to 2,920. [51]

The total number of convictions for drug use as the main offence went from 7,434 in 1992 to 6,530 in 1997, with a low of 4,670 convictions in 1995. In 1997, 3,368 convictions were for use only. Of these, 14% were sentenced to imprisonment with an average length of 2.4 months, 35% received a deferred sentence (often associated with probation and court-ordered treatment), 33% were fined, 7% were given an alternative sentence, and 6% were sentenced to an educational measure. The number of convictions for use and transporting increased from 761 in 1991 (6.6% of convictions) to 3,478 in 1997 (22.2%). Convictions for use and trafficking also increased from 475 in 1991 to 1,501 in 1997 (4.1% compared to 9.6% of convictions related to drug offences). In 21% of the convictions for use and other drug-related offences, a prison sentence was given out. In 37% of cases involving drug use and trafficking and 21% of drug use and transporting, individuals received a mixed sentence (prison time and deferred sentence). The average length of imprisonment was 16.8 months in 1997. [52]

In 1998, the number of cannabis seizures was 40,115, up from 27,320 seizures in 1996. However, the quantities seized were smaller in 1998 than in 1996 (55,698 kg compared to 66,861 kg).

Costs

In 1995, public funds devoted to implementing the French drug policy was 4.7 billion Francs. Out of the total expenses (specific budget and interdepartmental credits), approximately 1536.56 million Francs were spent on Justice, 1260.54 million F on police services, 469.55 million F on the gendarmerie, and 450.25 million F on customs expenses. The amount spent on enforcement was considerably higher than that spent on health (656.3 million F) and social affairs (28.58 million F).

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[50] *Ibid.*, page 114.
[51] *Ibid.*, page 164 and 165.
[52] OFDT, 1999, page 121-123.

More recent figures on interministerial credits indicated that for 1998, the expenditures of health and social affairs were set at 47.9 million F , those of Justice at 18.9 million F, the Ministry of the Interior (police) at 18.5 million F and Defence (gendarmerie) at 10.7 million F.

THE NETHERLANDS[53]

Much has been said about the Dutch approach to the drug issue. The following is one example:

> *In Holland, studies conducted in the early 1990s show the negative impact of tolerance of illegal drugs:*
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> - *the number of "coffe shops" that have derived income from the sale of hashish since decriminalization in 1990 rose from 20 to 400 in Amsterdam in 1991 to more than 2,000 throughout all of Holland;*
> - *from 1984 to 1988, the number of hashish smokers 15 years of age or more doubled in Holland; from 1988 to 1992, the number of smokers 14 to 17 years of age doubled again, and the number of users 12 and 13 years old tripled;*
> - *the rate of violent crimes committed in Holland is the highest in Europe and is still rising.* [54]
>
> *In the Netherlands (you have to be careful because there are enormous social and cultural differences preventing any general comparison between Canada and that country), the harm-reduction-based drug policy draws a very clear distinction between cannabis and so-called hard drugs. Since the policy was adopted, cannabis has appeared to be less dangerous and its social approval has increased, particularly among young people whose cannabis use has quadrupled. Cannabis use in that country, as in most continental European countries, based on the statistics cited, remains below that of Canada. But that simply means that we must be even more vigilant. The tendency to have a problem situation and the probability that it will occur appear higher in the country.* [55]

Various witnesses cited the article by Larry Collins published in the prestigious *Foreign Affairs*. However, that article is full of errors of fact.

In view of the climate surrounding the drug policy debate, it is difficult to describe the Dutch approach without giving the impression that one is taking a position. First, we should recall a number of observations we made in Chapter 6, to which we will return in the comparative analysis in the next chapter. First of all, international comparison of use trends must be carefully drawn because of the different methodologies used in the surveys. Second, international comparisons tend to show

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[53] This section draws largely on the research report prepared for the Committee by the Library of Parliament: B. Dolin, (2001) *National Drug Policy: The Netherlands.* Ottawa: Library of Parliament, prepared for the Senate Special Committee on Illegal Drugs; available online at www.parl.gc.ca/illegaldrugs.asp.

[54] Canadian Police Association, Brief to the Senate Special Committee on Illegal Drugs, May 28, 2001.

[55] Brief of Dr. Colin Mangham, *Consequences of the Liberalization of Cannabis Drug Policy*, September 17, 2001.

that "*the relationship between the figures measuring cannabis use levels and the legislative model in effect in a country is not obvious or systematic*."[56]

As was the case for France, we begin with a brief overview of drug legislation in the Netherlands, then describe the broad outlines of the current Dutch policy and the tools used to implement it. We then present current legislation in a more detailed manner and the reports on which it is based, then, lastly, provide some figures on drug use and repression.

Dutch pragmatism?

Like the other colonial powers, the Netherlands maintained opium production authorities and trading posts in their colonies, a system that generated significant tax revenues: between 1816 and 1915, net profits from the sale of opium represented approximately 10 per cent of total revenue from the colonies for the Dutch treasury. The country was also the largest producer of cocaine for medical purposes. It was not until the end of World War II and the independence of Indonesia that the Netherlands terminated the opium monopoly.

> *Vested economic interests in the production and trade of drugs may explain the Dutch reluctance to endorse strong international drug control. Clearly, the Netherlands attempted to protect these interests at the conferences and did so successfully, at least temporarily. (…) Incidentally, the Netherlands also objected to the inclusion of marihuana in the convention.* [57]

During the 1920s and 1930s, the country came under criticism from the League of Nations and the United States in particular over its extensive drug trade. The Netherlands was one of the main heroin producers and the principal producer of cocaine. However, the Dutch negotiators at the international conferences on the various conventions, as well as a portion of the Dutch population itself, did not believe in a system based on prohibition and, already at the turn of the century, felt that a system of government control would be more effective.

It was this attitude that led a number of analysts to represent the Dutch approach to drugs as pragmatic.

> *Dutch society is a pragmatic society. It is a nation of traders, going back to the XVIIth century. Traders are more pragmatic than other people. The pragmatism finds its roots in Dutch history, which is characterized by its fight against the sea, the natural enemy of the Netherlands since the Middle Ages. The Netherlands is roughly the size of Vancouver Island, and today one-half of the country is at sea level.*

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[56] H. Martineau and É. Gomart, *Politiques et expérimentations sur les drogues aux Pays-Bas.* Rapport de synthèse. Paris: OFDT, 2000, page 44.

[57] M. De Kort, "A Short History of Drugs in the Netherlands", in E Leuw and I. Haen Marshall, eds., *Between prohibition and legalization. The Dutch experiment in drug policy.* Amsterdam: Kugler, 1994, page 11.

> *A system of dykes was built to protect the country. Centuries ago, everyone in Dutch society, from the aristocracy to the farmers worked together to prevent seawater from flowing into the country. The pragmatic attitude comes from that. It is impossible to completely eliminate the problem of the water. It is better to control it with canals.* [58]

However, other factors beyond pragmatism are at work. One Dutch government publication suggests that the nature of Dutch society is the reason for its approach:

> *Some knowledge of the characteristics of Dutch society is required to appreciate the Dutch approach to the drug problem. The Netherlands is one of the most densely populated urbanized countries in the world. Its population of 15.5 million inhabitants occupies an area of 41,526 square kilometers. The Netherlands has always been a transit country: Rotterdam is the largest seaport in the world and the country has a highly developed transportation sector. The Dutch firmly believe in individual freedom and expect the state to be reserved in its approach to religious and moral questions. Free and open debate on such questions is one of the characteristics of Dutch society. Considerable value is attached to the well-being of society as a whole, as may be seen from the extensive social security system and universal access to health care and education.* [59]

It follows that, by tradition, the Dutch are not accustomed to using criminal law to address social problems.[60] Furthermore, the Netherlands is a country of consensus, where there is a long tradition of cooperation between local, regional and national authorities, and between the various sectors of the government.

Whatever the reasons, the Dutch experience has received considerable media coverage, surprisingly, much more than the Spanish approach, which, in many respects, is even more liberal. Being called upon to defend it in Europe and in other international forums, the Dutch have often presented it as a position of compromise between that of the "hawks" of the war on drugs and that of the "doves" of legalisation.[61] It is unlikely that the approach is the result of specific cultural factors and that the Dutch experience cannot apply to other countries. On the contrary, it appears to be the rational solution to a problem by politicians, and that cannot be claimed to be an exclusively Dutch characteristic.

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[58] Tim Boekhout van Solinge, testimony before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, 19 November 2001, Issue 11, page 53-54.

[59] "Drug Policy in the Netherlands", Government of the Netherlands, available online at: http://www.netherlands-embassy.org/c_hltdru.html.

[60] Boekhout van Solinge, "La Politique de drogue aux Pays-Bas: un essai de changement", *Déviance et Société*, Vol. 22, page 69-71.

[61] C.D. Kaplan *et al*., "Is Dutch Drug Policy an Example to the World?" in Leuw and Marshall, eds., *op. cit*.

Essential expert reports

Unlike most other countries where commissions of inquiry produced reports in the 1970s, the Netherlands is the only country that has implemented the recommendations of its commission.

The Hulsman Commission(1968-1971)

In 1968, the National Federation of Mental Health Organizations[62] established a commission with a broad mandate to "clarify factors associated with the use of drugs" and "to suggest proposals for a rational policy."[63] Chaired by criminal law professor Louk Hulsman, the Commission had a diverse membership including law enforcement officials, alcohol treatment experts, psychiatrists, a drug use researcher and a sociologist.

The commission's final report, presented in 1971, provided an analysis of drug use and the social mechanisms behind drug problems. New approaches were suggested, including:

- The use of cannabis and the possession of small quantities should be taken out of the criminal law immediately. For the time being, production and distribution should remain within criminal law, but as misdemeanours.
- The use and possession of other drugs should temporarily remain in the realm of criminal law, as misdemeanours, but in the long run all should be decriminalized.
- People who have problems with their drug use should have adequate treatment facilities at their disposal.

In recommending the gradual decriminalization of all drugs, the report noted that illicit drugs can be used in a controlled and limited way and that marginalizing drug-using subcultures has significant negative repercussions. Specifically, becoming a member of the "drug scene" may familiarize a cannabis user with other drugs and patterns of use. Although the commission found no evidence of a "stepping stone" sequence of drug use – what in other contexts has been referred to as "gateways" – it accepted the notion that one kind of drug user (e.g., heroin user) will contaminate another kind of drug user (e.g., cannabis user) when the two kinds of drug use are forced into one marginalized subculture.

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[62] In the Netherlands, public and private agencies have jurisdiction over mental health based on political affiliation and religious denomination. The National Federation of Mental Health Organizations was a coordination agency.

[63] Louk Hulsman, *Ruimte in het drugbeleid*, Boom Meppel, 1971, page 5, mentioned in Peter Cohen, "The case of the two Dutch drug policy commissions: An exercise in harm reduction 1968-1976" (1994, revised in 1996), Article presented to the 5th International Conference on Drug Harm Reduction, March 7-11, 1994, Addiction Research Foundation, Toronto, available online at: www.cedro-uva.org/lib/cohen.case.html.

With respect to the issue of law enforcement, the commission concluded that once started, drug policing would have to be constantly enlarged to keep pace with the never-ending escalation of drug use. It referred to the criminal law option of opposing drug use as inadequate and "extremely dangerous":

> *Time after time it will show that the means will fall short, upon which those who favour punishment will plead for increase of law enforcement, until it will be amplified a hundred fold from the present situation…This will boost polarization between the different parts of our society and can result in increased violence.* [64]

Although it had no immediate impact, the Hulsman report nevertheless influenced the government report of the Baan Commission.

The Baan Commission (1968-1972)[65]

A State Commission was also established in 1968 by the Under Secretary of Health. This commission contained some members of the Hulsman Commission, as well as officials from the Ministry of Justice, the Amsterdam Chief of Police, and additional psychiatrists and sociologists. In 1970, Pieter Baan, the Chief Inspector of Mental Health, assumed the chairmanship of the commission and a final report was presented in 1972.

The report suggested dividing drugs into those with acceptable and those with unacceptable risks. Further research would be needed to create a greater consensus among the experts as to how some individual drugs should be classified, but the report described cannabis products as relatively benign with limited health risks. However, even for those drugs that pose unacceptable risks, the report concluded that use of the criminal law is not an adequate approach. The Commission suggested the long-term goal of complete decriminalization once a good treatment system had been created. In the interim, the justice system should just be used as a tool for manoeuvring heavy users into treatment.

Other notable findings include:

- The special characteristics of youth culture are important determinants of drug use and if so-called deviant behaviour is stigmatized by punitive measures, the probability of intensification of this behaviour is a serious danger. This will initiate a spiral that will make the return of the individual to a socially accepted lifestyle increasingly difficult.
- Much drug use is short-lasting experimentation by young people.
- Cannabis use does not lead to other drug use, but as noted in the Hulsman report, the criminalization of cannabis promotes contact between cannabis users and the users of "harder" drugs.

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64 In Peter Cohen, "The case of the two Dutch drug policy commissions", *supra*, page 3.

65 *Working Party*, Department of Justice, The Hague, 1972.

- Drug users are better served by drug information and prevention efforts than by prosecution.
- The sometimes unusual behaviour of cannabis-consuming youth is more a result of specific subculture norms and ideologies rather than pharmacology.
- Cannabis use when driving or operating machines in factories is not responsible conduct, and the consumption of cannabis should be restricted to times of leisure in order to limit the risks to the individual or society .

The Baan report formed the basis of what was to become the system of tolerance toward cannabis in the Netherlands as part of a concern for public health and the separation of drug markets.

The Engelsman Report (1985)[66]

Taking notice of the limits of a public health policy essentially based on young people (the principal cannabis users) and of the evolution of heroin use, as well as the declining condition of users, the Engelsman report proposed to extend the Baan Commission's tolerance approach to other drugs. It also went further than the Baan report on the need to rely on the experience and word of users in determining policies, proposing in particular to exclude non-users from the circle of experts. In Engelsman's view, drugs and drug use were no longer the only factors involved in explaining the problems of drugs - hard drugs in this case - and that new factors included the perverse effects of repressive action (care and police) on users. Public policy proposals should therefore not be based on the panic reactions of society and should aim to integrate users and "normalize" their drug use. The state should therefore arbitrate between users and non-users with a view to protecting users. The Engelsman report, which was considered too radical in certain circles, remained a dead letter.

"Continuity and Change" Report – 1995[67]

In 1995, the Dutch government published a report entitled *Drugs Policy in the Netherlands: Continuity and Change*. This policy document was sponsored by: the Minister of Justice; the Minister of Health, Welfare and Sport; and the Secretary of State for the Interior. To some extent, this report was the Dutch response to international pressure (from both neighbouring countries and the USA) as well as an opportunity to make its cannabis policy clearer and to some extent stricter.

The report begins by noting that the Netherlands has always attempted a pragmatic approach to drug use, recalling that prohibitionist policies throughout the

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66 Interdepartmental Task Force on Drugs and Alcohol, The Hague: Department of Justice, 1985.

67 Department of Foreign Affairs (1995), *Continuity and Change.* 1995. The report is available online at: www.drugtext.org/reports/wvc/drugnota/0/drugall.htm.

world have proven to have a limited effect. Thus, the modest objective in Holland is to limit the health and social problems that result from the use of dangerous drugs. This harm reduction approach has led the Dutch government to distinguish between "hard drugs," i.e., those that pose an unacceptable risk to health, and "soft drugs" such as cannabis products, which although still considered "risky" do not present similar concerns. The underlying assumption made in the Netherlands with respect to cannabis is that people are more likely to make a transition from soft to hard drugs as a result of social factors, not physiological ones. Separating the markets by allowing people to purchase soft drugs in a setting where they are not exposed to the criminal subculture surrounding hard drugs is intended to create a social barrier that prevents people experimenting with more dangerous drugs.

The report goes on to review the effects of the Dutch drug policy, the treatment of addiction in the Netherlands, and enforcement under the *Opium Act.* Key conclusions and findings include:

- Decriminalization of the possession of soft drugs for personal use and the toleration of sales in controlled circumstances has not resulted in a worryingly high level of consumption among young people. The extent and nature of the use of soft drugs does not differ from the pattern in other Western countries. As for hard drugs, the report states that the number of addicts in the Netherlands is low compared with the rest of Europe and considerably lower than that in France, the United Kingdom, Italy, Spain and Switzerland.
- The number of heroin users under the age of 21 has continued to fall in the Netherlands.
- The use of cheaper forms of cocaine (i.e., crack) has not made significant inroads in Holland as had been feared as a result of developments in the United States.
- The tone of public debate in Holland is different than in other countries because drug use is no longer seen as an acute health threat but rather as a source of nuisance. Policies focusing on addiction and care have resulted in less HIV infection; in fact, levels continue to fall. As well, the mortality rate among addicts is low and is not increasing, as it is in other European countries.
- With respect to the legalization debate, the report concludes that, with a state monopoly or licensing system, the disadvantages would outweigh the practical advantages. Although the role of criminal organizations would be reduced, such a system would impose a considerable burden in implementation and monitoring, and would probably attract even more "drug tourists" and the nuisance they sometimes cause. Furthermore, the report suggests that this is not something that could be done by the Netherlands in isolation. The international conventions preclude outright

legalization and would have to be renegotiated or denounced. As well, even if just soft drugs were legal in Holland but not in the rest of Europe, the Dutch criminal organizations that export drugs would continue to exist and would still require significant law enforcement activity.

- Foreign concerns about the Dutch coffee shop policy have centred not on the use of cannabis in the establishments, but on drug tourists who take cannabis back to their home countries, something that has been particularly easy since the abolition of border controls under the Schengen Agreement. The report confirms the government's plan to reduce the purchase limit to 5 grams from 30 grams to see what impact this will have on illegal exports.[68]
- Given the lack of sufficient scientific data, the report endorses the 1995 recommendation of the Dutch Health Council that a medical trial into the effectiveness of prescribing heroin to addicts be undertaken.[69]

The report also notes three negative implications that need to be addressed: the nuisance caused by hard and soft drug users; the increasing presence of organized crime in the Netherlands; and the effect of Dutch policy on other countries.

- The criminal and general nuisance caused by Dutch and foreign hard drug users may have the effect of undermining public support for the policy of social integration of addicts. A small proportion of hard drug users commit a large number of property offences in order to buy their drugs. Contrary to expectations, the fact that methadone is easily obtained has scarcely improved the situation. Drug-related crime and anti-social behaviour, such as discarding used needles in public places, has affected the tolerance levels of residents in some socially disadvantaged neighbourhoods in the larger Dutch cities. Nuisance caused by the presence of coffee shops selling soft drugs has also been problematic in some municipalities.[70]
- Another complication has been the rise of criminal organizations involved in the supply and sale of drugs in Holland which has necessitated increased criminal law measures. The prosecution of drug traffickers will continue to be a top priority for the Dutch police and judicial authorities.
- Although the "ideological nature" of some foreign criticism suggests a lack of understanding of Dutch policy and is often based on purported health risks that are not supported in the scientific literature, there are problems in the Netherlands that have international implications. The Dutch, for example, are responsible for more than their proportional share of

[68] As noted in the section on current legislation, this reduced limit is now in effect.

[69] As noted in the section on current legislation, trials began in 1998.

[70] This concern was addressed subsequent to the Report by the "Damocles bill" of 1999, discussed herein, which provides greater powers to municipalities to shut down coffee shops that are a local nuisance.

trafficking in soft drugs, and drug tourists routinely purchase soft drugs in Holland with the intent of transporting them back to their home country. The report suggests that combating these problems will involve continuing and reinforcing current law enforcement activities that prioritize trafficking. As noted, the issue of soft drug tourists taking home their coffee shop purchases is to be addressed by decreasing the amount permitted for sale.

Three major principles have characterized the Dutch approach since 1976:

- Harm reduction: attenuation of risks and dangers related to drug use rather than prohibition of all drugs, the key elements of which are:
  - prevention or alleviation of social and individual risks caused by drug use;
  - a rational relationship between those risks and policy measures;
  - a differentiation of policy measures based on the risks associated with drugs;
  - repressive measures against drug trafficking are a priority; and
  - the inadequacy of criminal law with respect to other aspects apart from drug trafficking.[71]
- Policy of normalization: social control is achieved through depolarization and the integration of deviant behaviour rather than isolation and removal, as is typical of the deterrence model. This paradigm also suggests that drug problems should be seen as normal social problems rather than unusual concerns requiring extraordinary treatment.
- Market separation: by classifying drugs according to the risks posed and then pursuing policies that serve to isolate each market, it is felt that users of soft drugs are less likely to come into contact with users of hard drugs. Thus, the theory goes, users of soft drugs are less likely to try hard drugs.

Legislation

In 1919, the Netherlands passed its first law on opium under the influence of the international conventions, including the Hague Convention in 1912. That legislation prohibited the manufacture, sale, processing, transportation, supply, import, export and possession of cocaine, opium and its derivatives. The law was amended in 1928 to include cocaine derivatives and cannabis in the list of controlled substances. However, only the import, expert and transfer of those substances were prohibited. The offences

[71] M. Grapendaal, E. Leuw and H. Nelen, *A World of Opportunities: Life-Style and Economic Behaviour of Heroin Addicts in Amsterdam*. New York, S.U.N.Y. Press, 1995, mentioned in T. Boekhout van Solinge, "Dutch Drug Policy in a European Context", *Journal of Drug Issues* Vol. 29, No 3, 1999, page 511. Available online at: www.cedro-uva.org/lib/boekhout.dutch.html.

of possession and producing cannabis and cannabis derivatives were not punishable until 1953.

The *Opium Act*–also referred to as the *Narcotics Act*–is the Netherlands' main drug legislation. The *Act* criminalizes possession, cultivation, trafficking and importing or exporting. The 1976 Amendments establishes two classes of drugs: Schedule I drugs are deemed to present an unacceptable risk to Dutch society and include heroin, cocaine, amphetamines and LSD; Schedule II drugs include "traditional hemp products" such as marijuana and hashish.

Offences

The *Act* has three characteristic features:

- it criminalizes possession, trafficking, cultivation, transportation, manufacturing, import and export of drugs, **including cannabis and cannabis derivatives**;
- it draws a clear distinction between suppliers and users; the act punishes possession for the purpose of use, not use as such;
- differentiated penalties based on the substances involved.

The possession of all scheduled drugs is an offence, but possession of a small quantity of "soft" drugs for personal use is a minor offence. Generally, it is tolerated by law enforcement, particularly within the regulated coffee shop system, discussed in the following section. Importing and exporting are the most serious offences under the *Act.*

Penalties

The maximum penalty for importing or exporting hard drugs is 12 years' imprisonment and a fine of 100,000 Dutch florins.[72] Anyone found in possession of a quantity of hard drugs for personal use is liable to a penalty of one year's imprisonment and a fine of 10,000 florins. The maximum penalty for importing or exporting soft drugs is four years' imprisonment and a fine of 100,000 florins. Repeat offenders are liable to a maximum penalty of 16 years' imprisonment and a fine of 100,000 florins. Offenders may also be deprived of any money or property gained from their offence. The Netherlands also has guidelines for sanctions that the Public Prosecutor is directed to seek, based on: the type of drug involved, the amount of the drug and the specific offence. The following tables set out the current guidelines (1996).[73]

[72] 100,000 Dutch florins = approximately C$63,000.

[73] Source: Staatscourant (1996) in D.J. Korf and H. Riper, "Windmills in Their Minds? Drug Policy and Drug Research in the Netherlands", *Journal of Drug Issues* , Vol. 29, No. 3, 1999, page 451, Table 2.

SCHEDULE I SUBSTANCES ("HARD DRUGS")		
Offence	Amount	Sanction to be Sought[74]
Possession	< 0.5 g or < 1 user unit	Police Dismissal
	0.5-5 g or 1-10 user units	1 week - 2 months
Possession with Dealer Indication (i.e., intent to sell)	< 15 g or < 30 user units	Up to 6 months
	15-300 g or 30-600 user units	6-18 months
	> 300 g or > 600 user units	18 months - 4 years
Street or Home Dealing	< 1 g	Up to 6 months
	1-3 g	6-18 months
	> 3 g	18 months - 4 years
Middle-level Dealing	< 1 kg	1-2 years
	> 1 kg	2+ years
Wholesale Trade	> 5 kg	6-8 years
Import and Export	< 1 kg	Up to 3 years
	> 1 kg	3-12 years

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought (75)
Possession, Preparing, Processing, Sale, Delivery, Supply, Transporting or Manufacturing	Up to 5 g	Police Dismissal
	5-30 g	Fine of Dfl. 50-150
	30 g-1 kg	Fine of Dfl. 5-10 per g
	1-5 kg[76]	Fine of Dfl. 5,000-10,000 and 2 weeks per kg
	5-25 kg	Max. fine of Dfl. 25,000 and 3-6 months
	25-100 kg	Max. fine of Dfl. 25,000 and 6-12 months
	> 100 kg	Max. fine of Dfl. 25,000 and 1-2 years

[74] In addition to imprisonment, penalties sometimes include fines and property seizures (except for possession).

[75] For repeat offences within five years, the required penalty is increased by one-quarter. As to sales to "vulnerable groups" (that is to say to minors, psychiatric patients), a minimum fine of approximately Cdn $475 is also levied.

[76] Quantities greater than 1 kg are considered as suggesting drug trafficking.

SCHEDULE II ("SOFT DRUGS")		
Offence	Amount	Sanction to be Sought (75)
Cultivation	Up to 5 plants	Police Dismissal
	5-10 plants	Dfl. 50 par plant (repeat offenders: Dfl. 75 per plant)
	10-100 plants	Dfl. 25 per plant and/or ½ day per plant
	100-1 000 plants	Max. fine of Dfl. 25,000 and 2-6 months
	>1 000 plants	Max. fine of Dfl. 25,000 and 6 months – 2 years
Import and Export	The *Act* does not distinguish between quantities, but in practice the prosecutor's sentence recommendation will correspond to the quantity divisions for possession.	Sanctions for possession may be doubled to a maximum of 4 years and a maximum fine of Dfl. 100,000

The coffee shop system

Contrary to several stereotypes, cannabis possession is not decriminalized; strictly speaking, it is still a criminal offence. However, based on the principle of expediency, which is part of the criminal law tradition in the Netherlands, the possession of small amounts of cannabis for personal use has been decriminalized. The sale of cannabis is technically an offence under the *Opium Act*, but prosecutorial guidelines provide that proceedings will only be instituted in certain situations.

Without legalizing the sale of cannabis and cannabis derivatives, the municipalities may permit the establishment of coffee shops which are authorized to sell cannabis under certain conditions. An operator or owner of a coffee shop (which is not permitted to sell alcohol) will avoid prosecution if he or she meets the following criteria:

- no more than 5 grams per person may be sold in any one transaction;
- no hard drugs may be sold;
- drugs may not be advertised;
- the coffee shop must not cause any nuisance;
- no drugs may be sold to minor (under 18), nor may minors enter the premises;
- the municipality has not ordered the establishment closed.

> *The idea behind the Netherlands' policy towards the* coffee shops *is that of harm limitation. This is based on the argument that if we do not prosecute small-scale cannabis dealing and use under certain conditions, the users – who are mainly young people experimenting with the drug – are not criminalized (they do not get a criminal record) and they are not forced to move in criminal circles, where the risk that they will be pressed to try more dangerous drugs such as heroin is much greater.* [77]

It is common for municipalities to have a coffee shop policy to prevent or combat the public nuisance sometimes associated with these establishments. For example, suspicion of selling hard drugs or locating a coffee shop near a school or in a residential district may result in closure. In April 1999, the "Damocles Bill" amended the *Narcotics Act* by expanding municipal powers regarding coffee shops and permitting local mayors to close such places if they contravened local coffee shop rules, even if no nuisance was being caused. As a result of strict enforcement and various administrative and judicial measures, the number of coffee shops decreased from nearly 1,200 in 1995 to 846 in November 1999.[78]

There appears to be three types of policies on coffee shops:

- tolerance without condition as to the number of coffee shops, which is determined by market mechanisms; this situation is the most rare;
- conditional tolerance, setting a maximum number of coffee shops;
- zero tolerance: no coffee shop; this is the case in approximately 50 per cent of Dutch cities.

To determine the ideal number of coffee shops, the association of municipalities recommends that demographic factors (number of inhabitants, age groups) and urban development factors (role of the city with respect to the region; number of centres in the city) be considered, as well as any nuisance caused by the use of soft drugs.

> *Thus, in most municipalities, coffee shops are accepted on in the downtown area, and a maximum number is determined in accordance with criteria of distance – distance of the establishments from one another and distance between the coffee shops and certain institutions such as schools and psychiatric hospitals. (…) The difficulties encountered by certain mayors with regard to administrative judges have come from the fact that the absence of any complaints or contraventions has been considered by certain judges as an absence of any concrete evidence of nuisance. A "substantiated" policy is ultimately a policy based on a procedure for consulting drug addiction and public health experts, police experts and, in certain instances, the public itself (including users). This is also a balanced policy in the sense that it accommodates the interests not only of "average" citizens irritated by public nuisances, but also those of soft drug users.*[79]

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[77] Dr. Robert Keizer, *The Netherlands' Drug Policy*. Brief to the Senate Special Committee on Illegal Drugs, November 19, 2001.

[78] National Drug Monitor, "Fact Sheet: Cannabis Policy, Update 2000", Trimbos Institute, 2000.

[79] Martineau and Gomart, *op.cit.*, page 85, for the quotation and preceding information.

Since the memo on public nuisances was issued in 1993 and stricter conditions were set for the issuing of permits in 1999, municipal authorities have in fact been able to issue "nuisance permits", which are thus used to monitor the number of coffee shops, without moreover violating the fundamental orientations of the Dutch system.

Data on use

Despite the Dutch "pragmatism", there are ultimately few reliable historical data on use trends. It therefore cannot be asserted that use trends significantly increased after the coffee shop system was introduced, nor can it be stated that they declined. The creation of the Trimbos Institute and its designation as a focal point in the OEDT's European network are correcting this situation.

The following tables contain data from the most reliable surveys.

CANNABIS USE IN THE NETHERLANDS BY PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Has ever used	16%
Has used recently	2.5%
Has used for the first time in the past year	1%
Mean age of current users	28 years

CANNABIS USE IN THE FOUR LARGE CITIES AND IN SMALLER TOWNS AMONG PEOPLE AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

	Ever use	Recent use
Amsterdam	**37%**	**8%**
Utrecht	**27%**	**4%**
The Hague	**20%**	**4%**
Rotterdam	**19%**	**3%**
Smaller towns[(a)]	**11%**	

(a) Definition: Towns with less than 500 addresses per square kilometre.

CANNABIS USE BY PEOPLE AGED 16 AND ABOVE IN THREE URBAN AREAS. SURVEY YEAR 1999

	Ever use[(a)]	Recent use[(b)]
Utrecht	**30%**	**7%**
Rotterdam	**19%**	**6%**
Parkstad Limburg[(c)]	**13%**	**5%**

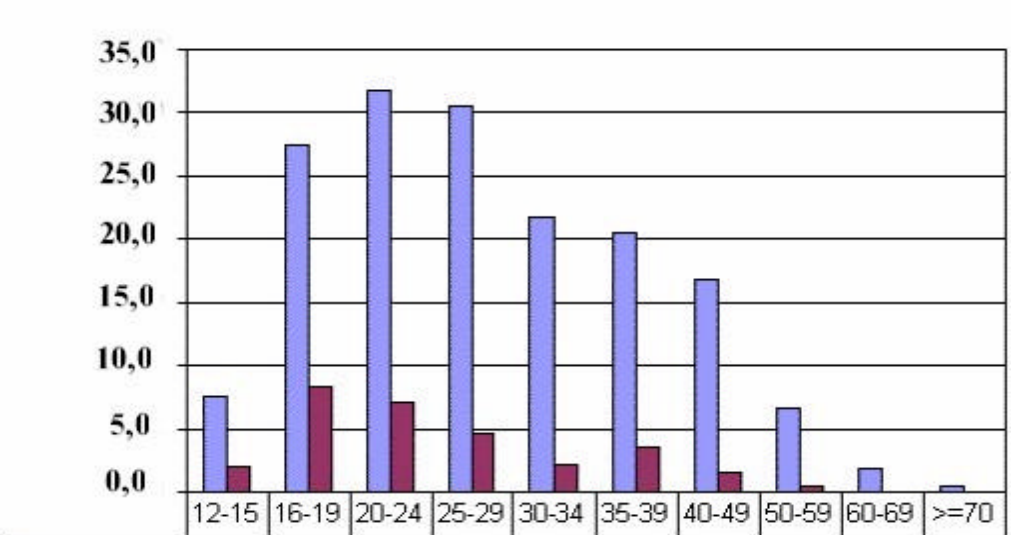
Percentage of users: [(a)] 16 to 70 years, [(b)] 16 to 55 years. Recent use: last month.

LEVEL OF CANNABIS CONSUMPTION IN THE NETHERLANDS BY RECENT USERS AGED 12 YEARS AND ABOVE. SURVEY YEAR 1997

Days of use in the last month	*Percentage among recent users*[(4)]
1-4	**45%**
5-8	**14%**
9-20	**15%**
More than 20 days	**26%**

[(a)] *Adds up to 100%.*

CANNABIS USERS IN THE NETHERLANDS PER AGE GROUP. SURVEY YEAR 1997[80]



	12-15	16-19	20-24	25-29	30-34	35-39	40-49	50-59	60-69	>=70
déjà utilisé	7,5	27,5	31,7	30,6	21,7	20,5	16,8	6,7	1,9	0,5
usage récent	2,0	8,3	7,1	4,7	2,1	3,6	1,5	0,5	0,0	0,0

[80] We have reproduced this table in its original format, thus we do not have the capacity to change text to English ; "déjà utilisé" means ever used, and "usage récent" means recent use.

WHERE DO YOUNG PEOPLE PROCURE THEIR CANNABIS?

	1996	1999
Obtain cannabis from friends	41%	47%
Purchase cannabis in coffee shops	41%	32%
Purchase cannabis from a dealer	11%	11%
Receive cannabis from others	5%	8%
Purchase cannabis at school	3%	1%
Grow it themselves[(a)]	-	2%

Pupils aged twelve and above in secondary schools (recent users)
[(a)] Only measured in 1999.

RECENT CANNABIS USE IN SPECIAL GROUPS

Young persons in	*Survey Year*	*Age*	*Recent Use*
Special schools for secondary education	1997	12-18	14%
Truancy projects	1997	12-18	35%
Judicial institutions	1995	-	53%
Youth care institutions	1996	10-19	55%
Young drifters	1999	15-22	76%

As seen in Chapter 6, the available data on the Netherlands place the country somewhere in the middle of the field, behind Australia, the United States, the United Kingdom, Spain and Denmark, and far ahead of Sweden and Finland.

Whatever the case may be, and despite what some analysts refer to as a disastrous situation, the Dutch experience poses fewer problems in relation to drug use in the Dutch population than internal difficulties in connection with the nuisances caused by the coffee shops for Dutch citizens and neighbouring countries, Germany, France and Belgium, as a result of narco-tourism. Even more significant, the Dutch system, with its half measures, is faced with the problem of supplying coffee shops with cannabis and cannabis derivatives, which is still entirely illegal.

Holland does not escape criticism any more than other countries. From a theoretical standpoint, the very principle of de facto legalization is debatable. It fosters arbitrary action and, in particular, leaves the field open to trafficking. As much as the legalization of drug use has made it possible to get a handle on the phenomenon and make it visible so that it can be more effectively addressed, the legalization of trafficking prevents any control. (…) In practical terms, the criticisms are equally fundamental. The main criticism is that the Dutch policy has not reduced the use of drugs, hard or soft. (…) Nor has the Dutch policy eliminated the risks associated with drug abuse. (...) But it must also be recognized, and it is to the credit

> *of the Dutch policy that, while the Netherlands has not actually done better than the prohibitionist countries in the fight against drug use, it has not done worse.*[81]

Ultimately, the most remarkable thing is the ability of the Dutch stakeholders themselves, as may be seen from their testimony before our committee, to admit the weaknesses and errors of their approach, while constantly seeking ways to correct them.

[81] Caballero and Bisiou (2000), *op. cit.*, page 770-772.

UNITED KINGDOM[82]

Ten-year strategy to battle drugs

In 1998, at the same time as the newly elected Labour government announced an imposing crime reduction program, it adopted a 10-year strategy, based on a similar model, to combat drug abuse in the UK.[83] The strategy has four objectives:

- To help young people resist drug misuse in order to allow them to achieve their full potential. The key objective is to reduce the number of people under age 25 reporting use of illegal drugs in the past month and previous year. The program relies on education in schools and prevention efforts focusing on young people at risk.
- To reduce levels of repeat offending among drug-misusing offenders, by giving them the opportunity to take appropriate treatment. To do this, various treatment options were added to the stages of arrest, probation and court appearance. In addition, new drug treatment and testing orders will be made available in all courts in England and Wales. This scheme allows a court, with the offender's consent, to make an order requiring the offender to undergo treatment either in parallel with another community order, or as a sentence in its own right. In addition, the program known as *Carats* (*Counselling, Assessment, Referral, Advice and Throughcare*) is available in all England and Wales prisons, and additional prison-based rehabilitation programs are planned.
- Acknowledging that waiting times are one of the main problems for people requiring treatment and that the supply of treatment services is well below demand, the government plan provides for the creation of a National Treatment Agency which will be responsible for the provision of drug treatment and the delivery of high-quality services. Harm reduction strategies will also be increased.
- To reduce access to drugs among five-to-16-year old children, increase the seizure of Class A drugs and increase assets seized from traffickers.

Ambitious targets relating to the drug strategy have been set out in the Anti-Drugs Co-ordinator's First Annual Report and National Plan, including:

- halving the numbers of young people using illegal drugs (especially heroin and cocaine);

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[82] This section draws largely on the research report prepared for the Committee by the Library of Parliament: G. Lafrenière, (2001) *National Drug Policy: United Kingdom*. Ottawa: Library of Parliament, prepared for the Senate Special Committee on Illegal Drugs; available online at www.parl.gc.ca/illegaldrugs.asp.

[83] *Tackling Drugs to Build a Better Britain*.

- halving the levels of re-offending by drug-misusing offenders;
- doubling the numbers of drug misusers in treatment; and
- halving the availability of drugs on the streets (especially heroin and cocaine).

Although the 10-year strategy is supposed to focus on the most harmful drugs (heroin and cocaine), the number of people fined, cautioned and in some cases jailed for possession of cannabis still exceeds 100,000 a year.[84]

Legislative framework

The main illicit drug legislation in the UK is the Misuse of Drugs Act 1971 (MDA) (which is equivalent to Canada's *Controlled Drugs and Substances Act*). This legislation and its regulations (Misuse of Drugs Regulations 1985) control the use of listed drugs (including both medical drugs and drugs with no medicinal use). They set out the circumstances in which it is lawful to import, produce, supply, possess with intent to supply, and possess controlled drugs.

Under Schedule 2 of this Act, drugs are classified as either A, B or C in theory to reflect the degree of harm they are considered to cause to the individual or society when misused. Each class has different maximum penalties that apply to prohibited activities in relation to drugs.

- *Class A* is reserved for the more harmful drugs to which more severe penalties apply. This class includes, among others, heroin, morphine, methadone, cocaine, opium and hallucinogens such as Ecstasy and LSD. Also included are liquid cannabis (hashish oil), cannabinol and cannabinol derivatives and any class B drug prepared for injection.
- *Class B* includes cannabis, cannabis resin, less potent opioids (codeine), strong synthetic stimulants (oral amphetamines) and sedatives (barbiturates).
- *Class C* is reserved for drugs that are considered the least harmful such as tranquillzers, some less potent stimulants and mild opioid analgesics.

The Home Secretary can change the classification of drugs through delegated legislation as was just recently done for cannabis. This modification means that possession of cannabis for personal use will not be an arrestable offence but obtain a police caution.

Sections 3 to 6 set out which activities in relation to drugs are prohibited. They include importation and exportation (the actual offences are contained in and prosecuted under the Customs and Excise Management Act 1979), production, supply,

[84] "Drug Laws: the debate nobody wants", *The Guardian*, May 14, 2001.

possession, and possession with intent to supply. Cultivation of cannabis is a separate offence but is also considered production. Under section 8, it is prohibited for the occupier knowingly to permit premises to be used for: production; the supply of any controlled drug; the preparation of opium for smoking; or the smoking of cannabis, cannabis resin or prepared opium. Section 9 provides a series of offences related to opium, including smoking or otherwise using opium. Section 9A prohibits the supply of any article which may be used in the unlawful administration of drugs (hypodermic syringes are excluded from this prohibition for the purpose of needle exchange programs). Sections 18 to 21 create other offences mainly dealing with incitement to commit an offence under the *MDA*.

Penalties are set out in sections 25 and 26. Section 27 deals with forfeiture.

- For class A drugs, the maximum penalties are as follows: seven years and/or unlimited fine for possession; life and/or unlimited fine for production or trafficking with a mandatory seven-year sentence for a third conviction for trafficking. The mandatory sentence for a third conviction of trafficking is found in the Criminal Sentences Act 1997.
- For class B drugs, the maximum penalties are: five years and/or unlimited fine for possession; and fourteen years and/or unlimited fine for production or trafficking.
- For class C drugs, the maximum penalties are: two years and/or unlimited fine for possession; and five years and/or unlimited fine for trafficking.

In addition, producers and traffickers are also liable to confiscation of assets under the Drug Trafficking Act 1994. As stated above, growers of cannabis may be prosecuted under section 4 (production) of the MDA rather than under section 6 (cultivation) of this Act. This is significant because production (but not cultivation of cannabis) is designated a trafficking offence for the purposes of the Drug Trafficking Act 1994. In 1997, a total of 4,168 people were dealt with for production offences of which 92% involved production of cannabis (25% of these offenders were cautioned and 18% of those who were found guilty were sentenced to immediate custody). Offences that are designated as trafficking offences for the purposes of the Drug Trafficking Act 1994 include production, supply, and possession with intent to supply as well as importation offences under the Customs and Excise Management Act 1979. In the UK, most drug offences may be tried summarily by magistrates or on indictment with a jury at a Crown Court. If tried summarily, the maximum cannot exceed six months and/or £5000 fine or three months and/or fine for less serious offences.

Section 7 allows for regulations to be made to exempt certain activities from the offence provisions. This allows for the use of drugs for medicine and for scientific research. The Misuse of Drugs Regulations 1985 divide drugs into five schedules. The regulations set out the classes of persons who are authorized to handle controlled drugs while acting in their professional capacities and lay down the conditions under which certain activities may be carried out. More severe rules regarding importing, exporting,

production, supply, possession, prescribing and record-keeping apply to Schedule 1 drugs with a gradual loosening of the rules for other schedules. For example, the most restricted Schedule 1 drugs (such as LSD and cannabis) can be supplied or possessed only for research or other special purpose by licensed individuals and are not available for normal medical uses and cannot be prescribed by doctors who do not have a licence. Schedule 2 drugs–which must be prescribed–are subject to a number of controls relating to prescriptions, secure storage and the need to keep records. Schedule 5 drugs, meanwhile, are subject to the least administrative controls and may be freely imported, exported or possessed for personal use.

Cannabis and certain psychoactive cannabinoids and derivatives are classified under Schedule 1 as having no therapeutic benefit. Thus, they cannot be prescribed and can only be possessed for research purposes by someone who is licensed to do so. Nabilone (a synthetic cannabinoid) is licensed for prescription to patients with nausea or vomiting resulting from cancer chemotherapy, which has proved unresponsive to other drugs. Dronabinol (a cannabinoid) has been rescheduled from Schedule 1 to Schedule 2 and can be prescribed. However, it remains unlicensed in the UK and has to be prescribed on a "named patient basis."

Section 10 allows the making of regulations dealing with safe custody, documentation of transactions, record-keeping, packaging and labelling, transport, methods of destruction, prescriptions, the supply of information on prescriptions to a central authority, the licensing of doctors to supply controlled drugs to addicted patients, and the notification by doctors of their addicted patients.

The Misuse of Drugs (Supply to Addicts) Regulations 1997 restrict to a few specially licensed doctors the ability to prescribe heroin, dipipanone and cocaine for the treatment of addiction.

Other relevant legislation in the field of drug misuse

The Medicines Act 1968 (equivalent to Canada's *Food and Drugs Act*) regulates the production and distribution of medicinal drugs and other medicinal products in the UK. It generally requires a marketing authorization or licence before a product may be distributed. The Act deals with the testing, sale, supply, packaging, labelling, prescribing, dispensing by pharmacists, and selling in shops of medicinal products. Many controlled drugs are also medicinal products and must thus satisfy the requirements of both the MDA and the Medicines Act 1968.

The MDA prohibits the importation or exportation of a controlled drug unless it is exempted by regulation or it takes place under the proper licence. The offences, however, are actually under the Customs and Excise Management Act 1979 which acts together with the MDA to prohibit unauthorized importation or exportation of controlled drugs. The offences under the Customs and Excise Management Act 1979 are usually charged and prosecuted by H.M. Customs and Excise rather than by the police and Crown prosecutors. In 1997, a total of 1,741 people were dealt with for

these offences, 68% of which involved cannabis (31% were dealt with by compounding and of those found guilty by the courts, 79% were sentenced to immediate custody).

Part II of the Criminal Justice (International Co-operation) Act 1990 controls the manufacture and supply of certain precursor chemicals which can be used in the manufacture of illicit drugs. Manufacture or supply contrary to the Act is a trafficking offence for the purposes of the Drugs Trafficking Act 1994. Regulations may be made dealing with notification of exports, record-keeping and the supply of information.

The Drug Trafficking Act 1994 was adopted to enable the UK to meet its obligations under the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1998 (The Vienna Convention). It creates offences in connection with laundering and handling of the proceeds of drug trafficking, and introduces confiscation measures. The burden of proof is placed on the defendant to prove that the assets were lawfully acquired and applies the civil standard of proof on the balance of probabilities. The MDA does not distinguish between trafficking and non-trafficking offences. Rather, this distinction is made in the Drug Trafficking Act 1994; the main consequence of designating an offence as a trafficking offence is that the confiscation provisions apply. In addition, an offender is liable for a third trafficking offence involving a Class A drug to a minimum penalty of seven years imprisonment under the Crime Sentences Act 1997.

Debate in the UK

As in Canada, the debate in the UK regarding cannabis would appear to revolve around two issues: (1) decriminalization or legalization of cannabis for recreational use; and (2) the medicinal use of cannabis.

Although cannabis is now a Class C drug, its recreational use is still prohibited in the UK. Under the MDA, it is illegal to grow, produce, possess, or supply cannabis to another person. It is also an offence to allow premises to be used for growing, preparing, supplying or smoking it. Maximum penalties for cannabis offences in the UK are fairly severe (these vary throughout the EU). As in Canada, there is considerable discretion in how the law is applied and in many cases the police caution those found in possession of small amounts of cannabis. In the *Report of the Independent Inquiry into the Misuse of Drugs Act 1971, Drugs and the Law*, the following was stated regarding the use of discretion, particularly with respect to cannabis:

> *Many cases are kept away from the courts by cautioning and compounding and, in Scotland, warning letters and fiscal fines. By far the largest increase in police cautioning in England and Wales has been for cannabis offenders, from 41% in 1990 to 55% in 1997. This has meant in practice a tripling in the number of cannabis offenders for which a caution was given, from 16,500 to 47,000. Cautions are part of an offender's criminal record. There is no provision at present for these records to expire under the Rehabilitation of Offenders Act 1974. The Government has recently issued a consultation paper proposing that this anomaly should be corrected and that cautions should be immediately spent. This*

would also apply to reprimands and warnings, which are to replace cautions for young people under 18 under the Crime and Disorder Act 1998.
Cautioning is not used by H.M. Customs and Excise or in Scotland. For importation and exportation offences, compounding – a monetary penalty in lieu of prosecution – may be used in cases involving cannabis not exceeding 10 grams in weight. While compounding does not necessarily become part of an offender's criminal record, it may be mentioned in subsequent court proceedings Its use for cannabis importation offenders fell between 1990 and 1997 from 58% to 45%.
…This discretion in the implementation of the MDA is desirable but produces anomalies in the differing regimes of cautioning and compounding, and inconsistencies in the cautioning rates between police forces. More than half of the arrests for cannabis offences result in a caution. We do not criticise the police for their extensive use of cautioning. It is currently the only realistic and proportional response. Without it, the courts would have ground to a halt. However, the use of discretion does not lessen the disproportionate attention that the law and the implementation of the law unavoidably give to cannabis and cannabis possession in particular.[85]

The use of cannabis for medicinal purposes has a long history in the UK. It was prescribed as a medicine in the UK until 1973. At that time, it became a drug that could not be legally used as a medicine and today its medicinal use remains prohibited. As will be discussed in the next section, the Science and Technology Committee of the House of Lords recommended that cannabis be made available for medicinal purposes in a 1998 report. This recommendation was rejected by the government, which indicated that before such a change could be considered, the safety and efficacy of cannabis would have to be demonstrated. G.W. Pharmaceuticals has been given permission to grow cannabis with the aim of developing a cannabis-based medicine; clinical trials have commenced in the UK.

Recent key reports and studies

Science and Technology Committee of the House of Lords

In 1998, the Science and Technology Committee of the House of Lords studied the issue of medicinal use of cannabis and tabled a report entitled Cannabis: The Scientific and Medical Evidence. The purpose was to examine the scientific and medical evidence with respect to the medicinal use of cannabis and determine whether current restrictions were appropriate. In addition, the Committee considered whether the prohibition on recreational use was justified based on the scientific evidence of adverse effects. However, the mandate did not include other issues such as the social and legal aspects of cannabis use.

The Committee discussed the long history of cannabis use both as a medicine (usually in the form of a tincture) and an intoxicant. The Committee noted that the

[85] Police Foundation (2000) *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, "Drugs and the Law", Chapter 7, paragraphs 28, 29 and 31.

"*advent of a host of new and better synthetic drugs led to the abandonment of many ancient herbal remedies, including cannabis*."[86] The *Medicines Act 1968* allowed the government to licence pharmaceutical companies and products, and cannabis was still able to be prescribed under certain conditions. In 1973, cannabis's licence of right was not renewed and the regulations under the *Misuse of Drugs Act 1971* prohibited medical use altogether (by listing cannabis in what is now Schedule 1).

The Committee then went on to review the pharmacology of cannabis and the different ways it may be administered, the toxic effects of cannabis, including: the short and long-term effects of it; whether the user develops tolerance to the drug; and whether it causes dependence. The Committee found that although cannabis "*is not in the premier league of dangerous substances, new research tends to suggest that it may be more hazardous to health than might have been thought only a few years ago*."[87]

Concerning the current medical use of cannabis in the UK (quite widespread even though it is illegal) as well as the current medical uses of cannabinoids (certain cannabinoids are legally in current use in UK medicine), the Committee proposed new indications for cannabis-based medicines (including alleviating certain symptoms related to multiple sclerosis). The Committee stated that it "*is important to distinguish the different substances and preparations; for instance, cannabis leaf must be distinguished from cannabis extract, and whole cannabis from THC. It is also important, although not always easy, to distinguish the various possible routes of administration, e.g. by smoking and by mouth.*"[88]

Based on evidence that cannabis can be effective in relieving the symptoms of multiple sclerosis and against certain forms of pain, the Committee recommended that clinical trials of cannabis for these conditions "be mounted as a matter of urgency." The Committee members did indicate that if a medicine became licensed (after clinical trials), they did not envisage smoking being used to administer it. Thus, they called for research into alternative delivery systems. The Committee also recommended that cannabis should be reclassified as a Schedule 2 drug so that doctors would be permitted to prescribe an appropriate preparation of cannabis, "*albeit as an unlicensed medicine and on the named-drug basis*"; this would also allow research without a special licence.

Compassion was the main reason for recommending the change to the law (a law under which patients risk prosecution to get help). Another reason was the inconsistent way in which the law was enforced, which brought it and Parliament into disrepute.

The Committee did note that cannabis-based medicine would not be appropriate for certain groups of patients such as pregnant women, people predisposed to schizophrenic illness or those with cardiovascular conditions. In addition, users would have to be warned of possible side-effects. The risk of addiction would have to be considered when deciding whether to prescribe. Thus, the Committee recommended that "*if doctors are permitted to prescribe cannabis on an unlicensed basis, the medical professional*

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[86] House of Lords, Select Committee on Science and Technology, Ninth Report, Session 1997-98, *Cannabis: The Scientific and Medical Evidence*, para. 2.6.

[87] *Ibid*., par. 4.1.

[88] *Ibid*., par. 5.1.

bodies should provide firm guidance on how to do so responsibly"[89] and that "*safeguards must be put in place by the professional regulatory bodies to prevent diversion to improper purposes*."[90]

With respect to the recreational use of cannabis, the Committee added that although the harms must not be overstated, there was enough evidence of toxic effects of cannabis to justify maintaining the current prohibition.

The government rejected the recommendation to reclassify cannabis. It indicated that before cannabis should be available for prescription, its safety, quality and efficacy would have to be demonstrated and a marketing authorization issued by the Medicines Control Agency. In addition, the government indicated that allowing prescriptions of cannabis would reduce momentum in research. The government was also concerned with the possibility of prescribed cannabis being used for improper purposes.

In March 2001, the Science and Technology Committee of the House of Lords presented another report dealing with the current state of research into the therapeutic uses of cannabis, the roles of the Home Office and the Medicines Control Agency in the licensing of cannabis-based medicines, and more recent issues relating to the prosecution of therapeutic cannabis users. The Committee reiterated that cannabis should remain a controlled drug and that the legalization debate should maintain a clear distinction between therapeutic and non-therapeutic use.

With respect to the current state of research, the Committee noted trials recently approved for funding by the Medical Research Council. The Committee was concerned about the long timeframe for developing usable therapeutic preparations from these trials. It was more encouraged with the progress being made by G.W. Pharmaceuticals, both with respect to establishing the efficacy of a cannabis-based medicine and in developing suitable medical preparations (e.g., a sub-lingual spray).

The Committee also discussed the prosecution of therapeutic users of cannabis. They noted that the decision to prosecute varies from region to region and that, in some cases, juries have acquitted therapeutic users who do not deny the offence but plead therapeutic use in mitigation while others are found guilty. The Committee believed that the acquittal of cannabis users by juries on compassionate grounds brings the law into disrepute. According to the Committee, this problem underlines the need to legalize cannabis preparations for therapeutic use.

The Committee noted that the decisions made by the Medicines Control Agency appear to be inconsistent. For example, although it is satisfied that the information on the toxicological profile of delta-9-tetrahydrocannabinol is adequate, it is not satisfied with the toxicology data of cannabidiol. The Committee was of the view that the Medicines Control Agency had "*not adopted a positive approach towards the licensing of a cannabis-based medicine*." The Committee was concerned that the Medicines Control Agency's approach places "*the requirements of safety and the needs of patients in an unacceptable*

[89] *Ibid*., par. 8.16.
[90] *Ibid*., par. 8.17.

balance." The Committee concluded that the Agency's attitude "*means that cannabis-based medicines are not being dealt with in the same impartial manner as other medicines*."

> *We believe that a thorough and impartial reappraisal of the published scientific literature on the safety of CBD and cannabis extracts should lead the MCA to reconsider their present overly cautious stance. We are at least encouraged that the MCA state that they are conducting a more detailed review of existing literature reports on cannabis and CBD.* [91]

The Runciman Report

In August 1997, The Police Foundation set up an independent inquiry (chaired by Viscountess Runciman) to assess the UK's legislation on the misuse of drugs. The main goal was to determine whether the legislation needed to be revised in order to be more effective and more responsive to the changes that had taken place in the 30 years since the original law was passed.

The report recognizes that the goal of drug legislation must be to control and limit the demand for and the supply of illicit drugs because eradication of drug misuse is not a realistic goal. The report also stated that the law must fulfil UK's international obligations and noted that international agreements – while restricting some options – allow for room to manoeuvre, particularly in the areas of drug use and possession.[92] The report discussed different approaches towards drug use and possession and towards minor acts of supply taken by some other European countries and found that the UK had a comparatively more severe regime of control of possession offences.

The report indicated that the law should be based on the following principles:

- as a means of reducing demand, the law is only one aspect of a broader agenda of health, prevention and education;
- it should reflect the latest scientific understanding and the social and cultural attitudes of modern British society;
- it should be realistically enforceable;
- it should infringe personal freedom only to the degree necessary to restrain serious levels of harm to users or others;
- it should target the drugs that cause the most harm;
- it should reflect the relative harmfulness of activities connected with each illicit drug or category of drugs, and provide for sanctions proportionate to that harm; and
- in its operation, the law should be accepted by the public as fair, consistent, enforceable, flexible and just.

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[91] House of Lords, Select Committee on Science and Technology, *Therapeutic Uses of Cannabis*, Second Report, March 14, 2001, par. 29.

[92] *Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, Drugs and the Law, Mars 2000, page 74.

The report noted a steady increase in the prevalence of both problem drug use (including injecting among problem drug users) and casual drug use in the UK over the past 30 years. Cannabis is the most widely used illegal drug, with age 30 being the big divide in drug use. Despite there being a steady rise in drug offences and seizures (including amounts seized) over the years, the report concluded that efforts to limit supply have in the most part failed. The report found that the public views health-related dangers of drugs as more of a deterrent than their illegality, availability or price. In addition, public attitudes to cannabis compared to other drugs were significantly different (cannabis was seen as the least harmful drug, its possession should be the lowest of priorities for police, and a number of people – a third to half – believe that the laws should be relaxed).[93] All age groups shared these views, although support for legalization was not as strong among older age groups. With respect to other drugs, strong drug laws were fully supported despite concern with health risks resulting from drug use. The public was much more concerned with trafficking than with possession offences. The inquiry found that there was a lack of data on drug use and the absence of detailed cost information about drug use (e.g., health care, enforcement and other social services costs). Thus, it was difficult to do any type of assessment of drug control and prevention strategies

The UK's drug classification was reviewed and the report recommended keeping the current three-tier drug classification system (class A, B and C). This classification enables authorities to distinguish between the relative risks of different drugs and allows sanctions to be applied that are proportionate to a drug's harm. However, the report found that the criteria by which drugs are classified should be clearly described. The classification should take into account modern developments in medical, scientific and sociological knowledge; as well, the main criteria should be dangerousness of the drug to the individual and to society. The report set out factors to consider, including: the risks of the drug itself (acute and chronic toxicity); risks due to the route of use; extent to which the drug controls behaviour (addictiveness/dependency) and ease of stopping; and social risks (costs to society in terms of crime, medical costs, social harm through intoxication, etc.). Based on these factors, the report recommended some changes to the drug classes to counteract what the members felt was a dangerous message, i.e., that all drugs are equally dangerous. The members of the inquiry believed that these changes would enhance the law's credibility and that education and attention should be refocused on the more harmful drugs such as heroin and cocaine. The report recommended the following changes:

- cannabis should be reclassified from a class B drug to a class C drug and cannabinols from class A to class C;
- heroin and cocaine would remain in class A (the most dangerous drug category) while Ecstacy and LSD would move to class B; and
- buprenorphine would move from class C to class B.

[93] *Ibid*., Chapter 2, par. 64.

It is interesting to note that the members of the inquiry would have classified alcohol as a class B drug bordering on A, while tobacco would have been on the borderline between B and C, if these substances were controlled under the MDA.

The report found that possession offences should remain, even if for personal use. However, the law should minimize the harmful consequences of a contravention in appropriate cases. The report concluded that for the majority of possession offences, imprisonment was neither proportionate nor effective. It recommended that imprisonment no longer be available for possession of class B or class C drugs. Imprisonment should remain a possibility for possession of class A drugs, although the maximum would be shorter than what is currently set out. This would reflect what the courts are currently doing; the average possession sentence is fairly short compared to the maximum available. In addition, the report recommends lowering the maximum fines for all classes of drugs. According to the report, imprisonment for possession would be rare. Non-custodial responses would include fines, probation orders, probation orders with treatment conditions attached, and conditional discharges. These sanctions would be most suitable for possession of class B and class C drugs where a caution was not appropriate. The report noted that in over 50% of cases, police use cautioning. This approach was supported but the report felt that this discretion needed a proper framework. Thus, cautions should become a statutory sanction with guidelines set out in regulations. This would allow the enforcement of conditions attached to a caution. Finally, the report recommended that a caution should not carry a criminal record. If the recommendation to reclassify cannabis as a class C drug were carried out, it would have certain consequences, including that police would no longer be allowed to arrest for possession of cannabis. For arrestable offences, the police have powers to insist that suspects accompany them to the police station and to search their premises without a warrant. Police would still have the power to stop and search for all drugs, however.

With respect to trafficking, the report mentioned that there should be an attempt to differentiate between acts of different gravity with respect to supply offences (for example, supply between friends versus as part of an organized criminal group and supply of class A drugs versus other drugs). The report recommended a separate offence of dealing, the main ingredient of which would be the pattern of activity of illicitly transacting business in drugs. The offence would be a trafficking offence for the purposes of the Drugs Trafficking Act 1994. The report also recommended that the maximum penalty for trafficking in class A drugs be lowered to 20 years and that the maximum for class C drugs (including cannabis) be raised to seven years. The report also recommended the adoption of sentencing guidelines, for trafficking offences in particular. The report also mentioned the ineffectiveness of the laws dealing with confiscation of assets (in their view, a pragmatic problem rather than a legislative one). The report recommended improving the effectiveness of the current system by setting up a new national confiscation agency and making several other changes.

Although the inquiry members believed that the drug legislation in general did not need radical change, the legislation's application to cannabis was the exception. Thus, many of the more significant changes apply to this drug. The report noted that it was the drug most widely used and most likely to bring people in contact with the justice system. The report also noticed the gap between how the law is written and how it is practised with respect to cannabis (due to the use of discretion). The members of the inquiry were of the view that cannabis was less harmful to the individual and society than other illicit drugs (although not harmless). With respect to cannabis, it was felt that the current law produces more harms than it prevents and that the law's response is disproportionate to the drug's harm. The report, thus, recommended penalties for cannabis possession for personal use be decreased and that imprisonment not be an option (normal sanctions for possession and cultivation for personal use would be out-of-court disposals, including informal warnings, statutory cautions or a fixed out-of-court fine). In addition, the report stated that cultivation of small amounts of cannabis should be prosecuted under section 6 (cultivation of cannabis) rather than section 4 (production) so that it not be considered a trafficking offence. The cultivation offence should be treated in the same way as possession of cannabis. In addition, permitting people to smoke cannabis on their premises would no longer be an offence. The members of the inquiry were of the view that the benefits of such a strategy outweigh the risks and that this would promote the targeting of enforcement on those drugs and activities that cause the most harm.

The report concluded that demand is not significantly reduced by the deterrent effect of the law. Education and treatment can be successful, however. Thus, the members recommended a less punitive approach to possession offences and a more punitive approach to trafficking (particularly with respect to profits obtained from drugs). The members believed that harm could be reduced with credible education and treatment when needed. They indicated that treatment is cost-effective in reducing problem drug use and associated criminal activity and recommended a substantial reallocation of resources from enforcement (currently 62%) to treatment (currently 13%).

With respect to the medicinal use of cannabis, the report concluded that the therapeutic benefits of cannabis for certain serious illnesses outweighed any potential harm. They endorsed the view of the House of Lords report that cannabis and cannabis resin should be moved to Schedule 2 (thus permitting possession and supply for medical purposes). Because the House of Lords recommendation was rejected by the government and because it would be years before a licensed cannabis product becomes available, the report recommended a new defence in law: duress of circumstance on medical grounds for those accused of the possession, cultivation or supply of cannabis for the relief of certain medical conditions.

In its reply to the report, the government rejected or referred for further consideration many of the recommendations made by the inquiry. On the key issues of reclassifying cannabis and the depenalization of cannabis, the government did not

support the inquiry's recommendations. With respect to the reclassification of cannabis, the government was mainly concerned with the health risks associated with its use. With regard to depenalization, the government rejected removing imprisonment as a possible sanction. In addition, they did not want the police powers of arrest to be abolished for these offences. In dealing with the medicinal use of cannabis, the government indicated that the quality, efficacy and safety of a medicinal form of the drug must be established before prescribing should be allowed.

As we now know, the government has since reclassified cannabis and abolished prison terms for possession for personal use.

Other reports

A Working Party of the Royal College of Psychiatrists and the Royal College of Physicians also published a report in 2000. Entitled *Drugs: Dilemmas and Choices*, the report examined key issues in preventing drug misuse. In particular, it states:

> *Spending on prevention: Three-quarters of UK expenditure is devoted to enforcement and international supply reduction. There is little evidence that this is money well-spent. The proven cost-effectiveness of methadone maintenance and abstinence-based programmes for heroin addicts suggests that more of the available budget should go to treatment programmes. New money for treatment announced by the Government is welcome, but calls for expansion of unproven and untested treatments must be resisted.*
> *Research: Current UK expenditure on drugs research does not begin to match the magnitude of the problem. Just one per cent of the annual drugs prevention budget would inject £14 million into research – over double the current spent.*
> *Improving the value of treatment: Systematic investment in staff training, monitoring of patients and essential support services is needed to bring improvement rates achieved by UK treatment programmes closer to those in the United States. In particular, more extensive drug treatment facilities are needed for adolescents.*
> *Private prescribing: Private prescribing of substitute drugs leaves scope for malpractice that comes close to 'buying a prescription'. Doctors treating drug-users outside the health service are not currently required to have extra training in addictions and receive little monitoring or regulation.*
> *Drug-testing by employers: Although expensive and surrounded by legal and ethical issues, the technology exists for drug-testing of employees using hair samples. This provides a record of drug-use over the previous three months and could, therefore, have a major impact on the prevalence of drug-use in future.*
> *Ecstasy: Many young people use Ecstasy, and some drugs education campaigns may have proved counter-productive. Any advice given to young people should take account of the likely impact on those who continue to use drugs as well those who will be deterred.*
> *Amphetamine: Dependence on amphetamine, especially when injected, probably carries more risk to users and public health than heroin. Little research has been carried out into dependence or treatment.*
> *Cannabis: Cannabis is not a harmless drug, but its ill-effects on health are almost certainly less than those of tobacco or alcohol, which are legal. More research is needed into the medicinal benefits and long-term ill-effects of the drug. Legislative experiments, as in the Netherlands, should be encouraged. People requiring cannabis to relieve disabling medical conditions, such as multiple sclerosis, should not be prosecuted.*

Future policy: The Government's Ten-Year Strategy for Tackling Drug Misuse recognises the need for greater investment in treatment. But there are no easy answers, and ambitious targets for reducing the proportion of young people using heroin and cocaine by 50 per cent by 2008 are unlikely to be achieved by the modest initiatives announced so far. Attempts to curb the illegal international drugs trade have consistently failed and will probably continue to do so. If the prevalence of drug-use and drug-related crime continues to rise, the pressure on the UK and other governments to change policies that are clearly failing is bound to increase. [94]

Administration

Because of the complexity of the drug problem, many different departments and organizations are involved in implementing the UK drug strategy. The key organizations in the UK's drug strategy are the drug action teams at the local level, which are responsible for ensuring that the strategy is translated into concrete action.

Costs

Public costs

In 1997/1998, most of the costs were directed at enforcement. The total expenditure of £1.4 billion was spent on the following activities:

- *drug misuse, enforcement and international supply reduction* accounted for 75% (enforcement includes police, court, probation, and prisons – 62%; international supply, which encompasses customs and excise, Foreign and Commonwealth Officer – 13%);
- *treatment and rehabilitation*–13%; and
- *education and prevention*–12%.[95]

Following a comprehensive spending review in 1998, an additional £217 million were to be allocated over a three-year period to drug activities. "A substantial share of these new funds will be directed at initiatives designed to break the link between drug misuse and crime, including Arrest Referral Schemes and Drug Treatment and Testing Orders. The idea is to provide every drug misusing offender entering a police station or prison with a chance to seek treatment by the year 2002."[96] The extra funds were to be spent as follows:

- £133 million for the implementation of the strategy to tackle drug misuse in the criminal justice system.

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[94] Joseph Rowntree Foundation, *Drugs: dilemmas, choices and the law*, November 2000. This article may be found at http://www.jrf.org.uk/knowledge/findings/foundations/N70.asp.

[95] *Tackling Drugs to Build a Better Britain, The Government's Ten-Year Strategy for Tackling Drugs Misuse*, April 1998, in the chapter entitled: "Resourcing and Managing the Work".

[96] DrugScope, *UK Drug Situation 2000*. The UK Report to the European Monitoring Centre for Drugs and Drug Addiction, November 2000, page 7.

- Prisons would receive £60 million for treatment services and £12 million for voluntary drug testing in prisons.
- £61 million for the piloting and implementation of Drug Treatment & Testing Orders.
- £70.5 million would be allocated to health and local authorities to fund new treatment services and to improve community care for drug misusers.
- Health Authorities would receive £50 million for treatment services and for young people at risk.
- Local Authorities would receive £20.5 million to improve access to services and increase numbers in treatment programs.
- £10.5 million would be allocated to support Drug Action Teams across the country and for national research into effectiveness of anti-drugs activity.
- £3 million would be allocated to support cross-departmental development of more effective drugs education.
- £6 million over 3 years would be provided for a major new research program.
- An extra £3 million would be available from the Confiscated Assets Fund in 1999/2000, to be increased to £5 million and £7 million in subsequent years.[97]

Social costs

The UK Anti-Drugs Co-ordinator's Annual Report 1999/2000 stated that drug misuse costs Britain over £4 billion per year in crime, sickness and absenteeism. In addition, it was estimated that one-third of property crime is related to drugs.

Statistics

The Office for National Statistics estimates that the illegal drugs market alone accounts for nearly 1% of national output, equivalent to £8.5 billion a year.[98]

Despite the criticisms made in certain reports, the UK has an impressive database on drug use trends. Every two years since 1983, the Home Office has conducted the national British Crime Survey, which includes a series of questions on illegal drug use. The Home Office also keeps detailed data on arrests, convictions and sentences. The *DrugScope* organization is the British correspondent for the OEDT.

Use

In the 16-59 age group, 32% in England and Wales say they have "ever used a drug" (1996 = 29% and 1994 = 28%). This rises to 50% for the 16-24 age group.

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[97] *Ibid.*, page 11-12.

[98] "The Untouchables", *Economist*, April 21, 2001, Vol. 359, No. 8218, page 49.

Recent drug use was less common, however. For example, in the 1994, 1996 and 1998 surveys, 10%-11% reported drug use in the last year and 6% reported drug use in the last month. Drug use does change with age: 30% of 16- to 24 year olds reported drug use in the last year and 20% in the last 30 days (this compares to 3% and 1.5% for 45-to 54 year olds). In addition, there is a higher prevalence of drug use in males than in females. With respect to children, surveys in England show that 13% of respondents aged 11 to 15 reported ever taking a drug. For children, prevalence increases with age. For example, 3% of 11- to 12-year-olds, 13% of 13- to 14-year-olds, and 31% of 15 year-olds reported ever using drugs.

Cannabis is the most widely cultivated, trafficked and used illicit drug in the UK. The young use it most commonly, with usage declining with age. Almost half of 16- to 24 year olds in England and Wales report ever using cannabis, with 17% using it in the last month. Only 5% of adults aged 55 to 59 report ever using this drug.

Offences

As stated, people arrested in the UK may be dealt with in different ways including cautioning by police or prosecution (except in Scotland where other procedures are available). Under the Customs and Excise Act 1979, compounding (the payment of a monetary sum in lieu of prosecution) is available in cases of importation of small quantities of cannabis (10 grams or less). In addition, the authorities may use their discretion and take no further action. This last option would not appear in criminal statistics.

The total number of people dealt with for drug offences went from 35,000 in 1988 to 153,000 in 1998. Of these, 127,840 were found guilty, cautioned, fined or settled with by compounding. In 1997, the number was 113,150. The most common drug was cannabis at 76%. Almost 90% of MDA offences are possession offences and, generally, three-quarters of all possession offences involve cannabis. The number of people who receive cautions has increased dramatically over the years and of the people found guilty, cautioned, fined or settled with by compounding, cautioning now accounts for almost 50%. Thus, many of the cases are dealt with outside the courts.

In 1998, the number of drug seizures was 149,900, an 8% increase over 1997. Cannabis was involved in 76% of the cases. Between 1995 and 1999, the average price of most drugs remained relatively stable.

SWEDEN[99]

When contrasting a successful model with the Dutch "failure", the witnesses we heard invariably mentioned Sweden. In Sweden, the drug phenomenon is considered one of the most serious social problems (if not the most serious), and drugs are viewed as an external threat to the country.[100] Drug addiction is often viewed as the cause of other social problems and the drug problem itself as jeopardizing Sweden's traditional values. These concerns have intensified since Sweden became a member of the European Union (EU) in 1995, since most of the other members of the EU have adopted a more liberal attitude on drug issues. In comparison to other western European countries, Swedish drug policy is regarded as restrictive. One of the aims of the policy is to make it clear that drugs are not tolerated in society, and its overall goal is a drug-free society. In particular, we observe that:

- harm reduction programs are available in a limited fashion only;
- treatment is based on obtaining complete abstinence and it is possible to force people into treatment;
- drug use is an offence, and urine and blood tests are used to detect those suspected of drug use;
- drug legislation is strictly enforced;
- discussions regarding the medical value of cannabis are almost non-existent;
- Swedish legislation strictly adheres to, and even exceeds, the requirements set out in the three United Nations drug conventions.

While Swedish drug policy is currently very restrictive, this was not always the case. In fact in the 1960s, its policy was fairly liberal, basically reflecting a harm reduction approach.[101] For example, from 1965 to 1967, it was possible for severe drug abusers to obtain prescriptions for morphine and amphetamines. This non-scientific experiment (involving approximately 120 people) was used by Nils Bejerot, a police doctor and very influential figure in Swedish drug policy, in his study of the relationship between drug use and drug policy in the period between 1965-1970. Some of his

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[99] This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: G. Lafrenière, (2001) *National Drug Policy: Sweden.* Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp. For more information, see also T. Boekhout van Solinge, (1997) *The Swedish Drug Control System: An in-depth review and analysis*, Centre for Drug Research, University of Amsterdam, Amsterdam, 1997.

[100] European NGO Council on Drugs and Development, *A Snapshot of European Drug Policies : Report on the state of drug policies in 12 European countries*, October 2001, page 27.

[101] United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile : Sweden*, 1998, page 1.

findings included: that changes from restrictive to permissive policy and vice versa was reflected in the rates of intravenous drug use; that this experiment was the origin of the Swedish drug epidemic; and that the experiment did not have the desired effect of crime reduction. His findings are still widely accepted in Sweden even though they have been criticised.[102]

With increased drug use in 1965, the Committee on the Treatment of Drug Abuse was established: it published four reports from 1967 to 1969. The first report dealt with treatment and the second with repressive measures. It is this second report which led to the adoption of the *Narcotic Drugs Act* in 1968. The Committee's reports indicated that the drug problem was on the increase. This finding, in conjunction with the findings of Bejerot, are partly responsible for the more restrictive approach adopted by Sweden in the late 1960s. In addition, since 1968, the government organized a massive media and school campaign against drugs. This led to a generation growing up with messages based on the gateway theory, among others.[103] This theory is used as a justification for being restrictive in relation to cannabis and "*Swedish drug policy actually focuses on cannabis, since it is alleged 'drug careers' start with this substance*."[104] In addition, the dangers caused by cannabis itself (psychosis, addictive character, higher risk of suicide, etc.) are seen as reasons for having a restrictive policy.

Over time, Swedish policy became more restrictive and repressive, resulting in the strengthening of penalties, criminalizing of use, and allowing of urine and blood tests for those suspected of use. Although the original goal of the urine and blood tests was to detect new users and provide them with appropriate treatment, it would appear that the tests are no longer being used for this sole purpose as known drug users are also being targeted.[105]

Some authors have drawn a link between Sweden's restrictive drug policy and its restrictive alcohol policy. The temperance movement has a long history in Sweden and the country has developed a fairly restrictive alcohol policy, including a state monopoly on the sale of alcohol.

> *Swedish attitudes towards alcohol are relevant since a restrictive alcohol policy makes a restrictive drug policy a logical option. Moreover, the total consumption model on which the alcohol policy is based, is thought to be valid for illicit drugs as well. By limiting the total consumption of drugs, the total harm caused by drugs is alleged to be lower as well. However, it was shown that this correlation is far from clear when it comes to (different) illicit drugs.* [106]

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102 Boekhout van Solinge, *op. cit.*, page 45.
103 European NGO Council on Drugs and Development, *op. cit.*, page 27.
104 Boekhout van Solinge, *op. cit.*, page 88.
105 *Ibid.*, page 116-117.
106 *Ibid.*, page 103.

National strategy

Following the creation of a Commission on Narcotic Drugs, the Swedish government presented a new action plan in January 2002, which is to be valid until 2004. A total of SKR 325 million (approximately $50 million Canadian) has been allocated over the three-year period to combat illegal drug use. The action plan was presented as a means to reverse the disturbing trend in drug abuse. [107]

The policy's objectives are to:

- reduce the number of new recruits to drug abuse (mainly through prevention directed at young people);
- encourage more drug users to give up the habit (through care and treatment); and
- reduce the supply of drugs (through criminal measures).

One of the key new features of the drug strategy is the creation of a national anti-drugs coordinator position. The position was created to have clear leadership in the drug policy area, make it possible to follow up on the plan's goals, and determine whether new initiatives are required to combat new problems. The key tasks for the new anti-drugs coordinator are to:

- develop cooperation with authorities, municipal and county councils, NGOs, etc.;
- shape public opinion;
- undertake a supporting function for municipal and county councils in the development of local strategies;
- initiate methods development and research;
- serve as the Government spokesperson on drugs issues;
- evaluate the action plan; and
- report regularly to the Government (at least once a year).

Of the SKR 325 million, 100 million (approximately $15 million Canadian) has been allocated to a special drugs initiative within the Swedish Prison and Probation Service. The goal is to offer care and treatment to all drug abusers in this system. In addition, the National Prison and Probation Administration is required to:

- develop methods for preventing drugs being brought into institutions and detention centres;
- investigate the obstacles to treatment outside institutions; and
- produce special programmes for contract care, i.e. care in accordance with a contract between the person convicted and the community.

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[107] Ministry of Health and Social Affairs, *National Action Plan on Narcotic Drugs*, Fact Sheet, February 2002.

With respect to the police, the National Police Board and the National Council for Crime Prevention will be required to carry out their own review of police efforts to combat drug-related crime.

In Sweden, while the national policy is created at the national level, much of the responsibility for implementing the goals of the action plan remains with the municipalities. For example, they have responsibility for the care of drug abusers pursuant to the *Social Services Act*. In addition, prevention initiatives are also carried out at the local level. Thus, strategies in municipalities will be based on local concerns. Enforcement of the legislation remains at the national level, however, through the police and customs services.

Treatment is one of the three pillars of Sweden's drug policy. One of the stated goals of Swedish drug policy is to rehabilitate the user rather than to punish them by way of the criminal justice system. Since 1982, it has been possible to force people into drug treatment (also applies to alcohol and other products) for a period of up to six months. The main reason for this type of treatment is to protect the user or others in cases of life threatening situations and to motivate the user to continue treatment on a voluntary basis. The use of compulsory treatment appears to be uncommon and its effectiveness has been questioned.[108] In the last several years, there has been a shift from compulsory treatment and institutional treatment towards out-patient treatment. It would appear, however, that treatment is less easily available today than it was 10 to 15 years ago. In addition, the time a user spends in treatment has shortened. These changes are due to cutbacks in social service spending at the municipal level that occurred in the 1990s. "*Whereas in 1989 there were 19,000 people in treatment centres (for both alcohol and drugs), in 1994 this number had dropped to 13,000. In the same period, the number of people in compulsory care dropped from 1,500 to 900. Due to the budget cuts, 90 treatment homes were closed between 1991 to 1993*."[109]

Methadone substitution programs have been available in Sweden since the end of the 1960s. Currently, approximately 600 people are involved in methadone substitution programs in Stockholm, Uppsala, Malmo and Lund. The programs are strictly regulated and are officially viewed as being experimental. Some of the conditions for participation include that: the patient must be aged over 20 and demonstrate at least four years of intravenous opiate abuse; he or she must have tried several forms of drug-free treatment; the person in question must have entered the program on a voluntary basis (for example, the person must not be detained, under arrest, sentenced to a term of imprisonment or be an inmate of a correctional facility). For those participating in methadone substitution programs, other drugs are not permitted and the patient must visit the clinic on a daily basis. At this time, the maximum number of people that may be in the program at one time is 800. Pilot projects are under way with Subutex.

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[108] Boekhout van Solinge, *op. cit.*, page 165.
[109] *Ibid*., p 125.

While Sweden has spent large sums of money on treatment, few of its programs have been properly evaluated. Therefore, it is difficult to provide details of their effectiveness. "*The official aim is to rehabilitate drug addicts and a lot of effort and financial means are allocated to achieve this; much more than in many other European countries. However, despite all these good intentions, the reality is that the effectiveness of these very expansive programmes is relatively low. In the long run, the Swedish drug treatment programmes do not show better results than what is found internationally*."[110]

With respect to harm reduction initiatives, there are few low threshold services in Sweden and most are staffed by voluntary organizations. They offer a series of services, but no prescriptions. Needle exchange programs are operated at clinics for infectious diseases in hospitals in Lund and Malmo, and are thus fairly limited. Harm reduction initiatives, such as needle exchange programs, are difficult to promote under a vision of a drug-free society where drug use is not accepted. A proposal in the late 1980s to introduce needle exchange programs throughout Sweden was quashed by Parliament because it "*was felt that a higher availability of needles would not stop the spread of HIV, on the contrary, it was thought to increase intravenous drug use*."[111]

The criminal justice system also plays a role with respect to treatment. In 2000, more than 5,000 drug users were placed in prison. While in prison, offenders have access to treatment programs for drug abuse and some offenders are transferred outside prison for treatment. There are also initiatives to keep drugs out of prisons, for example by conducting searches and urine tests. While in prison, the offender is not offered syringes and substitution treatments are not available.

Swedish legislation allows, under certain conditions, that a sentence may be served outside prison. The necessity of drug treatment is one of the reasons that is often given. Another alternative to imprisonment is a probationary sentence combined with institutional drug treatment. An example of an alternative to prison is the following:

> *Since 1998, persons with drug addiction problems who have committed a drug offence can access treatment signing a 'treatment contract.' It is a real contract between the drug addict and the Court in which the two parties have rights and obligations like in all contracts. However, certain conditions must be fulfilled by the drug addict: the person must need treatment and he must be motivated to undergo treatment; he/she is a misuser of drugs; and the drug habit contributed to the drugs crime, which should not be serious (less than 2 years foreseen as penalty). The person is not sent to prison and a personalised plan of treatment is established. The health authorities are responsible for the treatment and shall report to the local prison and probation administration and to the public prosecutor if the probationer seriously neglects the obligations stated in the personal plan.* [112]

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[110] *Ibid*., page 162.
[111] *Ibid*., page 129.
[112] European Monitoring Centre for Drugs and Drug Addiction, *Country Profiles – Sweden*, European Legal Database on Drugs, 2001.

With respect to prevention, drug education programs start early and regularly appear throughout the school curriculum. "*Without exaggeration, this opinion-forming could be described as a process of indoctrination. Considering the magnitude of these programmes, the contents of them have gradually become something indisputable and conclusive that one incorporates them into one's own value system*."[113]

With respect to cannabis, it is viewed as a dangerous drug "*and its use is regarded as the beginning of a career in drugs*."[114] This is one of the reasons that prevention measures pay specific attention to cannabis as this should lead to less experimenting with the drug and thus prevent new recruits from joining the drug scene.

Legislative framework

Classes of drugs

The main drug legislation in Sweden is the *Narcotic Drugs Criminal Act 1968*. The term "narcotic drugs" is defined in section 8. They include medicinal products or substances hazardous to health with addictive properties and which are subject to control under an international agreement to which Sweden is a party or which the government has declared to be 'narcotic drugs' within the meaning of the Act. No distinction is made between soft and hard drugs. As will be discussed later, the nature of the substance is, however, among the criteria to determine the seriousness of an offence. Narcotic drugs are set out in five lists. List I deals with illegal drugs without medical use; lists II to IV deal with narcotic substances with medical usage and regulation of its import/export; and list V deals with narcotic substances outside international controls. Pursuant to the legislation, narcotic medicines may only be supplied on prescription from a doctor, dentist or veterinarian.

Offences

In Sweden, almost all forms of involvement with narcotics are prohibited pursuant to the *Narcotic Drugs Criminal Act.* This Act lists the behaviours and practices which constitute drug offences and includes possession for personal use, supply (which is fairly broadly defined), manufacture, etc. Even consumption (drug use) has been prohibited since 1988. In this case, "*it is not addiction which is a criminal offence according to this law, but the act of adding a drug to the human body*."[115] The police are entitled to conduct urine or blood tests in the case of people suspected of having used drugs.

The *Smuggling Criminal Act 2000* regulates illegal import and export of drugs. Other relevant legislation includes: the *Doping Criminal Act 1991* which regulates the importation, supply, possession of performance enhancing drugs for example; the *Act*

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[113] *Ibid*., page 177.

[114] Boekhout van Solinge, *op. cit.*, page 15.

[115] N. Dorn and A. Jamieson, *European Drug Laws: the Room for Manoeuvre*, London: DrugScope, 2001, page 188.

on Prohibition of Certain Substances which are Dangerous to the Health 1999 which regulates possession and supply of substances that entail danger to life or health and are being used, or can be used, for the purpose of intoxication – this legislation does not regulate substances regulated by other Acts.

The other relevant laws are: the *Social Service Act 1980*, which covers the possible forms of care for drug users; the *Act on the Forced Treatment of Abusers*, which provides that an addict who is dangerous to himself or to others may be ordered by a court to undergo compulsory treatment (which involves deprivation of liberty for up to six months for adults and even longer for those up to the age of 20). Other legislation deals with possible expulsion from school for students who abuse drugs, revocation of a driving licence for drug addiction, etc. There is zero-tolerance with respect to driving under the influence of drugs.

Penalties

Punishment is determined by rules contained in the Swedish *Penal Code*. There are three degrees of penalties for drug offences: minor, ordinary and serious. Penalties for minor drug offences consist of fines or up to six months' imprisonment, for ordinary drug offences, up to three years, and for serious offences, two to ten years imprisonment. The penalties regulated under the *Smuggling Criminal Act*, are identical to the penalties listed above.

The seriousness of the offence is based on the nature and quantity of drugs and other circumstances. The government has stated that the term "minor drug offence" is to be reserved for the very mildest of offences. For example, it should generally only involve personal use or possession for personal use of very small amounts. In these cases, a fine may be warranted. The fine is based on the offender's income. Minor offences involve: amphetamine up to 6 g, cannabis up to 50 g, cocaine up to 0.5 g and heroin up to 0.39 g; ordinary offences involve: amphetamine from 6.1 g to 250 g, cannabis from 51 g to 2 kg, cocaine from 0.6 g to 50 g and heroin from .04 g to 25 g; and serious offences involve: amphetamine 250 g or more, cannabis 2 kg or more, cocaine 51 g or more and heroin 25 g or more. The trafficking of drugs generally leads to imprisonment.

With respect to smuggling, the determination of the seriousness of the offence considers whether it formed part of an activity pursued on a large scale or on a commercial basis, involved particularly large quantities of drugs or was otherwise of a particularly dangerous or ruthless nature.

In 1996, of the 5,862 people sentenced for drug-related offences, 3,760 were sentenced for minor offences, 1,708 for ordinary offences and 391 for serious offences. Of the 1,274 who were sentenced to imprisonment, 54 were for minor offences, 893 for ordinary offences and 326 for serious offences.[116]

[116] *Ibid*., page 206.

As in other countries, there are several alternatives to imprisonment. For example, the court can choose other sanctions including probation, conditional sentence or compulsory treatment. These sanctions appear to be used frequently in drug cases.[117]

> *Generally a drug addict who is found guilty of any type of crime can in certain circumstances be ordered to undergo detoxification treatment. Treatment can take place in conjunction with a prison sentence or else together with probation, a conditional sentence or conditional release from prison. The consent of a convicted person to undergo treatment under certain conditions may constitute a reason for ordering probation instead of imprisonment (so-called* contract treatment*). In practice, probation and conditional sentencing in connection with compulsory treatment are usually used for drug offences of* normal *severity, that is in cases where imprisonment would otherwise be imposed.*[118]

Swedish legislation also allows for the forfeiture of any drugs used in the commission of an offence, any gains made, the property used as an aid in an offence, etc.

Prosecutorial discretion

The prosecutor has an absolute duty to prosecute, but there are a number of exceptions. In the Circular of the Prosecutor-General on Certain Questions regarding the Handling of Narcotics Cases, the Prosecutor-General stated that the dropping of prosecutions for narcotic drug offences should be limited to cases involving only possession for personal use of indivisible amounts or corresponding to at most a roll-up of cannabis resin or a dose of some stimulant of the central nervous system, with the exception of cocaine, i.e. such a small amount of a narcotic substance that it would not normally be further divided and sold. Having regard to the difficulties in individual cases of determining the magnitude of this quantity, prosecutions should go ahead in cases of doubt. If circumstances give grounds for assuming that the possession, despite the small amount, is not intended for personal use, the prosecution should not be dropped. As a consequence of these remarks, prosecutions should also not be dropped where an abuser is found in possession of narcotic drugs amounting to personal use for a certain period. In addition, it is of great importance that the dropping of prosecutions should be mainly limited to occurrences of the nature of first offences.[119]

Debate in Sweden

The Swedish vision of a drug-free society is so widely accepted that it is not questioned in the political arena or the media. The drug policy has support from all political parties and, according to the opinion surveys, the restrictive approach receives broad support from the public. For example, a survey in 2001 revealed that 96% were

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[117] *Ibid*., page 190.
[118] *Ibid*., page 191.
[119] European Monitoring Centre for Drugs and Drug Addiction, *op. cit.*

opposed to legalizing any drug that is classified. In addition, another survey in 2000 revealed that 91% were against decriminalizing cannabis use.[120]

> *The role of public opinion is central to understanding the attitude of the different political parties. Opinion polls show that a large majority of the people subscribe to a restrictive drug policy. The same polls indicate that drugs are perceived as one of society's main social problems. The moral panic surrounding drugs is such, that no political party dares to speak out against any measures that may appear to move in the direction of a more liberal drug policy. Supporting the restrictive policy, or even asking for more restrictive measures to curb increase in the drug problem are essential for a political party to win votes. Saying the contrary, to back a more liberal approach, is not an option for a political party and would almost mean its political death. It has been pointed out that anti-drug pressure groups have been the driving forces behind influencing public opinion, and through them the political parties. It has also been shown that besides the social movements, the media have also contributed to the drug scare that exists today and the defining of drugs as a major social problem.* [121]

Thus, the Swedish population in general has a negative view of drug use and is convinced that drugs pose a major threat to society. These themes have been advanced by government, the media and other organizations in Sweden, and others do not often criticize them. Scientists are generally the only group that raises doubts with respect to the current policy.

Recent reports

In 1998, the government created a Commission on Narcotic Drugs. Its mandate was to evaluate Sweden's drug policy and to propose, within the concept of a restrictive drug policy, measures for its strengthening and streamlining. The Commission was not to deviate from the overall aim of a drug-free society. The terms of reference were to:

- propose improvements of methods and systems to assess the drug situation and to evaluate the goal of a drug-free society;
- evaluate and propose measures to strengthen and streamline drug prevention measures;
- analyse the development of treatment programmes, including those in the prison and probation system, and propose measures to improve treatment and rehabilitation of drug abusers;
- evaluate the extent and focus of national funds for the development of treatment and of measures to prevent drug-related crime,
- analyse the need for changes in the working methods in the judicial system and in penal and criminal procedural legislation;

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[120] National Institute of Public Health, *National Report: Sweden 2001*, Stockholm, December 2001, page 14.

[121] Boekhout van Solinge, *op. cit.*, page 172-173.

- review existing research, propose how research can be stimulated, strengthened and organized and identify important but neglected areas for research in the drug field;
- frame strategies for targeted information measures and for the formation of opinion.

The Commission recently published a report entitled *The Crossroads* (referring to one direction that calls for a significant increase of resources in the form of commitment, direction, competence and funding and another that implies a lowering of goals and considerable acceptance of drug abuse).

The Commission noted that the drugs issue was not a political priority in recent years. This situation has led to reduced funding for all sectors involved, while the drug problem has become more severe and widespread. The following are some of the Commission's main findings and recommendations.[122]

Leadership: The Commission noted that there is a need for stronger priorization, clearer control and better follow-up of drug policy and of concrete initiatives at all levels of government.

Demand reduction: The Commission noted that there are no hard boundaries between preventive measures, care and treatment, and the restriction of supply. For preventive measures to succeed, they must be "*included in a system of measures restricting availability, and there must be clear rules which include society's norms and values, as well as effective care and treatment*."[123] The Commission viewed care and treatment as an essential element of drug policy measures as they help reduce drug abuse and also the harm to drug abusers. In addition, the Commission found a need for improving the competence of those in the field of care and treatment. It set out the following guiding principles regarding care and treatment:

- all drug abusers shall be reached by an offer of help and, if necessary, the abuse treated.
- advice, support and assistance shall reach people at an early stage of abuse.
- measures of care shall be aimed at achieving a life free from substance abuse and illegal drugs.
- care and other measures on behalf of substance abusers shall be of good quality.
- measures to combat substance abuse shall be sustainable and long-term.

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[122] The Swedish Commission on Narcotic Drugs, *Summary of the report The Crossroads from the Swedish Commission of Narcotic Drugs*, Sweden, 2000.
[123] *Ibid.*

Supply reduction: The Commission did not find any real deficiencies in the legislation or the working methods used by drug authorities, although it was vital that these authorities be allocated more resources. Police and customs have not gained control over the illegal market. In fact, indicators show that supply is more generous, prices are lower than in the past and the variety of drugs has expanded. With respect to combating illegal drug trade, the Commission recommended that the organizational structure of the police be examined (for example, the way in which the dissolution of specialized drug squads has affected the quality of police investigations) and that any shortcomings be followed up. The Commission also recommended that special investigation methods (such as controlled deliveries) be reviewed and that the findings lead to the drafting of guidelines on the subject.

Competence development and research: Competence development and research: The Commission was of the view that it was important to improve knowledge concerning different aspects of narcotic drugs, measures used to combat drug abuse and the effect of drug policy.

Costs[124]

As in other countries, systematic figures on drug-related costs are not readily available.

Public costs

Treatment for alcohol and drug abuse has been estimated to cost municipalities SKR 3.7 billion (over $500 million Canadian) per year (55% of which is for institutional care). The police used 6% of its budget to combat drugs during 2000 (for a total of SKR 702 million–over $100 million Canadian). The police had 869 people involved in drug issues while customs had 1,080 involved in border defence. No costs were available for customs.

Social costs

The Commission on Narcotic Drugs estimated the social costs at SKR 7.7 billion per year (does not take into account prevention, training and evaluation).

[124] The following information is based on the European Monitoring Centre for Drugs and Drug Addiction, *National Report – Sweden 2001*, *op. cit.*, page 15.

Administration[125]

As discussed above, the coordinator will now be responsible for coordinating the national drug policy. In the past, this role had been played by the Ministry of Health and Social Affairs. With respect to the legal distribution of narcotic drugs and psychotropic substances, the Medical Products Agency is responsible for issuing authorizations for the import and export of drugs. This Agency also provides drug related statistics to the UNDCP.

The Swedish National Police have responsibility for drug enforcement. The Drug Offences Division of the National Police Board conducts criminal investigations in relation to organized crime, or other drug-related offences, on a national or international scale. The Swedish Customs Service is responsible for points of entry.

The National Institute of Public Health coordinates demand reduction activities. It is also the National Focal Point in the REITOX network. Operational activities are coordinated at the regional and municipal level. There is also local coordination with the participation of social services, the police, prison and probation services, medical services, schools and other concerned parties. Thus, in prevention and care and treatment, local groups and municipalities play a key role.

Because of its encompassing nature, the drug issue also involves many other ministries, for example the Ministry of Justice and the Ministry of Foreign Affairs.

Statistics

Use[126]

Pursuant to surveys among youths in the 9th grade (15-year-olds) and among 18-year-old military conscripts, an obvious trend seen in the 1990s was the increase in lifetime prevalence use of drugs among teenagers, particularly older teenagers. There was also been an increase in recent use (last year, last 30 days) among teenagers and younger adults. For example, the percentage of 15 year olds who had tried drugs rose from 4% to 9% from 1992 to 2000. It is interesting to note that the number was 14% in the beginning of the 1970s and had decreased to around 8% in 1982. With respect to military conscripts, the trend was similar. According to these surveys, consumption of illegal drugs was low compared to other European countries, although the trend pointed to an increase in use. It should be noted that these numbers have been criticized. First, they are applicable to only 15-16 year old students and 18-year-old conscripts. Thus, these prevalence rates did not consider older groups where some first-time experimentation with drugs will occur. In addition, it has been argued that drug use is under-reported when drugs are viewed in such a negative light and the

[125] The information in the following section is based on the United Nations Office for Drug Control and Crime Prevention, *Country Drug Profile – Sweden, op. cit.*, page 12.
[126] OEDT, *National Report – Sweden 2001, op. cit.*

questionnaires are filled out at school (where some will feel they are being observed by their teachers).[127]

In 2000, the running three-year average of lifetime prevalence for the 15-64 age group was 12% (with the highest at 17% for the 24-44 age group). Since 1988, last year prevalence has never been over 1%. Overall, males are twice as likely to have used drugs than females although the difference is not as high in lower age groups.

Most who have experimented with drugs have tried cannabis, and the majority of these have tried only cannabis (in Sweden, cannabis is usually taken in the form of hashish). The second most popular drug in Sweden are amphetamines. Cocaine would be the third most popular drug for older people, while for youths it would be ecstasy and LSD. During the 1990s, the availability of drugs increased, in particular amphetamine and heroin. It would appear, however, that heroin use is on the increase in Sweden.

In general, the surveys indicate that overall drug use is fairly low in Sweden. With respect to severe drug abusers (defined as intravenous or daily drug use), it would appear that Sweden has a fairly serious problem with a range of between 14,000 and 20,000 people in this class. This is close to the European Union average.[128]

Offences

The number of suspected people reported increased from 6,567 in 1985 to 12,470 in 1999. The police registered 32,423 violations of the *Narcotic Drugs Criminal Act* in 2000, a figure which is similar to the numbers in the previous decade. The number of violations to the *Goods Smuggling Act* has decreased by 85% since 1980, to 350.

In 1998, 92% of these offenders were suspected for use or possession (from 76% in 1975). In addition, the number of those suspected of selling or manufacturing is now 19% (from 40% in 1975).

The number of sentences for violations of the *Narcotic Drugs Criminal Act* or the *Goods Smuggling Act* was 12,470 in 1999 (up from 2,601 in 1975). Cannabis was involved in 51% of sentences in 1998. In 1998, the sentences were divided in the following fashion: 38% were fines; 27% were prison terms; 14% were prosecution waivers; 14% were probation; and, 8%, other sanctions. Imprisonment was generally from two to six months.[129]

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127 Boekhout van Solinge, *op. cit.*, page 138.
128 United Nations Office for Drug Control and Crime Prevention, *op. cit.*, page 9.
129 National Report 2001, page 27.

SWITZERLAND[130]

Switzerland's drug policy has attracted considerable attention in recent years. As a result of widely distributed pictures of the open drug scene in Zurich, the country's injection clinics and heroin prescriptions for drug "addicts" are now known around the world. More recently, Switzerland's Parliament introduced a bill to regulate the production and sale of cannabis, and that bill is currently under study.

Switzerland is a Confederation[131] consisting of 26 cantons and half-cantons and has a population of slightly more than seven million inhabitants. The cantons are currently subdivided into 2,904 political communes. The federal Constitution, which was passed in 1848, is the legal basis of the federal state. It guarantees the fundamental rights of individuals and the people's participation in the country's political life, divides jurisdictions between the Confederation and the cantons and defines the powers of the federal authorities. Switzerland is made up of various linguistic, ethnic and denominational communities. Under Article 4 of the Constitution, German, French, Italian and Romansch are the country's four national languages. German is the language spoken by the majority of Swiss (63.7 per cent). All the cantons have their own constitution, parliament, government and courts. The cantons have certain legislative powers which have been conferred on them by the federal Constitution.

Switzerland's political structure is important to our understanding of that country's drug policy. In fact, some writers[132] argue that there are in fact 26 drugs policies in Switzerland, one for each canton and half-canton. This diversity is often overlooked, since the media and drug literature have focused in particular on the "open drug scenes" in Zurich and on the medical prescription of heroin for severally dependent persons, a practice endorsed by the Swiss Confederation.[133]

A harm reduction policy

The recent history of Switzerland's drug policy began towards the end of the 1960s with the increase in psychoactive drug use. As a result, the cantons developed a first drug policy, which was based on three pillars, namely:

- the repression of drug use and trafficking;
- prevention measures aimed at young people;

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130 This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: C. Collin, (2002) *National Drug Policy: Switzerland*. Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

131 This term is used to designate the federal state.

132 Yan Boggio *et al.*, (1997) *Apprendre à gérer : La politique suisse en matière de drogue*, Geneva: Georg, 1997.

133 *Ibid.*, page 38.

- treatment based on abstinence, which at the time already included methadone programs.[134]

At the beginning of the 1980s, the HIV-AIDS epidemic hit many countries, including Switzerland. There were "open drug scenes" in several Swiss cities, such as Zurich, Bern, Olten and Solothurn. As a consequence, the miserable state of drug dependent persons was becoming increasingly visible contributing to growing concern over the situation. Public and social services were created to help the "addicts" and protect them against HIV and AIDS. Needle exchange programs were set up and "addicts" were encouraged to be vaccinated against hepatitis. The Swiss Federal Office of Public Health (SFOPH) supported many of these services and still does so today, arguing that they help prevent the spread of AIDS. However, the main pillars of Switzerland's official drug policy remained prevention, treatment and law enforcement.

In the 1990s, Switzerland introduced new measures to reduce the problems associated with drug use and adopted a new national drug strategy. The new strategy introduced another pillar, namely harm reduction, which led to the creation of a four-pillar approach. The role of the Confederation in the area of drug policy becomes more defined and aims to support the efforts made by cantons, cities and communes and by private organizations by providing them with reference material, scientific data and training for professionals.

On February 20, 1991, the Swiss government adopted a program of federal measures to reduce the problems related to drug use,[135] currently known as "ProMeDro,"[136] and which was based on the concept of harm reduction. The objectives of the program were as follows:

- to decrease the number of new drug users and to prevent people from becoming drug dependent;
- to help users overcome their addiction (through treatment and social reintegration);
- to improve the living conditions and the health of drug users, to reduce harm and to maintain their social integration.[137]

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[134] Swiss Federal Office of Public Health, *The Swiss Drug Policy*, September 2000, available online at http://www.bag.admin.ch/sucht/f/index.htm.

[135] Swiss Federal Office of Public Health, *Mesures fédérales pour réduire les problèmes de la drogue*, Basic document of the Federal Office of Public Health, decision of the Federal Council of February 20, 1991, Doc. no. 3.4.1f.

[136] The acronym "MaPaDro" was used to refer to the program of federal measures for the period 1990-1996. The acronym "ProMeDro" is used to refer to the program of federal measures for the period 1997-2002. To avoid confusion, "ProMeDro" is used throughout.

[137] Swiss Federal Office of Public Health, *Programme de mesures de santé publique de la Confédération en vue de réduire les problèmes de drogue (ProMeDro) 1998-2002*, October 1998.

To achieve these goals, the following measures were introduced:

- primary and secondary prevention measures aimed at young people and awareness campaigns to prevent them from experimenting with drugs;
- patient management and treatment to help users overcome their addiction;
- harm reduction, AIDS prevention and social reintegration measures to help addicts cope with their dependency in the best possible health conditions and to ensure that the door to a drug-free life remains open;
- ongoing training and development programs for professionals (including those working in the areas of sentencing, programs and social services, as well as hospital workers, pharmacists and family doctors) and for people acting as mediators (such as teachers, youth group facilitators, business personnel and parents);
- the development, co-ordination and regular publication of scientific research on drugs;
- the evaluation of projects and measures in the fields of prevention, patient management and treatment to help identify any gaps or shortcomings, but also to pinpoint and highlight any progress achieved;
- the development of new documentation and information services normally provided by the Swiss Confederation; and
- the co-ordination of measures adopted by the Confederation.

These measures mark the beginning of Switzerland's drug policy, based on a four-pillar approach: prevention, law enforcement, treatment and harm reduction. Between 1991 and 1999, the SFOPH initiated and/or supported approximately 300 projects and programs under the "ProMeDro" initiative at the cost of 15 million francs per year.

Among other activities, the Federal Council asked for a study on heroin-assisted treatment for severely dependent heroin addicts who had failed at other treatment programs. In 1992, the Council passed an order authorizing clinical trials with the medical prescription of heroin, along with a strict scientific evaluation of the trials. The trials began in 1994 and ended on December 31, 1996. The final evaluation report was published in July 1997 and concluded that:

- heroin-assisted treatment for severely dependent heroin addicts improved their physical and/or psychic health, as well as their quality of life (in terms of housing, work and other areas);
- participants' illegal use of heroin and cocaine decreased;
- the users involved in the program committed fewer crimes (the incidence of theft and property and drug trafficking offences fell sharply).[138]

[138] M.F. Aebi, Martin Killias and Denis Ribeau, "Prescription médicale de stupéfiants et délinquance : Résultats des essais suisses", *Criminologie*, Vol. 32, no. 2, 1999, page 127-148; see also the testimony of

The Federal Council followed the report's recommendations, and on March 8, 1999, passed the *Ordinance governing the medical prescription of heroin* authorizing heroin assisted treatment, setting objectives, eligibility criteria, administrative measures and providing for such treatment.

Over the same period in 1993 and 1994, two people's initiatives were presented with opposite objectives. The first initiative called for a strict, abstinence-oriented drug policy ("Youth Without Drugs"),[139] and the second proposed the legalization of drug use ("DroLeg").[140] The federal government and Parliament found both initiatives too extreme and recommended their rejection. On September 28, 1997, Swiss voters rejected the initiative "Youth Without Drugs" by a majority of over 70%. On November 29, 1998, Swiss voters rejected the "DroLeg" initiative with a majority of over 74%. By rejecting both initiatives, the Swiss population showed its massive support for the Confederation's more measured approach to drug policy.

Between the time that these popular initiatives were launched and subsequently voted down, some major events influenced the evolution of Swiss drug policy. In 1994, the violence occurring on the "open drug scenes," from Letten to Zurich, made headlines in the international media. Certain government parties (Socialist, Christian Democrat and Radical) clamoured for decriminalization of drug use, increased access to heroin-assisted treatment, stronger prevention measures and stiffer sentences for drug traffickers.[141] The open drug scene in Zurich was shut down in 1995,[142] resulting in new co-operation between the Federal Council, canton representatives and the city of Zurich. A joint task force, called the Drug Delegation, was established. This unusual co-operation made it possible to implement measures that would never have got off the ground under more traditional circumstances: the creation of prison spaces in Zurich for drug traffickers, the adoption of emergency federal measures allowing for more drug addicts to participate in heroin-assisted treatment and the creation of centres for the treatment of hard core users.[143] Today the "open drug scenes" are a thing of the past.

Finally, in October 1998, the program of federal measures to reduce the problems related to drug use (ProMeDro) was renewed for a four-year period. The Confederation set a budget of 18 million francs per year to run this program and staffed it with 15

Professor Ambros Uchtenhagen, Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

[139] For more information on this initiative, see the Youth Without Drugs Web site at http://www.jod.ch/f_fr_index.htm.

[140] For more information on this initiative, see the DroLeg Web site at www.droleg.ch.

[141] Swiss Federal Office of Public Health (2000), *op. cit.*, page 10.

[142] See the testimony of the Chief of the Zurich Criminal Police, Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

[143] Boggio *et al.*, 1997, *op. cit.*, page 75-80.

positions from the Federal Office of Public Health.[144] The main priorities for ProMeDro from 1998 to 2002 are as follows:

- to strengthen the Confederation's commitment to primary and secondary prevention and early intervention to prevent addiction;
- to consolidate the range of treatments in a co-ordinated system, thereby increasing the likelihood that addiction can be overcome;
- to consolidate harm reduction and social integration measures;
- to establish and operate effectively a national epidemiological monitoring centre based on the focal points REITOX model of the European Monitoring Centre for Drugs and Drug Addiction;[145]
- to forward, in an effective manner, the findings of epidemiological studies, scientific research and evaluations to experts and decision makers;
- to implement a process to foster quality management throughout the entire ProMeDro program, tailored to the needs of the different fields, useful to and used by more than half of the addiction agencies and decision makers concerned (Confederation, cantons, communes, private institutions);
- to ensure optimum co-ordination and organization for various commissions and forums, mainly for the Conference of Canton Delegates on Drug Addiction Problems and the National Drug Liaison Committee.[146], [147]

The Confederation has thus set itself up as a political hub for drug policy and national co-operation

First pillar: prevention

Prevention measures are aimed primarily at achieving three objectives:

- to prevent drug use among individuals, especially children and youth;
- to prevent the problems and harmful effects related to drug use from spilling over onto the individual and society;

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[144] Federal Office of Public Health (1998), *op. cit.*, page 5.

[145] The EMCDDA coordinates a network of 15 information centres, or national focal points, located in each of the member states. For more information, visit the EMCDDA Web site at http://www.emcdda.org/mlp/ms_fr-4.shtml.

[146] The Conference of Canton Delegates usually meets four times a year. It coordinates drug addiction measures, establishes an annual program and priority catalogue, ensures the exchange of information, debates and adopts positions and responds to consultations, defines and discusses related issues and provides development sessions. See http://www.infoset.ch/inst/kkbs/f-statuten.html (in French). The National Committee consists of representatives from the cities, cantons and the Confederation. Its role is to provide follow-up on implemented measures and ensure that those measures are harmonized.

[147] Federal Office of Public Health (1998), *op. cit.*, page 6-7.

- to prevent individuals from going from casual drug use to harmful use and addiction, with all of its known consequences.

It should be pointed out that the most notable change in prevention has been a transition from the concept that prevention was a matter of preventing someone from ever trying drugs to today's concept of preventing the health and social problems related to drug use, thereby integrating the person's social network and environment as well.

Second pillar: treatment

In Switzerland, there are many types of in-patient and out-patient treatment available to people suffering from drug addiction. The objectives sought through treatment include:

- breaking drug "addicts" of their habit;
- social reintegration;
- better physical and mental health.[148]

As mentioned earlier, heroin assisted treatment has been a recognized type of therapy in Switzerland since 1999. By the end of 1999, there were already 1,650 treatment spaces reserved for hard-core heroin dependent persons in 16 treatment centres. In addition, during the same period, approximately 50% of opiate addicts (estimated to be 30,000) were being treated with medically prescribed methadone, compared to 728 individuals who were receiving this type of therapy in 1979. Those individuals addicted to one or more drugs also have access to in-patient treatment based on abstinence, to a limited number of spaces in transition centres, specialized withdrawal units or clinics, and treatment institutions, as well as out-patient consultation centres.[149] In March 1999, there were 100 institutions providing in-patient withdrawal and rehabilitation treatment in Switzerland, for a total of 1,750 spaces.[150]

Third pillar: harm reduction

The first so-called "low threshold" coping skills institutions made their appearance in Switzerland in the mid 80s. Their purpose was to reduce the health and social risks and consequences of addiction. First and foremost, these institutions gave drug dependent persons a roof over their heads and were often equipped with cafeterias, showers and laundry facilities. They provided addicts with someone who would listen and talk to them. These facilities have evolved over the past ten years and now incorporate medical support for harm reduction (for example, prevention of AIDS and other infections, needle exchange, out-patient medical care, etc.) and social support

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[148] *Ibid.*, page16.

[149] *Ibid.*, page 16-17.

[150] Federal Office of Public Health, *The Swiss drug policy: A fourfold approach with special consideration of the medical prescription of narcotics*, 1999, page 7.

(street work, soup kitchens, emergency shelters, low threshold centres, etc.). The Swiss Federal Office of Public Health supports many harm reduction projects as part of ProMeDro. Such projects include:

- needle exchanges for drug addicts and inmates;
- injection sites (a statutory notice makes such sites legal);
- offers of employment and housing;
- support for women who prostitute themselves to buy drugs;
- consultation services for the children of drug-addicted parents.[151]

Furthermore, the cantons, communes and private institutions also provide such programs. In 1995, the SFOPH established a central service to support certain social assistance agencies, particularly those with low thresholds, and to advise the cantons, communes and private institutions on planning and funding harm reduction programs. Drug "addicts" have access to such programs without having to meet any particular prerequisites. The objective of these harm reduction services is to limit as much as possible the negative consequences of addiction so that the "addict" is able to resume a normal existence. In addition, these measures are aimed at safeguarding and even increasing the addict's chances of breaking the drug habit.[152]

Fourth pillar: enforcement

The primary goal of enforcement is to reduce supply and to fight the trafficking of narcotics, the illegal financial transactions related to such trafficking (for example, money laundering) and organized crime. Users are not the number one target of police operations in Switzerland. Enforcement of the federal *Narcotics Act* is, to a large extent, the responsibility of the cantons, although the Confederation does monitor the situation closely and can call for and carry out police investigations into drug trafficking. It should be noted that canton and commune laws on policing differ and sometimes result in varying interventions. Furthermore, the drug milieu changes quickly and the methods used to fight drug-related problems are improving and adapting to this milieu.[153] These methods include:

- focussing enforcement activities on the manufacturing of drugs, trafficking and money laundering;
- assigning more officers to the "drug police" and making greater use of specialists from other sectors (finance professionals);
- intercantonal and international cooperation (agreements with police forces from neighbouring countries);

[151] Boggio *et al.*, 1997, *op. cit.*, page 19.
[152] *Ibid.*, page 18-19.
[153] *Ibid.*, page 20-21.

- accelerating and improving the processing of information (networking systems and access to the police department networks from many European countries);
- improving cooperation between the police and the private sector (banks, chemical industries, etc.);
- improving police effectiveness and making greater use of front-line liaison workers;
- strengthening the legal structure (for example, policing legislation, witness protection).[154]

The legal framework

Narcotics legislation in Switzerland has, as is the case in many other countries, been closely tied to the evolution of international conventions. For instance, the 1924 *Narcotics Act* was implemented to enable Switzerland to fulfil the commitments it had made by signing the International Opium Convention of 1912. This law prohibited certain narcotics such as opium, coca leaves, morphine, heroin, cocaine and their derivatives. As a result of Switzerland's signing other conventions and of experience gained from enforcing the 1924 *Act*, the federal *Narcotics Act* was totally revamped and a new law adopted on October 3, 1951. This legislation prohibited the growing, manufacture, sale, distribution and possession of opiates, coca derivatives and cannabis. The purpose of the *Act* was, on the one hand, to regulate the use of narcotics for medical purposes and, on the other hand, to fight against both the abuse and illicit trafficking of narcotics. The *Act* was amended slightly in 1970 when Switzerland signed the Single Convention on Narcotic Drugs of 1961.

Indeed, up until the 1960s, the *Act* was primarily a response to Switzerland's commitments under international conventions because narcotic use was relatively marginal and there was not any real narcotics abuse problem per se to warrant specialized legislation. Moreover, the Federal Council had recognized as early as 1951 that drug addiction was a serious pathology that should not be prosecuted as a crime or an offence. When drug-related problems emerged in the early 1970s, the *Act* was revised in 1975 to provide for medico-social and assistance measures for drug addicts, differentiated punishment for drug use and tougher criminal provisions for illegal drug trafficking.[155]

Following Switzerland's accession to the 1971 UN Convention on Psychotropic Substances, the 1972 amendment to the Single Convention and the adoption of the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Switzerland has not yet ratified this convention), the *Narcotics Act* was revised in 1996 to provide for the control of narcotic raw materials. Since then, dependence-producing

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[154] *Ibid.*, page 21.

[155] Swiss Federal Council, *Message concernant la révision de la loi sur les stupéfiants*, March 9, 2001.

substances and preparations with morphine-, cocaine- or cannabis-like effects have been considered narcotics under this legislation (*Narcotics Act*, s. 1).[156] The list of substances is currently compiled by the Swiss Agency for Therapeutic Products.[157]

With respect to the production, distribution, acquisition and use of narcotics, the current legislation provides that narcotics and psychotropic substances cannot be cultivated, manufactured, prepared or sold without cantonal authorization, in accordance with conditions set by the Federal Council (*Narcotics Act*, s. 4). In addition, a special permit from the Federal Office of Public Health is required for the importation or exportation of controlled narcotics (*Narcotics Act*, s. 5). Furthermore, under section 8 of the *Narcotics Act*, the following narcotics cannot be cultivated, imported, manufactured or sold: smoking opium, heroin, hallucinogens (such as LSD) and hemp for the extraction of narcotics or hash. Section 8 also sets out the conditions governing the treatment of addicts with medical prescription of certain narcotics.

The current legislation also contains criminal provisions that apply to: anyone who unlawfully cultivates, manufactures, extracts, processes or prepares narcotics; anyone who, unless authorized, stores, ships, transports, imports, exports, provides, distributes, sells, etc., or buys, holds, possesses or otherwise acquires narcotics; and anyone who finances illicit traffic in narcotics, acts as an intermediary or encourages consumption (*Narcotics Act*, s. 19). Section 19 offenders are liable to imprisonment or a fine depending on the seriousness, according to the *Narcotics Act*, of the act committed. The intentional consumption of narcotics or the commission of a section 19 offence for personal use is punishable by detention or a fine (*Narcotics Act*, s. 19a). For petty offences, the appropriate authority may stay the proceedings or waive punishment and may issue a reprimand (*Narcotics Act*, s. 19a(2)). However, preparing narcotics for personal use or for shared use with others at no charge is not punishable where the quantities involved are minimal (*Narcotics Act*, s. 19b). Finally, anyone who persuades or attempts to persuade someone to use narcotics is also punishable by detention or a fine (*Narcotics Act*, s. 19c).

A bill to decriminalize cannabis[158]

The Swiss Federal Council recently submitted a major bill to Parliament, the cantons and the public for a fundamental revision of the *Narcotics Act*. That bill, which is set to go through the various stages of canton and national consultation, is based on the observation, similar to our own findings, that:

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[156] *Loi fédérale sur les stupéfiants et les substances psychotropes*, October 3, 1951 (as of November 27, 2001) available on line at http://www.admin.ch/ch/f/rs/812_121/index.html#fn1.

[157] New name of the therapeutic products agency, in effect since January 1, 2002.

[158] See testimony of Ms. Diane Steber Büchli, Swiss Federal Office of Public Health, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, February 4, 2002, Issue 13.

> *(…) with regard to cannabis, the gap is too great between the actual situation, the statutory provisions and their implementation. As the Federal Commission on Drug Issues states in its report on cannabis, the prohibitionist system does not prevent cannabis use and cannabis users no longer tend to consider themselves drug users. The risks that cannabis represents for public health must be assessed differently from the way the legislator did it in 1975.*
> *At the time, cannabis was considered a gateway drug. It was felt that the pharmacological properties of cannabis led young cannabis users to opiate or amphetamine use. That view was refuted with the 1989 report of the Sub-commission of the Federal Commission on Narcotics.*
> *The most recent research supports current findings that the effects of cannabis are less hazardous to health than the effects of alcoholism or tobacco abuse. (…)*
> *(…)*
> *The number of users of cannabis derivatives has increased. In 1992, according to the Swiss Health Survey of the Federal Statistics Office, 16.3 per cent of young Swiss citizens aged 15 to 35 said they had previously used hash at least once in their lives. In 1997, 26.7 per cent gave the same answer. All OECD countries have observed the same trend. In the United States, for example, the life prevalence of cannabis use in individuals 18 years of age increased from 32.6 per cent in 1992 to 49.6 per cent in 1997.* [159]

The cannabis revision bill is also based on the observation, **in which we wholeheartedly concur**, that "*the available scientific literature establishes no relationship between severity of legislation and life prevalence of cannabis use*."[160] It further emphasizes that:

> *The weaknesses of the present act are apparent when it comes to fighting the cultivation of hemp used to produce narcotics and the production and sale of cannabis-based products. Enforcing the act in this area is a highly heterogeneous and costly enterprise; the result is a large market that is very difficult to control and has expanded beyond our borders. Moreover, the need to revise statutory provisions in this area is virtually undisputed.* [161]

The purpose of the revision of the act is thus, in particular, to:

- adapt the Act to the actual situation;
- decriminalize cannabis use and acts leading thereto;
- reinforce youth protection;
- regulate the cultivation, manufacture and trafficking of cannabis;
- restrict the obligation to prosecute;
- reinforce repression in certain areas in a targeted manner.[162]

More specifically, the bill would provide (art. 19c) for the decriminalization of the use of cannabis-related products. In addition, preparatory acts to personal use of cannabis-related products would be decriminalized if committed without affording a

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[159] Swiss Federal Council, *Message concernant la révision de la loi sur les stupéfiants*, 2001, page 3554-3555.
[160] *Ibid.*, page 3560. We further discuss this issue in Chapter 21.
[161] *Ibid.*, page 3540.
[162] *Ibid.*, page 3556.

third party the opportunity to use drugs. While the bill does not set out specific limits on quantity–as it would be left to the courts to determine whether it was related to personal consumption - the government publication explaining the bill mentions that as a principle, it does related to personal consumption if the quantity does not exceed what is needed for weekly use. In general, this would mean quantities of 30 grams for possession and 10 average-size plants for cultivation. The publication states that these quantities would vary depending on the person, the way it is consumed, etc.[163]

Article 19d would confer on the Federal Council the power – and not the obligation – to determine priorities in criminal prosecutions. Under this power, the Federal Council could, after consultations with the cantons, set out the conditions under which the prosecution and criminalization of certain offences would be waived, if they are conducted under the legal framework discussed in the next paragraph.[164]

If the Federal Council uses its power under article 19d, article 19f sets out conditions under which the cultivation, production and distribution of cannabis and its derivatives would be allowed. Distribution would not be prosecuted under certain conditions: selling to persons under 18 years of age would not be permitted; the product must not represent a significant risk to health; public order must not be disturbed, advertising would be prohibited, etc. Producers must also submit to a set of strict rules: they may produce solely for point of sale located in Switzerland, notify authorities regarding all crops (species, cultivation area, location, etc.), and specify THC levels. The Federal Council can establish a series of rules such as size and lay out of cultivation areas, the number of distribution centres, etc. In addition, cantons would be able to set out more restrictive rules, particularly with respect to cultivated areas and distribution centres.[165]

The Council did request legal opinions on whether its proposals satisfied the three international conventions.[166] The two opinions concurred that the decriminilization of personal use and related acts would not contravene international conventions. In addition, the waiver of prosecution (or limitation of criminal prosecution) for cultivation, production and distribution would also be consistent with the three conventions. The Federal Council concludes in its *Message* that:

> *In their essential points, the two legal opinions come to the same conclusions. The only difference is in the matter of whether, in cases where a waiver of criminal prosecution in matters pertaining to the cultivation of cannabis and the manufacture and distribution of cannabis products would be introduced, the provisions are sufficient or whether they should be supplemented by a licensing system.*

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[163] *Ibid.,* pp. 3596-3597.
[164] *Ibid.,* p. 3598.
[165] *Ibid.,* p. 3600.
[166] The findings of one of the experts consulted are presented in Chapter 19 above.

It should be noted on this point that the Netherlands also has a partial limitation on the obligation to prosecute in the areas referred to and that it has not introduced a licensing system. Nevertheless, the principle of the Dutch system has never been disputed as being inconsistent with the UN conventions.[167]

Administration of Swiss drug policy

The Confederation is the hub of Swiss drug policy and co-ordination and harmonization of the various policies and measures put in place by cantons, cities, local authorities and private institutions. Under section 15c of the *Narcotics Act*, the Confederation is responsible for the following tasks [translation]:

- Through grants or other measures, the Confederation shall encourage scientific research on the effects of narcotics, the causes and consequences of narcotics abuse and ways to combat that abuse.
- The Federal Council shall establish the procedures for awarding and calculating grants and shall determine grant amounts.
- The Confederation shall assist cantons and private organizations in the administration of the *Act*. The Confederation shall, *inter alia*, set up a documentation, information and co-ordination office and encourage the training of staff specialized in the treatment of addicts?. The Federal Council shall establish the relevant procedures.

Under section 15a of the *Narcotics Act*, the cantons are responsible for the following tasks [translation]:

- To prevent narcotics abuse, the cantons shall promote information and consultation and set up the institutions needed to do so.
- The cantons shall provide for the protection of those in need of medical treatment or other assistance on account of narcotics abuse and shall assist their return to work and society.
- The appropriate authorities may delegate certain tasks and responsibilities to private organizations.
- The cantons may prohibit the acquisition of narcotics. They shall give notice of their decisions to the Federal Office of Public Health, which shall relay those decisions to health officials in the other cantons for the information of physicians and pharmacists.
- Prescribing, dispensing and administering narcotics for the treatment of addicts shall be subject to special cantonal authorization.

[167] Federal Council, *ibid.*, page 3621.

- Where, owing to addiction, a person might constitute a danger to traffic circulation, the service with knowledge of that danger shall advise the appropriate authority.

In principle, the administration of the *Narcotics Act* falls under cantonal jurisdiction, as the cantons have authority for criminal procedure. There are usually a number of stages in cantonal criminal proceedings: police investigation, preliminary hearing, dismissal or referral to court and court decision. In minor cases punishable by fine or detention–and this is the case for a number of offences under the *Narcotics Act*– a penalty can be imposed by an administrative authority (for example, a prefect). The subject, however, is entitled to object and be tried by a court, usually a police court composed of a single, legally trained judge. Cases of moderate seriousness are usually tried by a district court (correctional court) over which a legally trained judge presides, assisted by lay judges. Finally, the most serious offences are heard by assize courts made up of at least one legally trained presiding judge and a jury of citizens. However, because this type of procedure is lengthy, elaborate and costly, most cantons tend to replace assize courts with either district courts or a higher court made up of permanent judges (criminal court).[168]

The Confederation also plays a role in combating drug trafficking; under section 29 of the *Narcotics Act*, the Federal Office of Police (FOP) is the central Swiss agency responsible for controlling illicit traffic in narcotics. The FOP gathers information for the prevention of offences under the *Act* and to facilitate the prosecution of offenders. In order to do so, the Office maintains contact with other federal government agencies involved (Office of Public Health, Customs Administration, the Swiss Post Office administration, cantonal police authorities, central agencies in other countries and the International Criminal Police Organization (Interpol)). To its cantonal and international partners, the FOP is a focal point for information, co-ordination and analysis in the area of Swiss internal security.[169] Since 1996, after a trial period, the Office has operated a drug database called DOSIS. This database is an invaluable tool for the cantons. Cantonal narcotics squads are connected to the system and have direct access to DOSIS because they are required, as is the FOP, to enter information into the database. This system thus promotes co-operation between the FOP and cantonal police authorities. Only information on the illicit narcotics trade is entered into the system; information on those who only use drugs is excluded.[170]

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[168] Federal Court, *L'organisation judiciaire en Suisse*, available online in French at: http://www.bger.ch/index.cfm?language=french&area=Federal&theme=system&page=content&maskid=195

[169] Federal Office of Police, *Un aperçu de l'OFP*, available online in French at http://www.bap.admin.ch/f/index.htm.

[170] Federal Office of Police, *Exploitation définitive de la banque de données en matière de drogue DOSIS*, June 26, 1996, available online in French at http://www.bap.admin.ch/f/index.htm.

Statistics on narcotics use and offences under the Narcotics Act

This section summarizes parts of a Federal Office of Police publication entitled *Situation Suisse: Rapport de Situation 2000* [2000 Situation Report on Switzerland],[171] prepared by the Analysis and Prevention Service as an interim document, given that a comprehensive report is to be published in 2002. It should be noted that the statistics in the report are distorted by methodological deficiencies. Switzerland is a federal state with 26 cantonal entities (cantons and half-cantons) and offences are not recorded based on the same criteria in every canton. Furthermore, the statistics do not make it possible to control double or multiple entries; some suspects may appear repeatedly in the same year or in different cantons. Finally, only some of the criminal acts under the criminal code are taken into account.[172]

Use

The report found the following trends in 2000:

- a sharp rise in marijuana use;
- a sharp rise in cocaine use;
- a sharp rise in multiple addictions (use of various kinds of narcotics);
- a sharp rise in synthetic drug use (amphetamines and methamphetamines) – Thai pills[173] have become the "in" drug;
- a downward trend in injection heroin use;
- virtually no open drug scenes in Swiss cities;
- 205 deaths due to drugs and recorded by the police (as compared to 405 in 1991) – those over 27 were the most affected age group, for men and for women, and Zurich and Bern were the most affected cantons, with 50 and 36 deaths due to drugs, respectively;
- 18- to 24-year-olds remain the most frequent users of marijuana, hash and hallucinogens, while those over 30 are the most frequent users of cocaine and heroin.[174]

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[171] Federal Office of Police, *Situation Suisse : Rapport de situation 2000*, Analysis and Prevention Service, 2001, available online in French at http://www.bap.admin.ch/f/index.htm.

[172] *Ibid.*, page 7.

[173] According to the Federal Office of Police press release, Thai pills contain metamphetamine, and their structure closely resembles that of ecstasy. They come from Thailand, where they go by the name of "Yaba" (drug that makes you go crazy). The tablets bear the letters "WY" and smell like vanilla. The substance is usually smoked, using a sheet of aluminium, or absorbed. The risk of addiction among people absorbing the product by smoking it is at least three times greater than among ecstasy users. This drug is a powerful stimulant with effects comparable to those of crack, but longer lasting. These pills may result in irreparable physical and mental damage (loss of memory, depression). They may also cause paranoid hallucinations and violent fits and create psychological dependence faster than ecstasy.

[174] Federal Office of Public Health, 2000, *op. cit.*, page 17-37.

Offences

Federal *Narcotics Act* drug-related offences reported cases rose from 44,307 in 1999 to 46,558 in 2000. This represents a significant increase over the 18,800 reported cases in 1990. A comparison of the number of reported cases per offence type in 1997 and 2000 reveals a downward trend in drug trafficking, smuggling, dual offences and an overall increase – with the exception of 1999[175] – in drug use cases.

The number of reported cases of drug dealing in 2000 fell to 3,021 from 3,711 in 1999. This represented a drop of 18.5%. However, some cantons posted a major hike in reported cases. A case in point was the city of Basel, which recorded an increase of 31%. The report urges caution in interpreting these figures, suggesting that the major drop in the number of reported cases is not in fact due to an improved situation in these specific cantons, but rather to a decrease in the number of cases reported by the police as investigation capacity and officers are deployed in other areas. It should be noted that of a total of 3,021 drug trafficking cases, 78% involved foreigners and 22% Swiss citizens. With respect to the sex of offenders, 82% were men and 7% were women. The sex of the remaining 11% was unknown. The largest percentage (45%) of male offenders were aged between 18 and 24, whereas the majority of female offenders were over 30 (56%), followed by the 18-to-24 age group (27%).[176]

[175] *Ibid.*, page 18-19.
[176] *Ibid.*, page 20-23.

AUSTRALIA[177]

Cannabis was generally little known or used in Australia before the 1960s. However, the drug legislation that was passed in the majority of states and territories in the late 1800s and early 1900s (mainly because of the large number of Chinese who smoked opium) provided a framework that lent itself well to the prohibition of cannabis. The first Australian measures designed to control cannabis use were part of an act passed in 1928 in the state of Victoria to penalize the unauthorized use of Indian hemp and Indian hemp resin. Similar acts were subsequently passed in the other states of the Commonwealth. Penalties for the cultivation, possession and use of cannabis were generally quite harsh in the 1960s and 1970s.[178]

The incentive to revise the laws on cannabis use in South Australia came from the recommendations made in 1979 in the *Report of the South Australian Royal Commission into the Non-Medical Use of Drugs.*[179] One of those recommendations was that small-scale cannabis use not be considered a criminal offence. In support of that recommendation, the Royal Commission cited a number of overseas states, including 10 American states, where such a measure had yielded good results.

National drug strategy[180]

The National Campaign Against Drug Abuse (1985-1992)

The inception of the National Campaign Against Drug Abuse (NCADA) in 1985 was a watershed in Australian drug policy and introduced a focus on public health and harm minimization. The NCADA emphasized that drug use should be treated primarily as a health issue. The decision was made deliberately to situate the program within the Federal Department of Health rather than the Federal Attorney General's Department, due at least in part to the emergence of HIV/AIDS. But the program from the start involved a strong partnership between the Commonwealth (or federal government), States and Territories. It also intended to foster a partnership between health and law enforcement in a comprehensive strategy involving an integrated approach to licit as well as illicit drugs.

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177 This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: R. MacKay, (2001) *National Drug Policy: Australia*. Ottawa: Library of Parliament, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

178 For a history of the laws relating to cannabis in Australia, see: McDonald *et al.*, *Legislative Options for Cannabis Use in Australia*, Commonwealth of Australia, 1994, available online at: http://www.druglibrary.org/schaffer/Library/studies/aus/cannabis.htm.

179 South Australian Government, Royal Commission of Inquiry into the Non-Medical Use of Drugs South Australia 1979, *Final Report* (Chairperson: Sackville).

180 For an outline of the National Drug Strategy from 1985 to the present, see: http://www.aic.gov.au/research/drugs/strategy/index.html.

The philosophy of harm minimization includes the strategies of supply, demand and harm reduction. The mission of Australia's drug strategy is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs.

The National Drug Strategy (1993-1997)

A further principle underlying the new drug strategy was that reliable data, new approaches and evaluation of effort were required. As part of this new effort, the Ministerial Council on Drug Strategy (MCDS) commissioned two independent evaluations of the NCADA to assess progress and make appropriate recommendations. After these two evaluations, one released in 1988 and the other, *No Quick Fix*, in 1992, the campaign was relaunched as the National Drug Strategy (NDS). Incorporating the recommendations from the two evaluations, the National Drug Strategy continued to stress the importance of harm minimization principles. Some of the goals of the Strategy were to:

- Minimize the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs;
- Minimize the level and impact of criminal drug offences and other drug-related crime, violence and antisocial behaviour within the community;
- Minimize the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs; and
- Prevent the spread of hepatitis, HIV/AIDS and other infectious diseases associated with the unsafe injection of illicit drugs.

The strategic plan identified six specific concepts which were to underpin the development and implementation of drug policy: harm minimization; social justice; maintenance of controls over the supply of drugs; an intersectoral approach; international cooperation; and evaluation and accountability.

Overall responsibility for the broad policy direction and operation of the NDS rests with the MCDS, which comprises both health and law enforcement ministers from each State and Territory as well as from the Commonwealth government. The council meets annually. The National Drug Strategy Committee (NDSC) provides administrative support for the MCDS. It is mandated to develop proposals for the NDS, implement the NDS, develop policy proposals relating to licit and illicit drugs and liaise with other governmental agencies on matters relating to the NDS. It consists of one health and one law enforcement representative from each jurisdiction. The MCDS and NDSC develop national policies and directions which individual jurisdictions then implement as appropriate within their social, political and economic environments.

Report on the National Drug Strategy (1997)[181]

In 1997 a report evaluating the National Drug Strategy (1993-1997) was produced. This report, entitled *The National Drug Strategy: Mapping the Future*, lauded the NDS for a unique combination of features which had brought it international attention and acclaim:

- The NDS recognizes the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options based on the concept of harm minimization. These range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot be reasonably expected to stop using drugs at the present time;
- The NDS adopts a comprehensive approach to drugs, which encompasses the misuse of licit as well as illicit drugs. Policies and programs to address the problems of illicit drugs, alcohol, tobacco and pharmaceuticals all fall under the aegis of the NDS;
- The NDS approach to drugs stresses the promotion of partnerships–between health, law enforcement, education, non-overnmental organizations, and private industry; and
- The NDS attempts to address drug issues in a balanced fashion. This refers to the appropriate balance of effort between the Commonwealth, States and Territories, a balance between supply and demand reduction strategies, and a balance between treatment, prevention, research and education.

Contrary to the fears of many that harm minimization policies might lead to increased public acceptance and use of illicit drugs, the evaluation found that there was no discernible trend in the use of drugs such as heroin, amphetamines and cocaine, although there was some increase in marijuana use. The NDS was also found to have contributed to the success of the National HIV/AIDS Strategy in reducing the spread of HIV, Hepatitis C and other infectious diseases among intravenous drug users.

The National Drug Strategic Framework (1998/1999-2002/2003)[182]

The National Drug Strategic Framework maintains the policy principles of the previous phases of the National Drug Strategy and adopts the recommendations of the

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181 See Eric Single and Timothy Rohl, *The National Drug Strategy: Mapping the Future*, A Report commissioned by the Ministerial Council on Drug Strategy, Canberra, April 1997. Available online at: http://www.health.gov.au/pubhlth/publicat/document/mapping.pdf.

182 Ministerial Council on Drug Strategy, *National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships*, Prepared for the Ministerial Council by a joint steering committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs, Canberra, November 1998. Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

report from the previous phase. Its focus remains on harm minimization and continues to seek a balance between supply-reduction, demand-reduction and harm-reduction strategies, emphasizing the need for integration of the various strategies. It also continues the emphasis on evidence-based practice, based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions.

This next phase of the NDS places emphasis on extending the partnership between health and law-enforcement agencies to take in a broader range of partners, as recommended in the evaluation report. Thus the Intergovernmental Committee on Drugs, which consists of health and law enforcement officers from each Australian jurisdiction, is expanding to include officers from the portfolios of customs and education. The MCDS will now be supported by the Australian National Council on Drugs, consisting of people with relevant expertise from the government, non-government and community-based sectors to provide policy advice. These bodies will develop a series of National Drug Action Plans which will specify priorities for reducing the harm arising from the use of licit and illicit drugs, strategies for taking action on these priorities, and performance indicators.

The National Illicit Drug Strategy (1998 –)[183]

In 1997, the Australian government launched the National Illicit Drug Strategy "Tough on Drugs" as the next major phase of the National Drug Strategy. Its implementation began in 1998. The Strategy encompasses a range of supply reduction and demand reduction measures at a total cost of AUD $516 million. Funding for the Strategy is split between demand-reduction strategies, which are being implemented by the Department of Health and Aged Care and the Department of Education, Training and Youth Affairs, and supply-reduction strategies, which are being implemented by the Attorney-General's Department, the Australian Federal Police and the Australian Customs Service. AUD$213 million has been allocated for a range of supply reduction measures to intercept more illicit drugs at borders and within Australia. Law enforcement efforts include funding for 10 new Federal Police anti-drug mobile strike teams to help dismantle drug syndicates within Australia as well as increased funding for the Australian Customs Service to enhance its capacity to intercept drug shipments.

The remaining AUD$303 million has been allocated for demand reduction initiatives which cover five priority areas:

- Treatment of users of illicit drugs, including identification of best practice,
- Prevention of illicit drug use,
- Training and skills development for front line workers who come into contact with drug users,
- Monitoring and evaluation, including data collection,
- Research.

[183] For further details on the National Illicit Drug Strategy, see the Australian Department of Health and Aged Care Web site: http://www.health.gov.au/pubhlth/strateg/drugs/illicit.

In conjunction with the new strategy, the Intergovernmental Committee on Drugs has been established to provide policy advice for government ministers on a full range of drug-related matters.

In June 1999, Commonwealth, State and Territory health and law enforcement Ministers agreed on a national approach to the development of a drug diversion initiative. This was designed to support the diversion of illicit drug users from the criminal justice system into education and treatment. Diversion involves a graduated series of interventions appropriate to the seriousness of the offence and the circumstances of the offender. Diversion is not considered appropriate for trafficking offences. Drug-involved offenders can be cautioned on the streets and provided with treatment referral information if their offence is possession of a small quantity of drugs. They can be sent for assessment or directly to treatment rather than prison, as long as the offence is not serious and they do not pose a threat to society. Courts and correctional systems can also use commitment or referral to community-based treatment as an adjunct to probation or parole from prison. There is also treatment within correctional facilities and corrections-operated or funded therapeutic communities and halfway houses.[184]

Assessment of the National Drug Strategy (2001)[185]

Based on the concept of harm minimization rather than the need to eliminate drug use, the NDS recognizes the complexity of drug issues and the need to provide front-line health professionals and others dealing with drug problems with a wide range of options. These options range from abstinence-oriented interventions to programs aimed at ameliorating the consequences of drug use among those who cannot reasonably be expected to stop using drugs immediately. The goals, strategies, guiding principles and performance indicators for the NDS are established by a National Drug Strategy Committee. This committee consists of high-level civil servants from health and law enforcement ministries of each state and territory as well as their counterparts from the federal government. This shared decision-making has been seen as a strength of the NDS since it enhances government co-operation and ensures a high level of visibility for the drug strategy.

Professor Eric Single noted that the Australian government had followed up on a number of the recommendations he had made to improve the NDS. For example, the NDS was renewed for five years, funding was increased, a specialized NDS unit was

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184 For further information, see: Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs, 2001 to 2002-03*, Prepared by the National Expert Advisory Committee on Illegal Drugs, Canberra, July 2001. Available online at: http://www.health.gov.au/pubhlth/nds/resources/publist.htm.

185 See testimony of Professor Eric Single before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, May 2001. Available online at: www.parl.gc.ca/drogues-illicites.asp.

created within the Commonwealth Ministry of Health, and action plans were developed with regard to other recommendations.[186]

Legislative framework

Under Australia's federal structure, criminal law– and responsibility for enforcing drug laws–is primarily the responsibility of state governments. Australia has ratified the three major international treaties on illicit drugs, and the obligations under those treaties are effected in three pieces of federal legislation: the *Narcotic Drugs Act 1967*, the *Psychotropic Substances Act 1976* and the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*.

The drug laws in Australian jurisdictions

The law relating to illicit drugs is made and enforced in Australia on a state and territorial level. It varies markedly between jurisdictions, but its structure is broadly similar. The key legislation from each jurisdiction is as follows:

New South Wales	*Drug Misuse and Trafficking Act 1985*; *Drug Court Act 1998*
Victoria	*Drugs, Poisons and Controlled Substances Act 1981*
Queensland	*Drugs Misuse Act 1986*; *Drug Rehabilitation (Court Diversion) Act 2000*
Western Australia	*Misuse of Drugs Act 1981*
South Australia	*Controlled Substances Act 1984*
Tasmania	*Poisons Act 1971*
Northern Territory	*Drugs of Dependence Act 1990*
Australian Capital Territory	*Drugs of Dependence Act 1989*
Commonwealth	*Customs Act 1901* *Narcotic Drugs Act 1967* *Psychotropic Substances Act 1976* *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*[187]

[186] *Ibid.*

[187] The illegal drug legislation in effect in the states and territories may be consulted online at: http://www.aic.gov.au/research/drugs/context/legislation.html.

Each act creates, in one form or another, the basic offences of possession, use, cultivation, production and trafficking, supplying and selling. The acts also contain lengthy schedules, derived from various international conventions, listing which drugs are prohibited, and defining various amounts, such as "traffickable" and "commercial" quantities. These quantities are used to determine maximum penalties for sentencing purposes.

The typical maximum penalties for the more serious offences, such as trafficking in "commercial quantities," are in the range of 25 years to life, although most jurisdictions apart from Queensland set lower maximums for offences involving cannabis. Most acts provide for persons who have been found guilty of simple possession and/or use offences to receive a term of imprisonment, but it is very uncommon now for this penalty to be imposed. Particularly for the less serious offences, there is often a very substantial gap in sentencing between the "law on the books" and the "law in practice." For example, in Queensland, where the offence of possession carries a notional maximum penalty of 15 years imprisonment and a maximum fine of AUD $300,000, the standard penalty applied in the Magistrates Court – where the overwhelming majority of possession charges are heard – is a fine of a few hundred dollars, often with no conviction being recorded.[188]

Since 1987 in South Australia, 1992 in the Australian Capital Territory, and 1996 in the Northern Territory, people detected committing "minor" cannabis offences have been able to avoid a court appearance altogether by paying a relatively modest "on-the-spot" fine. While cannabis possession is still prohibited, it is sanctioned by a civil, not a criminal, penalty. In addition, Victorian legislation provides for the imposition of pre-conviction bonds for first offenders charged with minor drug offences (*Drugs Poisons and Controlled Substances Act 1981*, s. 76). First offenders are given a bond, and no conviction is recorded if the bond conditions are complied with. But in Victoria, New South Wales, Tasmania, Queensland, and Western Australia all cannabis possession, use and supply is criminally prohibited with criminal penalties being imposed. In addition, in all jurisdictions the penalties imposed for commercial dealing are still very substantial, especially for offences at the upper end of the scale.

In the civil prohibitionist jurisdictions, the offences attracting a civil infringement notice include possession of small amounts of cannabis plant (up to 100g in South Australia, 25g in the Australian Capital Territory, and 50g in the Northern Territory) and cultivation of cannabis plants (up to three in South Australia, five in the Australian Capital Territory, and two in the Northern Territory). Failure to pay the fines may result in court appearances and subsequent conviction.

The criminal prohibitionist jurisdictions have also recently adopted "diversionary" cautioning procedures which allow first or second time cannabis possession/use

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[188] For more information on Australian drug laws, see David Brereton, "The History and Politics of Prohibition", in *Drugs and Democracy*, *supra.*

offenders to receive a caution or education/counselling session instead of the normal court appearance.

"Drug Courts" have been established in four Australian jurisdictions – Queensland, New South Wales, South Australia, and Victoria. In Queensland and New South Wales these "diversionary" courts have been established by legislation while in South Australia and Victoria they operate on a less formalized basis.[189]

A notable feature of Australian drug laws is the use of provisions which contravene the long-established principle that the burden of proof in criminal cases should be on the prosecution to prove each element of the offence beyond reasonable doubt. For example, the *Drugs Misuse Act 1986* (Queensland) contains a "deeming provision" for the offence of possession. This means that, if a prohibited drug is found on someone's premises, this will be regarded as conclusive evidence that the drug was in the possession of the occupier, unless he or she can persuade the court that they "neither knew nor had reason to suspect that the drug was in or on that place" (s. 57(c)). Another example is s. 235 of the Commonwealth *Customs Act 1901*. This provision requires a person who has more than a certain quantity of drugs in his or her possession to prove, on the balance of probabilities, that he or she did not intend to engage in commercial dealings in relation to those drugs. If the person cannot prove this, they will be sentenced on the basis that they had an intention to traffic.

Another aspect of Australian drug laws to note is the wide range of powers which are available to police and other law enforcement bodies to detect and investigate drug offences. Under the Queensland *Drugs Misuse Act 1986*, for example, police have had the power in relation to any quantity of any illegal drug to: stop, search, seize and remove motor vehicles; detain and search persons; order internal body searches; and enter and search premises with or without a warrant (s. 18). In addition, for offences such as drug trafficking, Queensland police are empowered to apply to a court to have listening devices installed on private premises.

For law enforcement bodies operating at the federal level, and in most states other than Queensland, telecommunications interception powers are also available for the investigation of serious drug offences under the Commonwealth *Telecommunications (Interception) Act 1979*.

Over the last decade, most jurisdictions have also passed confiscation of profits legislation which can be used to attack the assets of drug traffickers and producers. In most cases this action can be taken only after the person has been convicted, but in New South Wales a confiscation order can be made without requiring a conviction, where the Supreme Court is satisfied that "it is more probable than not" that the person has engaged in drug-related activities (*Criminal Assets Recovery Act 1990*).

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[189] For further details on Australian drug courts, see: http://www.aic.gov.au/research/drugs/context/courts.html

Decriminilization in Australia[190]

While the National Drug Strategy provides a general framework for responses to drug problems, drug offences and the associated penalties in Australia are a matter of state and territorial jurisdiction. Some Australian states and territories have adopted cannabis decriminilization measures while others have not.

The first Australian jurisdiction to adopt cannabis decriminilization measures was South Australia. The Cannabis Expiation Notice (CEN) scheme came into effect in South Australia on 30 April 1987. Under this scheme, adults coming to the attention of police for "simple cannabis offences" could be issued with an expiation notice. Offenders were able to avoid prosecution by paying the specified fee or fees (ranging from AUD $50 to AUD $150) within 60 days of the issue of the notice. Failure to pay the specified fees within 60 days could lead to prosecution in court, and the possibility of a conviction being recorded. Underlying the CEN scheme is the rationale that a clear distinction should be made between private users of cannabis and those who are involved in dealing, producing or trafficking in cannabis. This distinction was emphasized at the introduction of the CEN scheme by the simultaneous introduction of more severe penalties for offences relating to the manufacture, production, sale or supply of all drugs of dependence and prohibited substances, including offences relating to larger quantities of cannabis.

The CEN scheme was modified by the introduction of the *Expiation of Offences Act, 1996* which now provides those served with an expiation notice the option of choosing to be prosecuted in order to contest being given the notice. Previously those served with a notice had to let the payment of expiation fees lapse in order to secure a court appearance to contest the notice. In choosing to be prosecuted, however, people issued a notice have their alleged offence converted from one which can be expiated to one which still carries the possibility of a criminal conviction.

The Australian Capital Territory (in 1992) and the Northern Territory (in 1996) introduced similar expiation schemes. Victoria implemented a system of cautions for minor cannabis offenders in 1998 and Western Australia has followed with a similar scheme.

In all cases, cannabis possession remains a criminal offence. By their nature, these provisions reduce, as necessary, the prison term in which the possession of small quantities of cannabis for personal use would previously have resulted.[191]

Various evaluation studies since conducted have revealed significant savings and reduced negative social impact on persons convicted of minor cannabis offences. None

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190 For further details on this topic, see: Eric Single, Paul Christie and Robert Ali, "The Impact of Cannabis, Decriminilisation in Australia and the United States", *Journal of Public Health Policy*, 21,2, Summer 2000, page 157-186. Available online at: http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-f/ille-f/presentation-f/single-f.htm.

191 For a fuller discussion of the legislative possibilities concerning cannabis, see McDonald *et al.*., *Legislative Options for Cannabis Use in Australia, supra.*

of the studies upon levels and patterns of cannabis use in South Australia[192] have found an increase in cannabis use which is attributable to the introduction of the CEN scheme. Cannabis use did increase in South Australia over the period from 1985 to 1995 but this was so throughout Australia, including in jurisdictions with a total prohibition approach to cannabis. In fact, the largest increase in the rate of weekly cannabis use across all Australian jurisdictions occurred in Tasmania, a prohibitionist state.[193]

A comparative study of minor cannabis offenders in South Australia and Western Australia concluded that both the CEN scheme and the more punitive prohibition approach had little deterrent effect upon cannabis users. Offenders from both jurisdictions reported that an expiation notice or conviction had little or no impact upon subsequent cannabis and other drug use. However, the adverse social consequences of a cannabis conviction far outweighed those of receiving an expiation notice. A significantly higher proportion of those apprehended for cannabis use in Western Australia reported problems with employment, further involvement with the criminal justice system, as well as accommodation and relationship problems.[194]

In the law enforcement and criminal justice areas, the number of offences for which cannabis expiation notices were issued in South Australia increased from around 6,000 in 1987/88 to approximately 17,000 in 1993/94 and subsequent years. This appears to reflect the greater ease with which police can process minor cannabis offences and a shift away from the use of police discretion in giving offenders informal cautions to a process of formally recording all minor offences. Substantial numbers of offenders still received convictions due to their failure to pay expiation fees on time. This was due in large part to a poor understanding by cannabis users of the legal consequences of not clearing expiation offences and due to financial difficulties. Most CENs are issued for less than 25g of cannabis and half of all CENs issued were received by people in the 18- to 24- year-old age group.[195]

The scheme has proven to be relatively cost-effective and more cost-effective than prohibition would have been. The total costs associated with the CEN scheme in 1995/96 were estimated to be around AUD $1.24 million while total revenue from fees and fines was estimated to be around AUD $1.68 million. Had a prohibition approach

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[192] Single, Christie, and Ali, *supra,* Notes 3, 11, 12, 18, 19 and 50. See also Maurice Rickard, *Reforming the Old and Refining the New: A Critical Overview of Australian Approaches to Cannabis*, Department of the Parliamentary Library, Information and Research Services, Research Paper No. 6 2001-02, 2001, page 29. Available online at: http://www.aph.gov.au/library (listed under Research Papers).

[193] Rickard, *op. cit.*, page 30.

[194] National Drug Research Institute, Curtin University of Technology, *The Regulation of Cannabis Possession, Use and Supply*, A discussion document prepared for the Drugs and Crime Prevention Committee of the Parliament of Victoria, Perth, Western Australia, 2000, page xxxiv.

[195] *Ibid.*, page xxxiii.

been in place, it is estimated that the total cost would have been around AUD $2.01 million, with revenue from fines of around $1 million.[196]

A report on the CEN scheme[197] noted that it appeared to have numerous benefits for the community, not the least of which were cost savings for the community as a whole, reduced negative social impacts for offenders, and greater efficiency and ease in having minor cannabis offences dealt with, associated with less negative views of police held by offenders. Yet the rate of expiation of notices has remained low, compared with other types of infringement notices, at around 45%.

Administration

Public costs

In financial terms, Commonwealth and State Government expenditure in response to illicit drugs in 1992 was estimated at AUD $620 million. Of this sum, 84% was allocated to law enforcement, 6% to treatment, and 10% to prevention and research. Commonwealth and state expenditure on methadone programs has been estimated at AUD $30 million per year.

Based on various more recent estimates, it is likely that more than AUD $200 million is spent annually in the health and social welfare sectors by governments as a direct or indirect result of the illicit drugs trade.[198] It is estimated that AUD $450 to AUD $500 million is the annual cost to the criminal justice system incurred by illicit drugs.[199] It is estimated that more than AUD $312 million is raised each year by heroin users/dealers through property crime.[200] Law enforcement estimates suggest that drugs generate at least AUD $2 billion annually within Australia. In addition, it has been suggested that a significant proportion of the estimated AUD $3.5 billion laundered in and through Australia each year can be attributed to illicit drugs.[201]

The economic costs associated with the prevention and treatment of drug-related illness, loss of productivity in the workplace, property crime, theft, accidents and law enforcement activities are over AUD $18 billion annually.[202]

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[196] Rickard, *op. cit.*,, page 33.

[197] Robert Ali *et al.*, *The Social Impacts of the Cannabis Expiation Notice Scheme in South Australia*, Department of Health and Aged Care, Canberra, May 1998. Available online at: http://www.health.gov.au/pubhlth/publicat/drugs.htm.

[198] John Broome, "Impacts Upon Social and Political Life", in *Drugs and Democracy*, *op. cit.*, page 117.

[199] *Ibid.*, page 117. See also: Adam Sutton and Stephen James, "Law Enforcement and Accountability", in *Drugs and Democracy*, *op. cit.*, page 163, where an estimate of AUD $404 million is given for the annual cost to the Commonwealth, States and Territories of enforcing laws against illicit drugs.

[200] Broome, *supra*, page 117.

[201] *Ibid.*, page 118.

[202] This figure includes costs associated with the use of alcohol and tobacco. See Timothy Rohl, "Evaluating the National Drug Strategy", in *Drugs and Democracy*, *supra*, page 134.

Social costs

In a study of the social impacts of a conviction for a minor cannabis offence on first time offenders, a significant minority of the sample was shown to develop less favourable attitudes towards police, and there was evidence that many respondents had experienced adverse consequences in terms of employment difficulties, further problems with the law, and problems in relationships and accommodation.[203]

A cost of making cannabis illegal is the exposure of cannabis buyers to a range of other potentially more harmful illicit drugs which are available for sale. Another cost is the involvement of organized crime in large scale cannabis production and distribution in Australia. Finally, the illicit drug market generates a sizeable cash economy. It is not too surprising that some police officers become involved in corrupt activities such as drug use, drug dealing, protection of drug dealers, theft of drugs and/or money, and the presentation of false evidence in court.[204]

Statistics

Use[205]

The Australian Institute of Health and Welfare conducts a National Drug Strategy Household Survey (NDSHS) every 2-3 years. This survey has been conducted since 1985 with the seventh survey taking place in 2001. The last survey for which results are available took place in 1998.[206] 10,300 Australians aged 14 years and older participated in the NDSHS. Respondents were asked about their knowledge of drugs, their attitudes towards drugs, their drug consumption histories, and related behaviours.

The results from the NDSHS in 1998 indicate that approximately 46% of the Australian population had used an illicit drug at some time, while 23% of Australians reported using any illicit drug in the twelve months preceding the survey. Marijuana was the most common illicit drug used, with 39.1% of those aged 14 years and over having used the drug at some time in their lives and 17.9% having used it recently. Of those who had used marijuana, almost half had used it in the past 12 months. The prevalence of lifetime use of pain-killers/analgesics (for non-medical purposes) was 11.5%, followed by hallucinogens (9.9%) and amphetamines (8.8%). Only 2.2% of the Australian population had ever used heroin, with 0.8% reporting recent usage. The

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[203] The Regulation of Cannabis Possession, Use and Supply, *supra*, page 40.

[204] *Ibid.*, page 40-43.

[205] Megge Miller, and Glenn Draper, *Statistics on Drug Use in Australia 2000*, Australian Institute of Health and Welfare, Canberra, May 2001. Available online at: http://www.aihw.gov.au/publications/phe/sdua00/index.html.

[206] For detailed results of the 1998 NDSHS, see: Pramod Adhikari and Amber Summerill, *1998 National Drug Strategy Household Survey: Detailed Findings*, Australian Institute of Health and Welfare (Drug Statistics Series No. 6), Canberra, October 2000. Available online at: http://www.aihw.gov.au/publications/health/ndshs98d/index.html.

prevalence of cocaine use was slightly higher, with lifetime use in 4.3% of the respondents and recent use in 1.4%.

The second national survey on the use of over-the-counter and illicit substances by secondary students was conducted in 1999. The survey collected data from 25,480 students aged 12-17 years from 434 secondary schools throughout Australia. According to the survey, substance use increased with age for all substances except for inhalants and steroids. Across all ages, the most common substances used were analgesics (for medical and non-medical purposes), with at least 95% of those surveyed reporting the use of this substance. Marijuana use was also relatively high, particularly among those aged 16-17 years, who were more likely than the general community to use marijuana (47% versus 39%). Overall, a similar number of male and female students had tried the substances surveyed. However, slightly more males (32%) than females (29%) had used marijuana, while slightly more females than males had used analgesics for any purpose (98% versus 96%). Apart from these two substances, lifetime and recent illicit substance use was similar for both males and females.

Offences[207]

Marijuana/cannabis is consistently the most common drug for which people are arrested in Australia, accounting for 70% of all illicit drug arrests in 1998-99. However, the number of persons arrested for either the possession or supply of marijuana has fallen sharply from almost 79,000 in 1995-96 to approximately 58,000 in 1998-99.

The most common drug-related offence for which people were imprisoned was dealing/trafficking in drugs. Of the 1,663 people in prison in 1999 for drug-related offences, 78% were imprisoned for dealing/trafficking offences, with a further 11% imprisoned for possession/use of illicit drugs. The proportion of the total prison population imprisoned for drug-related offences has steadily declined, from 11% in 1995 to 9% in 1999. The proportion of people imprisoned for possession/use of drugs has remained stable over the past five years at 1%, while the proportion of those in prison for dealing/trafficking drugs and manufacturing/growing drugs is steadily decreasing.

Attitudes to drug use and drug legalization

The regular use of illicit drugs was not considered to be acceptable among the vast majority of the respondents in the 1998 NDSHS. Males were more likely to accept regular illicit drug use than were females. Marijuana was the most widely accepted illicit drug, with 30.5% of males and 20.6% of females supporting regular use.

Support for the legalization of illicit drugs follows a similar pattern to that of the acceptability of regular illicit drug use. The legalization of marijuana was supported by 33.8% of males and 25.1% of females. By contrast, support for the legalization of heroin, amphetamines and cocaine was less popular. Only 7% of males and 5.1% of

[207] Miller and Draper, *supra*, page 53-58.

females supported the legalization of cocaine. Those who supported the legalization of heroin, amphetamines and cocaine were generally aged 20-29 and 40-49 years.

THE UNITED STATES[208]

A proper description of the illegal drug policies, and even more so of drug practices, in the United States would in itself be long enough to fill a single report. Consider this: the research budget of the National Institute on Drug Abuse (NIDA) alone amounts to US $1 billion, approximately 80 per cent of funding allocated to illicit drug research worldwide; the budget of the Office for National Drug Control Policy (ONDCP) is more than US $18 billion, compared to that of the Canadian Drug Strategy, which is CDN $16 million, approximately one-half of one per cent of the US office's budget; and total expenses relating to illegal drugs are approximately US $35 billion. Furthermore, given the complexity of the American political system and the diversity of its population, one can only imagine the difficulty of accurately representing US drug policies.

What is more, the United States and illegal drugs are inextricably intertwined. As seen in the last chapter, the USA has played and continues to play a preponderant role in the negotiation and enforcement of international drug conventions. To think of drugs where the United States is involved is automatically to think of the "war on drugs" and the legions of statistics on incarceration, harsh sentences and the enormous economic and social costs that result therefrom.

In this section, we can only scratch the surface of this complex issue. Fortunately, in previous chapters, we have discussed various figures on the United States, use rates in Chapter 6 and research into effects in Chapter 7, for example. Our task was made even more difficult by the fact that we were unable to hear government representatives at the public hearings. In our single day of hearings in the United States, we heard from the Governor of New Mexico, Mr. Gary Johnson, and Mr. Ethan Nadelman of the Lindesmith Centre-Drug Policy Foundation. It was not until June 10 of this year that we were able to have a private meeting with Dr. Hanson, the director of NIDA and, on June 11, an *in camera* session with Mr. Walters, the director of the ONDCP.

The federal-state legislative framework

Historically, most criminal law and its enforcement was a matter under the jurisdiction of the states. Article I of the U.S. Constitution delineates the federal government's areas of legislative authority and the Tenth Amendment expressly provides that all powers not granted to the central government belong to the states. Criminal law is not among the powers specified as being within the federal

[208] This section draws to a large degree on the report prepared for the Committee by the Library of Parliament: B. Dolin, *National Drug Policy: United States*. Ottawa: Library of Parliament, 2002, report prepared for the Senate Special Committee on Illegal Drugs, available online at www.parl.gc.ca/illegaldrugs.asp.

government's purview and in Congress' early days, federal criminal laws were restricted to acts injurious to the national government, such as treason and counterfeiting, or offences of an extra-territorial nature, such as piracy and felonies committed on the high seas.

Despite this, the U.S. Congress has managed to assume a significant role in the criminalization of drug use. Although the "Father of the Constitution," James Madison, had assured the states that their powers were "numerous and indefinite" and those of the central government "few and defined,"[209] judicial constitutional analysis subsequently provided a very wide interpretation of the sphere of congressional authority. Beginning with the 1819 case of *McCulloch v. Marlyland*[210] the U.S. Supreme Court has given a broad reading to the Article I provision that the federal government may enact all laws that are "necessary and proper" for executing its listed powers. Two of Congress' listed powers are taxation and the regulation of foreign and interstate commerce. As discussed below, the federal government has used these heads of power as the foothold for entering into the regulation of drug use.

Historical[211]

From the time of the U.S. Civil War (1861-1865) to the end of the 19th century, the use and sale of opium, morphine, cocaine and other psychoactive drugs were legal and common. Opium was available with or without a prescription and was an ingredient in many patent medicines, including various pain-killers, cough mixtures and teething syrups for infants. Cocaine was also used medicinally, as well as in soft drinks and wine.

Things started to change around the turn of the century. Heroin was first isolated in 1898 and was purported to convey the same benefits as opium or morphine, without the risk of addiction. The realization of heroin's addictive properties soon after its introduction coincided with racist appeals to protect American society from drugs. Initially, two drugs were targeted: Cocaine, associated mainly with Blacks who were said to go on violent rampages under its influence, and opium, the smoking of which was associated with the Chinese. Alcohol temperance societies and religious groups also played key roles in lobbying for prohibition.

Despite strong opposition from the patent medicine industry, the U.S. Congress passed the *Pure Food and Drug Act* in 1906. This legislation required over-the-counter medicines to list the amount of drugs contained in them in the hope that this would

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[209] In David P. Currie, *The Constitution of the United States: A Primer for the People*, Chicago: University of Chicago Press, page 26.

[210] 17 U.S. 316.

[211] See Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport: Greenwood Press, 2000; Joseph D. McNamara, "Commentary: Criminalization of Drug Use" *Psychiatric Times*; Vol. XVII(9) *Psychiatric Times*; Luna, Erik Grant, "Our Vietnam: The Prohibition Apocalypse", (1997) 46 Depaul L. Rev. 483. Stephen B. Duke, "Commentary: Drug Prohibition: An Unnatural Disaster", (1995) 27 Conn. L. Rev. 571).

reduce the use of such medicines. Soon to follow was the *Opium Smoking Act of 1909 (as Amended, 1914)* in which Congress banned the importation of the drug for non-medicinal purposes.

The *Harrison Narcotic Act* of 1914

The *Harrison Act* was a significant development in American drug policy. Earlier legislation enacted in 1909 had restricted the importation of opium in accordance with the international conventions against the use of the drug. Initially designed to medicalize cocaine and heroin by restricting their distribution to physicians, the *Harrison Act* was passed in 1914. Its stated purpose was soon altered by the influence of the prohibitionist fervour of the day and this legislation became the unusual model upon which the administration of American narcotics policy would develop. Constitutional limits, as perceived at the time, meant that federal laws had to focus on international controls, interstate transfer and taxation. The Act therefore addressed drug use by requiring anyone selling drugs to be licensed and to keep records of all sales, ostensibly for tax purposes. As part of this regulatory process, users had to obtain prescriptions. Even though the Act specifically provided that doctors could prescribe narcotics, they could only do so if it was in the course of their "professional practice."

There were court challenges to the legislation. However, the U.S. Supreme Court upheld the *Harrison Act* as a revenue act and not a policing measure.[212] It was subsequently held that the Act did not permit physicians to prescribe drugs to “addicts” to keep them physically comfortable or maintain their addiction.[213] The *Behrman* decision[214] of 1922 further restricted the ability of physicians to prescribe and the prosecution of pharmacists and physicians resulted in legal supplies of opiates and other drugs essentially becoming unavailable by the early 1920s.

Subsequent measures

In the Depression years, fears about "degenerate Mexicans" smoking marijuana also led to legislative action. Some suggest that this represents a common thread in American drug policy; that is, the determining factor in deciding whether a particular drug was criminalized was not its inherent properties or potential for social harm, but rather the kinds of people associated with its use.[215] By 1931, 29 states had outlawed marijuana and in 1937 Congress passed the *Marihuana Tax Act* which, like the *Harrison Act*, established federal control over marijuana pursuant to Congress’ revenue authority. Although opposed by the American Medical Association at the time, the Act had the support of the country’s top drug cop, the head of the Federal Bureau of Narcotics (FBN), Henry J. Anslinger.

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[212] *United States v. Doremus* (1919), 249 U.S. Reports 86. The *Harrison Act* was again upheld as a revenue measure in *United States v. Nigro* (1928), 276 U.S. Reports 332.

[213] *Webb et al. v. United States* (1919), 249 U.S. Reports 96.

[214] *United States v. Behrmann* (1922), 258 U.S. Reports 280.

[215] See Luna, *supra*, page 490-495.

Anslinger, a central figure in the history of American drug policy, had been named the commissioner of the FBN in 1930 and headed the organization through five presidential administrations, until 1962. Often compared to his contemporary J. Edgar Hoover, who controlled the FBI. with similar tenacity, Anslinger did not support a public health approach to drug policy and argued that jailing users was the only proper response. He often suggested that drugs were part of a foreign plot. During W.W.II, he accused the Japanese of using narcotics to sap America's will to fight; following the war, he asserted that it was the Communists who were attempting to do so.

Current legislation and enforcement

Federal law

The Controlled Substances Act

In 1970 the U.S. Congress enacted the federal Controlled Substances Act (the CSA) [216] pursuant to the federal authority to regulate interstate commerce.[217] This Act repealed most of the earlier federal legislation, including the *Harrison Act* and the *Marihuana Tax Act,* and is the foundation of U.S. federal drug law today. Based on a series of schedules, drugs are categorized and controlled to varying degrees. The most restrictions are placed on Schedule I drugs which cannot be possessed by anyone, except for the purpose of research that has been licensed by the federal government. This schedule includes drugs such as marijuana, heroin, MDMA, LSD and peyote which are deemed to have no medical use and a high abuse potential. Schedule II substances, which have an accepted medical use and are deemed to have an abuse potential less than those in Schedule I, are also subjected to tight controls. Included in Schedule II are cocaine, opium, morphine, meperidine (Demerol) and codeine.

The enactment of the CSA in 1970 represented a significant change in one key respect. Marijuana was differentiated from other drugs and federal penalties were reduced, not only for possession, but also for trafficking and distribution offences. This was to change, however, during the Reagan administration in the 1980s.

In 1982 President Reagan signed an executive order creating the post of White House Drug Policy Advisor. The *Comprehensive Crime Control Act* of 1984, the *Anti-Drug Abuse Act* of 1986 and the *Anti-Drug Abuse Amendment Act* of 1988 raised federal penalties for various drug-related offences (including marijuana offences), increased funding for drug control activities and sought to improve the coordination of federal drug control efforts. The *National Narcotics Leadership Act* of 1988 created the Office of

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[216] Comprehensive Drug Abuse Prevention and Control Act of 1970, Title II, 21 U.S.C., ss. 800-966.

[217] Congress need merely find that a class of activity affects interstate commerce to enact criminal penalties; no proof is required that the conduct involved in a single prosecution has an effect on commerce: see Ehrlich, Susan, "The Increasing Federalization of Crime" (2000) 32 Ariz. St.L.J.825.

National Drug Control Policy, the director of which is commonly referred to as the "Drug Czar."[218]

Many commentators have suggested that these laws were passed during a time of extreme anti-drug hysteria resulting from the introduction of crack cocaine.[219] Propagated by politicians and embraced by the mainstream media, myths regarding crack likely had a significant impact on the increased use of mandatory minimum sentences and the expansion of the American "war on drugs" during the Reagan era.

Scheduling under the CSA–the example of marijuana

An examination of a petition to the Drug Enforcement Administration to reschedule marijuana is instructive of the scheduling process under the CSA.[220] In concluding that marijuana should remain in Schedule I, the Department of Justice considered eight factors:

- The drug's actual or relative potential for abuse;
- Scientific evidence of its pharmacological effects;
- The state of current scientific knowledge of the drug;
- Its history and current pattern of abuse;
- The scope, duration and significance of abuse;
- What, if any, risk there is to public health;
- The drug's psychic or physiological dependence liability; and,
- Whether the drug is an immediate precursor of a substance already controlled under the CSA.

The petition to reschedule was denied in part on the basis that marijuana has a high potential for abuse. While the term "abuse" is not defined in the CSA, the administration examined various factors in ascertaining the potential for abuse. Most important was its finding that individuals are taking the substance in amounts sufficient to create a hazard to their health or to the safety of other individuals or the community. It was determined that while marijuana has low levels of toxicity compared to other drugs of abuse, there are a number of risks resulting from both acute and chronic use, such as dizziness, nausea, time distortions, impaired judgement and short-term memory impairment. Also noted were studies from some authors who described a "marijuana withdrawal syndrome" consisting of restlessness, mild agitation, insomnia, nausea and cramping that resolves within days.

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[218] The Office's home page can b e found at www.whitehousedrugpolicy.gov.

[219] See, for example, Craig Reinarman and Harry G. Levine, eds., *Crack in America: Demon Drugs and Social Justice*, University of California Press, September 1997. The organization Human Rights Watch in a May 2000 report on the United States referred to the phenomenon as a "moral panic" (available online at www.hrw.org/reports/2000/usa).

[220] Department of Justice, Drug Enforcement Agency, "Notice: Denial of Petition", April 18, 2001, in Vol. 66, No. 75 of the Federal Register, page 20037-20076.

Another significant element of the analysis that precluded rescheduling marijuana was the fact that the drug has no currently accepted medical use in the United States. The Food and Drug Administration has not yet authorized treatment using marijuana. To do so would require that the following conditions be satisfied:

- The drug's chemistry must be known and reproducible;
- There must be adequate safety studies;
- There must be adequate and well-controlled studies proving efficacy;
- The drug must be accepted by qualified experts; and,
- The scientific evidence must be widely available.

Proposed legislation

The legislative war on drugs continues in the U.S. Congress. The proposed *Drug Dealer Liability Act of 1999* passed in the U.S. House of Representatives and was received in the Senate at the end of 2000. It would impose civil liability on drug dealers for the harm caused–either directly or indirectly–by the use of controlled substances. Even the drug users themselves would be permitted to sue for damages, although the statute requires that they first disclose to narcotics enforcement officers everything they know about the source of the illegal drugs. While it is not clear whether this bill will be made law, a model *Drug Dealer Liability Act* has so far been adopted by 13 states.[221]

Legislation entitled the *Protecting Our Children from Drugs Act of 2000* was passed by the House of Representatives on 17 October 2000. It would amend the *Controlled Substances Act* to further increase penalties for drug dealers who involve children in the drug trade. Mandatory minimum sentences would increase for dealers who use children under 18 to distribute drugs in or near schools or other "protected locations" such as playgrounds and video arcades. Other proposed initiatives include the *Drug Free America Act of 2001*, the *Domestic Narcotic Demand Reduction Act of 2001* and the *Drug Treatment and Research Enhancement Act of 2001.*

Federal penalties

The following charts provide a summary of the fines and the terms of imprisonment for selected violations of the federal *Controlled Substances Act* and related federal laws.[222] Note that for a third felony drug offence involving amounts constituting a top level offence, there is a mandatory life sentence without the possibility of release. Also note that the indicated weights refer to any mixture containing a detectable

[221] Arkansas, California, Colorado, Georgia, Hawaii, Illinois, Indiana, Louisiana, Michigan, Oklahoma, South Carolina, South Dakota, Utah and the U.S. Virgin Islands.

[222] Congress has passed various anti-crime bills that include drug-related provisions, including the *Crime Control Act* of 1984 (P.L. 98-473), the *Anti-Drug Abuse Act* of 1986 (P.L. 99-570), the *Anti-Drug Abuse Act* of 1988 (P.L. 100-690), the *Crime Control Act* of 1990 (P.L. 101-647) and the *Violent Crime Control and Law Enforcement Act* of 1994 (P.L. 103-322). Collectively, these Acts enhanced drug-related penalties and provided new funding for drug control activities.

amount of the illegal drug regardless of the substance in the mixture. "Conspiracy" and "attempt" offences carry the same penalties as the underlying offence.

Table 1[223]

Unlawful distribution, possession with intent to distribute, manufacture, importation and exportation				
Substance	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
Heroin	First Offence	1 kg or more	4-10 million	10 years to life
		100 g – 1 kg	2-5 million	5-40 years
		Less than 100 g	1-5 million	Up to 20 years
	Second Offence[224]	1 kg or more	8-20 million	20 years to life
		100 g – 1 kg	4-10 million	10 years to life
		Less than 100 g	2-10 million	Up to 30 years
Coca leaves, Cocaine or "Crack"	First Offence	50 g or more	4-10 million	10 years to life
		5-50 g	2-5 million	5-40 years
		Less than 5 g	1-5 million	Up to 20 years
	Second Offence	50 g or more	8-20 million	20 years to life
		5-50 g	4-10 million	10 years to life
		Less than 5 g	2-10 million	Up to 30 years
LSD	First Offence	10 g or more	4-10 million	10 years to life
		1-10 g	2-5 million	5-40 years
		Less than 10 g	1-5 million	Up to 20 years
	Second Offence	10 g or more	8-20 million	20 years to life
		1-10 g	4-10 million	10 years to life
		Less than 10 g	2-10 million	Up to 30 years
Marijuana	First Offence	1,000 kg or more or 1,000 plants or more	4-10 million	10 years to life
		100-1,000 kg or 100-1,000 plants	2-5 million	5-40 years
		50-100 kg or 100 plants	1-5 million	Up to 20 years
		Under 50 kg[225]	250,000-1 million	Up to 5 years
	Second Offence	1,000 kg or more or 1000 plants or more	8-20 million	20 years to life
		100-1,000 kg or 100-1,000 plants	4-10 million	10 years to life

[223] Source: Charles Doyle, *Drug Offences: Maximum Fines and Terms of Imprisonment for Violation of the Federal Controlled Substances Act and Related Laws*, Library of Congress Congressional Research Service, November 1, 2000.

[224] A second offence is one committed after a prior conviction for *any* felony drug offence under *any* federal, state or foreign drug law.

[225] Distribution of a small amount of marijuana for no remuneration is treated as simple possession, the penalties for which are contained in the second chart.

Unlawful distribution, possession with intent to distribute, manufacture, importation and exportation				
Substance	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
		50-100 kg or 100 plants	2-10 million	Up to 30 years
		Under 50 kg	500 000-2 million	Up to 10 years

Table 2

Simple possession				
Drug	Offence Number	Amount of Drug	Fine (in dollars)	Imprisonment
Cocaine based	First	Over 5 g	Up to 250,000	5-20 years
	First	5 g or less	Minimum 1,000	Up to 1 year
All other	First	All amounts		
Cocaine based	Second[226]	Over 3 g	Up to 250,000	5-20 years
All other	Second	All amounts	Minimum 2,500	15 days to 2 years
Cocaine based	Third	Over 1 g	Up to 250,000	5-20 years
All other	Third	All amounts	Minimum 5,000	90 days to 3 years

State laws

General

In the U.S. a group called the National Conference of Commissioners on Uniform State Law has the task of drafting legislation that is to be recommended for adoption by all states in an effort to promote legislative consistency throughout the nation. The most recent Uniform Controlled Substances Act was drafted in 1994. The Act sets out the prohibited activities in detail but specific fines and sentencing are left to the discretion of the individual States. Most states have substantially adopted the major provisions of the Uniform Act[227] with the exception of New Hampshire and

[226] A prior conviction includes conviction of *any* offence under the *Controlled Substances Act* or any State drug law.

[227] The *Uniform Laws Annotated*, Master Edition, Volume 9, Parts II, III and IV, provides annotation materials for the adopting states. Under the heading "General Statutory Note", those jurisdictions that have based their drug legislation on the *Uniform Act* are stated to have substantially adopted the major provisions of the *Uniform Act*, but the official text of the State Act "departs from the official text in a such manner that the various instances of substitution, omission, and additional material cannot be clearly indicated by statutory notes." As such, it is recommended that recourse be had to the individual State legislation for specific details for the individual CSA. Another useful reference is Richard A. Leiter, ed., *National Survey of State Laws, 3d Ed.*, Detroit: Gale Group, 1999, which, at pages 152-188, provides charts that set out specific offences and penalties for cocaine, heroin and marijuana in all States.

Vermont where the state laws are not a substantial adoption of the Uniform CSA, although they contain some similar provisions and have the same general purpose. Also of note are the medical marijuana exemptions discussed below.

In terms of sentencing, there are significant discrepancies between states.[228] With respect to sentencing for other drug offences, some states have experimented with extremely harsh penalties. New York's "Rockefeller Laws," for example, are referred to herein in the section entitled "Key Reports and Studies." Other states that adopted similar "get-tough" penalties are now re-examining mandatory minimums, often as a result of fiscal considerations. For example, the state legislature in Louisiana overhauled its drug laws in June 2001. New legislation has cut drug sentences and repealed mandatory minimums for many non-violent crimes. As one republican legislator was quoted as saying, "*It's costing us too much to lock these people up and throw away the key*."

Medical marijuana

Since 1978, medical marijuana laws have been enacted in 35 states. Five have since expired or been repealed but the balance remain on the books. Of those remaining:

- 12 states have "Therapeutic Research Program" laws that purport to permit scientific research (although this is complicated by the federal prohibition).
- 10 states (and the District of Columbia) have symbolic laws that recognize the potential medicinal value of marijuana, but do not provide any protection from arrest.
- 8 states have laws that effectively allow patients to use medical marijuana despite federal law.

The following chart provides details of the eight states with effective medical marijuana laws. While marijuana possession is still a federal crime, most drug arrests are made by state and local officials. Since the federal government cannot force state and local police to enforce federal statutes, medical marijuana users are usually able to avoid prosecution in these states. However, since pharmacies do not sell marijuana, some distribution centres called "buyers' clubs" have emerged and these operations have been hampered by federal law enforcement.

Recently, the Supreme Court examined the issue of buyers' clubs in *Conant v. Oakland Cannabis Buyers' Cooperative*.[229] The court unanimously ruled that there is no medical necessity defence to the Controlled Substances Act's prohibitions on manufacturing and distributing marijuana. Because the CSA classifies marijuana as a Schedule I drug, marijuana has been deemed to have no medical benefits. While the decision in *Conant* does not render state laws regarding medical marijuana inoperative, it

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[228] Appendix 2 of the report by B. Dolin, *op. cit.*, states the main alternatives.

[229] No. 00-151. Argued March 28, 2001 – Decided May 14, 2001. Cited as: 532 U.S. __ (2001).

does enhance the federal government's ability to prosecute under the CSA in all states. That said, federal enforcement efforts have not, thus far, targeted individuals who possess or cultivate small amounts for medical use. Only the buyers' clubs (also known as "compassion clubs") have been targeted.

In respect of the following chart, it should be noted that the quantity of marijuana a patient may possess varies from state to state. The provisions exempting caregivers from criminal liability may also vary.

State and Date Enacted	Protection provided to Patients	Documentation Required
Alaska – 3 Nov. 1998	Affirmative defence[230] provided to those registered with the state	Signed physician statement confirming that patient was examined, has a debilitating medical condition and other
California – 5 Nov. 1996	Exemption from prosecution if marijuana possession or cultivation is solely for the medical purposes of the patient	Written or oral approval by physician who has determined that the patient's health would benefit from marijuana in the treatment of a qualifying
Colorado – 7 Nov. 2000	Exemption from prosecution if in possession of a registry card; affirmative defence if no card, but in compliance with	Diagnosed prior to arrest as having a debilitating condition and advised by the physician that marijuana might benefit
Hawaii – 14 June 2000	Exemption from prosecution if in possession of a registry card; "choice of evils" defence also available[231]	Card obtained with medical records or a statement from a physician that there is a debilitating condition and the potential benefits of marijuana would "likely outweigh the
Maine – 2 Nov. 1999	Burden on state to prove that patient's medical use was not authorized by statute	Medical records or physician's letter showing that the patient has a qualifying condition, that the risks have been discussed and that the patient "might benefit" from medical marijuana
Nevada – 7 Nov. 2000	Exemption from prosecution	"Advice required"; specifics yet to be determined by legislature
Oregon – 3 Nov. 1998	Exemption from prosecution if in possession of registry card; affirmative defence if no card, but in compliance with the law; choice of evils	Diagnosed within 12 months of arrest with a qualifying condition and advised by attending physician that marijuana "may mitigate the

[230] An "affirmative defence" requires the defendant to prove on a balance of probabilities that he or she is in compliance with the statute.

[231] The "choice of evils" deference refers to the defence of medical necessity. Long recognized in common law, a defendant is provided the opportunity to prove in court that his or her violation of the law was necessary to avert a greater evil; the pain of a debilitating disease or condition in the case of medical marijuana. Certain states, as noted in the chart, have codified the defence.

State and Date Enacted	Protection provided to Patients	Documentation Required
Washington – 3 Nov. 1998	Exemption from prosecution if patient qualifies, has no more marijuana than necessary for personal medical use and presents valid documentation to law enforcement; affirmative defence if in compliance with	Signed physician statement or medical records that indicate that physician is of the opinion that the "potential benefits" of marijuana "would likely outweigh the health risks"

Federal drug policy goals and objectives

National drug-control policy in the United States purports to be based upon prevention, education, treatment and research, complemented by "supply reduction" activities.[232] To quote from the 2001 Annual Report of the Office of National Drug Control Policy ("ONDCP"):

> *Through a balanced array of demand-reduction and supply-reduction actions, we strive to reduce drug abuse and availability by half and the consequences of drug abuse by at least 25% by 2007.* [233]

Using the metaphor of cancer for the nation's drug problem, the ONDCP lists the following strategic goals and objectives as being the heart of American federal action in this area.[234]

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Objective 1: Educate parents and other care givers, teachers, coaches, clergy, health professionals, and business and community leaders to help youth reject illegal drugs and underage alcohol and tobacco use.

Objective 2: Pursue a vigorous advertising and public communications program dealing with the dangers of illegal drugs, alcohol, and tobacco use by youth.

Objective 3: Promote zero tolerance policies for youth regarding the use of illegal drugs, alcohol, and tobacco within the family, school, workplace, and community.

Objective 4: Provide students in grades K-12 with alcohol, tobacco, and drug prevention programs and policies that are research based.

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[232] *National Drug Control Strategy: 2001 Annual Report*, Office of National Drug Control Policy, page 3.
[233] *Ibid.*, page 4.
[234] Available online at: http://www.whitehousedrugpolicy.gov/publications/policy/99ndcs/goals.html.

Objective 5: Support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modeling behavior to be emulated by young people.

Objective 6: Encourage and assist the development of community coalitions and programs in preventing drug abuse and underage alcohol and tobacco use.

Objective 7: Create partnerships with the media, entertainment industry, and professional sports organizations to avoid the glamorization, condoning, or normalization of illegal drugs and the use of alcohol and tobacco by youth.

Objective 8: Develop and implement a set of research-based principles upon which prevention programming can be based.

Objective 9: Support and highlight research, including the development of scientific information, to inform drug, alcohol, and tobacco prevention programs targeting young Americans.

Goal 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

Objective 1: Strengthen law enforcement – including federal, state, and local drug task forces – to combat drug-related violence, disrupt criminal organizations, and arrest and prosecute the leaders of illegal drug syndicates.

Objective 2: Improve the ability of High Intensity Drug Trafficking Areas (HIDTAs) to counter drug trafficking.

Objective 3: Help law enforcement to disrupt money laundering and seize and forfeit criminal assets.

Objective 4: Break the cycle of drug abuse and crime.

Objective 5: Support and highlight research, including the development of scientific information and data, to inform law enforcement, prosecution, incarceration, and treatment of offenders involved with illegal drugs.

Goal 3: Reduce health and social costs to the public of illegal drug use.

Objective 1: Support and promote effective, efficient, and accessible drug treatment, ensuring the development of a system that is responsive to emerging trends in drug abuse.

Objective 2: Reduce drug-related health problems, with an emphasis on infectious diseases.

Objective 3: Promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention.

Objective 4: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 5: Support and promote the education, training, and credentialing of professionals who work with substance abusers.

Objective 6: Support and highlight research and technology, including the acquisition and analysis of scientific data, to reduce the health and social costs of illegal drug use.

Objective 7: Support and disseminate scientific research and data on the consequences of legalizing drugs.

Goal 4: Shield America's air, land, and sea frontiers from the drug threat.

Objective 1: Conduct flexible operations to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Objective 2: Improve the coordination and effectiveness of U.S. drug law enforcement programs with particular emphasis on the Southwest Border, Puerto Rico, and the U.S. Virgin Islands.

Objective 3: Improve bilateral and regional cooperation with Mexico as well as other cocaine and heroin transit zone countries in order to reduce the flow of illegal drugs into the United States.

Objective 4: Support and highlight research and technology – including the development of scientific information and data – to detect, disrupt, deter, and seize illegal drugs in transit to the United States and at U.S. borders.

Goal 5: Break foreign and domestic drug sources of supply.

Objective 1: Produce a net reduction in the worldwide cultivation of coca, opium, and marijuana and in the production of other illegal drugs, especially methamphetamine.

Objective 2: Disrupt and dismantle major international drug trafficking organizations and arrest, prosecute, and incarcerate their leaders.

Objective 3: Support and complement source country drug control efforts and strengthen source country political will and drug control capabilities.

Objective 4: Develop and support bilateral, regional, and multilateral initiatives and mobilize international organizational efforts against all aspects of illegal drug production, trafficking, and abuse.

Objective 5: Promote international policies and laws that deter money laundering and facilitate anti-money laundering investigations as well as seizure and forfeiture of associated assets.

Objective 6: Support and highlight research and technology, including the development of scientific data, to reduce the worldwide supply of illegal drugs.

Administration of the policy

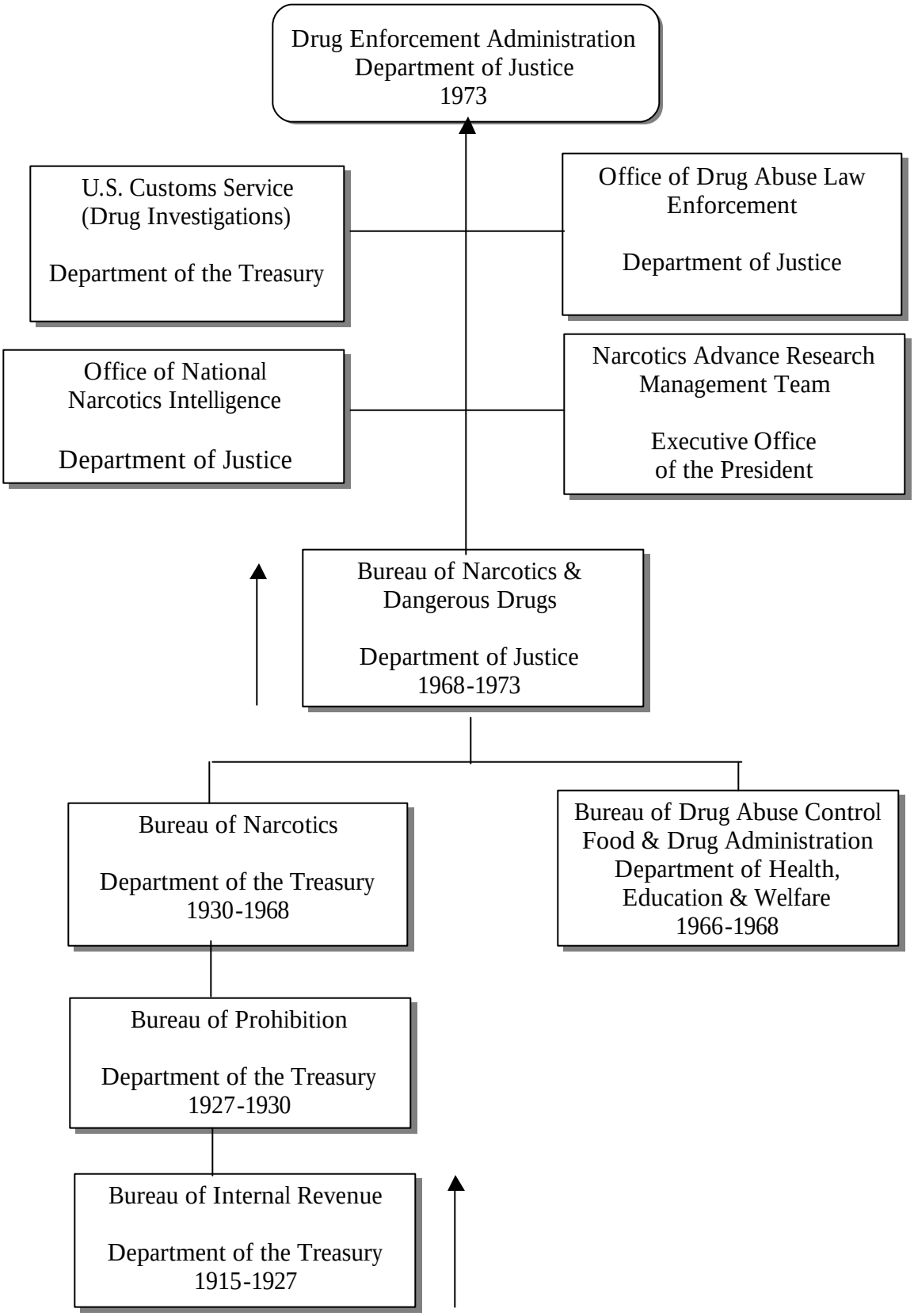
As previously stated, the national drug control budget is enormous. Over $18 billion has been budgeted for the year 2001 for the purpose of supporting the goals and objectives of the National Drug Control Strategy. Numerous federal departments, including Defense, Education, Justice, State and the Treasury, are involved and often must coordinate with state and local government agencies and a wide assortment of community and professional groups. This is all overseen by the ONDCP.

A key government department is the Department of Justice which is responsible for many of the agencies involved in this area and receives a significant portion of the drug control budget; over 8 billion dollars in 2001.[235] Various agencies receive funding through Justice, including the Bureau of Prisons, the F.B.I., INTERPOL, the U.S. Marshals Service, the Immigration and Naturalization Service and the Drug

[235] Source: Executive Office of the President of the United States, *Summary: FY 2002 National Drug Control Budget*, April 2001, page 11.

Enforcement Agency (DEA). The DEA[236] merits special mention in the Justice Department's administration of drug control policy. Its mission is to enforce the controlled substances laws and regulations and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets. Established in 1973, it is the successor of Anslinger's FBN and other enforcement arms of the federal government as illustrated in the following graphic.[237]

[236] The DEA's Web page is at http://www.usdoj.gov/dea/.
[237] Source: DEA Web site, at http://www.usdoj.gov/dea/agency/genealogy.htm.


Drug Enforcement Administration
Department of Justice
1973
U.S. Customs Service
(Drug Investigations)
Department of the Treasury
Office of Drug Abuse Law
Enforcement
Department of Justice
Office of National
Narcotics Intelligence
Department of Justice
Narcotics Advance Research
Management Team
Executive Office
of the President
Bureau of Narcotics &
Dangerous Drugs
Department of Justice
1968-1973
Bureau of Narcotics
Department of the Treasury
1930-1968
Bureau of Drug Abuse Control
Food & Drug Administration
Department of Health,
Education & Welfare
1966-1968
Bureau of Prohibition
Department of the Treasury
1927-1930
Bureau of Internal Revenue
Department of the Treasury
1915-1927

Apart from its law enforcement duties, the DEA manages national drug intelligence and is responsible, under the policy guidance of the Secretary of State and U.S. Ambassadors, for all programs associated with drug law enforcement counterparts in foreign countries. In this capacity, the organization liases with the United Nations, Interpol, and other organizations on matters relating to international drug control programs. American actions outside of U.S. territory include "Plan Columbia," a program targeted at reducing cocaine productivity in that country to which over a billion dollars has been committed, as well as well joint enforcement activities undertaken with other governments such as Mexico. As well, under the *Foreign Assistance Act*, the U.S. is required to impose substantial restrictions on bilateral assistance to those countries listed by the White House as being major drug producing or transit countries. Similarly, the *Foreign Narcotics Kingpin Designation Act* permits the President to designate foreign individuals as "drug kingpins," thereby denying them access to the U.S. financial system and making illegal any transactions between the "kingpin" and U.S. companies or individuals.

Current issues and debates

The costs of incarceration, the unequal impact of drug laws on racial minorities and police corruption resulting from the war on drugs are issues that have garnered increased attention in this ongoing debate. For example, the Republican Governor of New Mexico has called for the decriminalization of all drugs – "*Control it, regulate it, tax it*" he has been quoted as saying[238] – citing the mounting cost of addressing drug abuse problems with prison rather than treatment. At our hearings, the Governor told us:

> *I happen to believe that the war on drugs is an absolute miserable failure. (…) When I witness that half of what we spend on law enforcement, half of what we spend on the courts and half of what we spend on the prisons is drug related, I know that there is no bigger issue facing us today. In the United States we are spending $50 billion each year on drug-related crime. (…) Two-thirds of all prisoners in the United States are incarcerated on drug charges. Nearly 500,000 incarcerations, one-quarter of the prison population, are directly related to drugs. It costs over $8.6 billion each year just to keep drug offenders locked up in the United States. Even with all of those expenditures, illegal drugs are now cheaper, more available and more potent than they were 20 years ago.*
>
> *(…) In the United States, which one of these substances gets people arrested? We are arresting 1.6 million people every year. New Mexico has a population of 1.8 million. I live and I drive in New Mexico, a giant state, and I cannot help but think the equivalent of the population of New Mexico is getting arrested in the United States every single year. It's absolutely shocking. Out of those 1.6 million arrests, there are 800,000 for marijuana, and half of those arrests involve Hispanics. Are half the users of marijuana in the United States Hispanic? No, yet half the arrest disproportionally fall on the Hispanic communities.*

[238] "New Mexico Governor Calls for Legalizing Drugs", CNN.com, October 6, 1999, available online at www5.cnn.com/US/9910/06/legalizing.drugs.01/.

> *Given that situation, what do we need to do? First, we need to legalize marijuana. Second, we need to adopt harm reduction strategies with regard to all the other drugs. Third, we need to move away from a criminal model to a medical model.* [239]

Others criticize current policy on the basis that black Americans are disproportionately targeted in drug law enforcement. The group Human Rights Watch notes in a 2000 study that Blacks comprise 62.7% and whites 36.7% of all drug offenders admitted to state prisons, even though data confirms that this racial disparity "bears scant relation to racial differences in drug offending."[240] Various experts also pointed out the harmful effect of drugs on law enforcement, in particular Mr. Joseph McNamara, former chief of police of San Jose, California, now retired, who noted that the corruption of civil servants will be a serious problem as long as the current anti-drug policy remains in effect.[241]

Statistics

In Chapter 6, we presented an overview of data on cannabis use. We round out th description of the situation in the United States with a number of tables on certain selected indicators.

Estimated Domestic U.S. Drug Consumption (in Metric Tons)[242]

Year	Cocaine	Heroin	Marijuana	Methamphetamine
1996	288	12.4	874	14.3
1997	312	13.1	960	11.9
1998	291	12.5	952	15.9
1999	276	12.9	982	15.5
2000	269	12.9	1,009	15.5

[239] Testimony of Mr. Gary E. Johnson, Governor of New Mexico, before the Senate Special Committee on Illegal Drugs, Senate of Canada, first session of the thirty-seventh Parliament, November 5, 2001, Issue 9, page 36 to 38.

[240] Jamie Fellner, Human Rights Watch Associate Counsel, "United States: Punishment and Prejudice: Racial Disparities in the War on Drugs", Human Rights Watch, May 2000, paragraph 2 of "Summary and Recommendations", available online at www.hrw.org/reports/2000/usa.

[241] Joseph D. McNamara, "When Cops Become the Gangsters", *Los Angeles Times*, September 21, 1999, available online at www.nakedgov.com/mcnamara.htm.

[242] Source: Office of National Drug Control Policy, 2000. *What America's Users Spend on Illegal Drugs, 1988-1998*.

1997 National Household Survey on Drug Abuse: Past Illicit Drug Use[243]

Respondent Age	Ever Used	Past Year	Past Month
12 – 17	23.7 %	18.8 %	11.4 %
18 – 25	45.4 %	25.3 %	14.7 %
26 – 34	50.8 %	14.3 %	7.4 %
35 and over	31.5 %	6.1 %	3.6 %

1998 Drug Use Amount High School Seniors[244]

Drug	Ever Use	Past Year	Past Month
Marijuana	49.1 %	37.5 %	22.8 %
Cocaine	9.3 %	5.7 %	2.4 %
Crack	4.4 %	2.5 %	1 %
Stimulants	16.4 %	10.1 %	4.6 %
LSD	12.6 %	7.6 %	3.2 %
PCP	3.9 %	2.1 %	1 %
Heroin	2 %	1 %	0.5 %

Drug Prices and Purity Levels: Selected Years 1981-1998[245]

Purchase Amount	1981 Price/Purity (per pure gram)	1988 Price/Purity **(per pure gram)**	1996 Price/Purity (per pure gram)	1997 Price/Purity (per pure gram)	1998 Price/Purity (per pure gram)
Cocaine					
1 g or less	$378.70/40.02%	$218.33/75.99%	159.05/72.5 %	$178.97/64.72%	$169.25/71.23%
10-100 g	191.5/59.59%	78.84/ 83.53%	49.45/ 68.44p. cent	45.58/67.05	44.30/65.92
Heroin					
0.1 g or less	3,114.80/4.69	2,874.19/19.22	2,175.88/23.95	2,114.97/25.24	1,798.80/24.29
1-10 g	1,194.05/19.1	947.32/39.48	373.30/45.21	327.88/45.38	317.97/51.33
Marijuana					
10 g or less	$6.41	$12.50	$10.42	$10	$10.41
100-999 g	2.75	3.41	2.95	2.63	2.59

[243] Source: Office of National Drug Control Policy, Drug Policy Information Clearinghouse. *Drug Data Summary*, April 1999.
[244] *Ibid.*
[245] *Ibid.*

National Drug Control Budget[246]

Year	Amount (in $US billions)
1999	17.1
2000	17.9
2001	18.1
2002	19.2

Total Estimated Arrests and Drug Arrests, 1989-1999[247]

Year	Total Arrests	Arrests for all drug violations		Distribution of arrests for drug violations					
				Heroin/Cocaine		Marijuana		Other Drugs	
		Number	Per-cent	Sale	Possession	Sale	Possession	Sale	Possession
1989	14 340 900	1,351,700	.4	19.1	34.7	6.2	23.1	7.0	9.8
1990	14 195 100	1,089,500	.6	21.0	33.3	6.1	23.9	4.5	11.2
1991	14 211 900	1,010,000	.1	22.5	32.8	6.1	22.4	4.8	11.5
1992	14 075 100	1,066,400	.5	20.6	32.4	6.6	25.5	4.6	10.4
1993	14 036 300	1,126,300	.0	19.2	31.1	6.2	27.6	4.3	11.6
1994	14 648 700	1,351,400	.2	16.8	30.3	5.8	29.8	4.1	13.2
1995	15 119 800	1,476,100	.7	14.7	27.8	5.8	34.1	4.4	13.3
1996	15 168 100	1,506,200	.9	14.2	25.6	6.3	36.6	4.3	13.3
1997	15 284 300	1,583,600	0.3	10.3	25.4	5.6	38.3	4.7	15.8
1998	14 528 300	1,559,100	0.7	11	25.6	5.4	38.4	4.8	14.8
1999	14 031 070	1,532,200	0.9	10	24.5	5.5	40.5	4.1	15.4

[246] These figures represent funds specified for the purpose of supporting the goals and objectives of the National Drug Control Strategy and include funds budgeted for various departments, including Defence, Education, Justice, State, and Treasury,. Source: *National Drug Control Budget Executive Summary, Fiscal Year 2002*, Office of National Drug Control Policy, April 9, 2001.

[247] Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-2000).

Adults in Custody of State or Federal Prisons or Local Jails, 1989-1999[248]

Year	State Prisons	Federal Prisons	Total State & Federal Prisons	**Percent of prisoners who are drug offenders**		Local Jails
				Federal	State	
1989	629,995	53,387	683,382	49.9	19.1	395,553
1990	684,544	58,838	743,382	53.5	21.7	405,320
1991	728,605	63,930	792,545	55.9	21.3	426,479
1992	778,495	72,071	850,566	58.9	22.1	444,584
1993	828,566	80,815	909,381	59.2	22.1	459,804
1994	904,647	85,500	990,147	60.5	22.4	486,474
1995	989,004	89,538	1,078,542	59.9	22.7	507,044
1996	1,032,440	95,088	1,127,528	60.0	22.7	518,492
1997	1,059,588	99,175	1,176,922	62.6	20.7	567,079
1998	1,178,978	123,041	1,232,900	58.7	20.7	592,462
1999	1,209,123	135,246	1,366,369	57.8	Unavailable	605,943

Correctional population in the United States: selected statistics for 1997[249]

In 1997, an estimated 5.7 million adult residents of the U.S. (or approximately 2.8% of all U.S. adult residents) were under some form of correctional supervision. Approximately 70% were supervised in the community, through probation or parole. About 9.0% of black adults were under correctional supervision; for white adults, the figure was 2.0% and for other races it totalled 1.3%.

Federal drug prosecutions: selected statistics for 1999[250]

During 1999 U.S. attorneys initiated investigations involving 117,994 suspects. Of these suspects, 32% were investigated for drug offences. Suspects in criminal matters involving drug offences were more likely to be prosecuted in a U.S. district court (77%) as opposed to suspects involved in violent offences (59%), public order offences (53%) or property offences (50%). Of those convicted of felony drug offences in federal court in 1999, 93% received prison sentences. The average sentence of all offenders sentenced in federal court in 1999 was 57.8 months; for drug offenders, the average was 75.4 months.

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[248] Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 1999* (Aug. 2000), *Prisoners in 1998* (Aug. 1999), *Prisoners in 1997* (Aug. 1998), *Correctional Populations in the United States*, 1995, 1994, 1993, 1992, 1991, 1990, 1989. *Jails and Jail Inmates*, 1993-94. *Jail Inmates*, 1992; 1990. Data for 1997 percentages of drug offenders are estimated from Bureau of Justice Statistics, *Substance Abuse and Treatment, State and Federal Prisoners, 1997* (January 1999) and unpublished Bureau of Prisons Data.

[249] Source: *Correctional Populations in the United States, 1997*, Bureau of Justice Statistics, U.S. Department of Justice, (November 2000).

[250] Source: *U.S. Compendium of Federal Judicial Statistics, 1999*, (April 2001).

DEA seizures of non-drug property – 1997[251]

In fiscal year 1997, the Drug Enforcement Agency made 15,860 seizures of non-drug property pursuant to drug forfeiture laws. The total value of this property is estimated at $552 million.

Property Type	Number of Seizures	Value (in dollars)
Cash	8,123	284,680,029
Other financial instruments	507	73,602,092
Real property	748	108,833,498
Vehicles	3,695	47,379,874
Boats	111	5,884,754
Aircraft	24	8,945,000
Other means of transportation	172	1,734,731
Other	2,480	1,734,731

[251] Source: Official of National Drug Control Policy, Drug Policy Information Clearinghouse, *Drug Data Summary*, April 1999.

CHAPTER 21

PUBLIC POLICY OPTIONS

Public policy is not just a matter of enabling legislation, in this case criminal legislation. Nonetheless, when it comes to illegal drugs, criminal legislation occupies a symbolic and determinative place in public policy. It is as if this legislation is the backbone of our public policy. Public discussions of cannabis do not deal so much with such matters as public health, user health, prevention of at-risk or excessive use, but with such questions as the pros and cons of decriminalization, establishing a civil offence or maintaining a criminal offence, or possible legalization and the extent thereof. As we complete our report, the Minister of Justice is releasing trial balloons in relation to decriminalization. Apart from the merits of this approach–to be discussed at length in this chapter – it is clear that tinkering with the criminal legislation is not indicative of an authentic public policy. In this Committee's view, **a public policy on cannabis must be, first and foremost and essentially, a public health policy based on encouraging government and users to assume more responsibility.**

On a general level, the tendency to reduce drug issues to the legal framework fits neatly into the increasing juridicization of social relations, a situation in which legislation is the central, sometimes the only, tool of government policy. However, in the matter of illegal drugs, other factors are also at work.

On the one hand, this attitude has been at the very heart of the approaches to drugs throughout the twentieth century, approaches in which criminal prohibition guides - and restricts - public policy. It is only because of the AIDS crisis that the merits of harm-reduction approaches have been "discovered." Even then, decision-makers were often preoccupied more with protecting non-user members of society than with improving the health of drug users. When governments decided to tackle the criminal behaviour of drug users deriving from the criminalization of drugs (we do not mean organized crime and drug traffickers), the aim was not so much to improve drug users' living conditions but to protect non-users from drug-related "mischief."

On the other hand, criminal prohibition is often thought of as the "ultimate stronghold" against uncontrolled proliferation of drug use. Without criminal prohibition, we were told, cannabis consumption might well explode out of control. The underlying hypothesis, rarely stated explicitly, that criminalizing drugs contributes effectively to reducing their use, has never been demonstrated, however. Quite the

contrary, as this chapter will show, available data tend to demonstrate that prohibitionist policies have little impact on levels of use or availability of drugs.

Public policy cannot be reduced to adopting legislation, the more so since laws rarely contain clearly stated guiding principles setting out aims and objectives. In respect of illegal drugs, where the key issues are, first and foremost, matters of public health and culture (including education and research), and where criminal law should be used only as a last resort, public policy must be based primarily on clear principles and objectives. For this to come about, public policy must be equipped with a set of tools designed to deal with the various issues that drugs represent to societies. Legislation is only one such tool.

The social and economic costs of illegal drugs affect many aspects of society through lower productivity and business loss, hours of hospitalization and medical treatment of all kinds, police time and prison time, and broken or lost lives. Even if no one can pinpoint the exact figures, a portion of these costs arise, not from the substances themselves, but from the fact that they are criminalized. The drug most frequently associated with violence and criminal offences, including impaired driving, is in fact legal, alcohol.[1] Cannabis, the criminal organizations that control part of the production and distribution chain aside, neither leads to crime nor compromises safety. Even its social and health costs are relatively small compared to those of alcohol and tobacco. In fact, more than for any other illegal drug, we can safely state that **its criminalization is the principal source of social and economic costs**.

However, in spite of the fact that the principal social costs of drugs affect business, health and family, the emphasis on the legal debate tips the scales of public action in favour of law enforcement agencies. No one can deny that their work is necessary to ensure public order and peace and to fight organized crime. At the same time, over 90% of resources are spent on enforcing the law, the most visible actions with respect to drugs in the public sphere are police operations and court decisions and, at least in the case of cannabis, the law lags behind individual attitudes and opinions, thus creating a huge gap between needs and practice.

Most national strategies display a similar imbalance. The national strategies that appear to have the greatest chance of success, however, are those that strive to correct the imbalance. These strategies have introduced knowledge and observation tools, identified indicators of success with respect to their objectives, and established a veritable nerve centre for implementing and monitoring public policy. The law, criminal law especially, is put in its proper place, that of one method among many of reaching the defined objectives, not an aim in itself.

This chapter is divided into three sections. The first examines the effectiveness of legal measures for fighting drugs and shows that legal systems have little effect on consumption or supply. The second section describes the various components of a

[1] Please refer to the recent CCSA study: Permanen, K., et. al., *op. cit.*

public policy. The third considers the direction of criminal policy, and defines the main terms used: decriminalization, depenalization, diversion, legalization, and regulation.

INEFFECTIVENESS OF CRIMINAL POLICIES

Two key indicators are usually applied to measure the effectiveness of drug-related criminal policy: reduced demand and reduced supply. Some authors attempt to measure the economic efficiency of various control options[2]; we do not address this aspect as the data are incomplete.

The methods of measuring the impact of public policy on supply and demand are faced with a series of methodological pitfalls. Firstly, the two indicators are relatively artificial and not easily distinguished from one another. In other words, a given measure impacts both indicators simultaneously and are often accomplished by the same institution For example, a police officer conducting drug "education" in schools, theoretically for the purpose of affecting demand, also works to reduce supply. Secondly, the capacity of agencies responsible for affecting one or the other depends on a series of factors relating to their means and resources, their practices and skills, and their competence. For the police, the number of officers per capita and the general thrust of law enforcement services (community police, traditional more reactive police) as well as the priority given to drug-related offences, can influence the volume of reported incidents as well as the decision to lay a charge. Generally speaking, the total resources allocated by a government to its drug policy may affect one or both of these indicators. In short, effectiveness cannot be measured directly.

It is even more difficult to assess, even indirectly, the impact of action taken, when clear objectives, ideally associated with indicators, are not defined, as is the case in Canada at this time, as was seen in Chapter 11. This being the case, and because we are in no position to make a rigorous assessment of public policy on drugs, we will examine the question on the basis of a series of indirect indicators.

Impact on consumption

General policy direction

At the most general level, national governments (see preceding chapter) define a general direction for their policies on drugs. Some are more tolerant or permissive (e.g., the Netherlands, Belgium, Spain, and Germany); others stress prohibition and abstention (e.g., the United States, Sweden, France). Admittedly, these are crude

[2] See Jackson, A.Y. (2002) *op. cit.*, and our discussion in Chapter 18.

categories, ignoring the complexity of each country's policy. Even in the U.S.A. with its "war on drugs", individual cities and states may implement widely different measures. Furthermore, there is often a huge gap between public policy statement and concrete action. For example, in France, a tough stance on use is accompanied by limited user-related police activity. In Canada, as a number of witnesses told us, enforcement by police is often at odds with "lenient" court decisions. In other words, there is no direct relationship between political statements and concrete action.

Some comparative studies have attempted to determine whether or not public policy influences use levels. A study by Reuband compares "tolerant" European countries (the Netherlands, Spain, Denmark, and Italy) and restrictive countries (Germany, France, Norway, United Kingdom, and Sweden). The study found no significant differences between consumption levels, regardless of public policy direction.[3]

The "Message" of the *Conseil fédéral suisse sur la révision de la loi sur les stupéfiants* reports the results of a comparative study on seven European countries by Cesoni, which reached the conclusion that the legal regime had no influence on the frequency of consumption.[4]

Another study carried out for the *Office fédéral suisse de la Santé publique* classifies the policies of European countries on a line from "very liberal" to "very restrictive", relating them to the lifetime prevalence of cannabis consumption. The study shows no relation between severity of legislation and level of use.[5]

We have drawn up two similar charts, classifying the policies of the various countries and adding Canada, Australia, and the United States. We used the Chapter 6 data on lifetime prevalence of consumption in the general population (Chart 1) and in the past month among 15-16 year olds (Chart 2).

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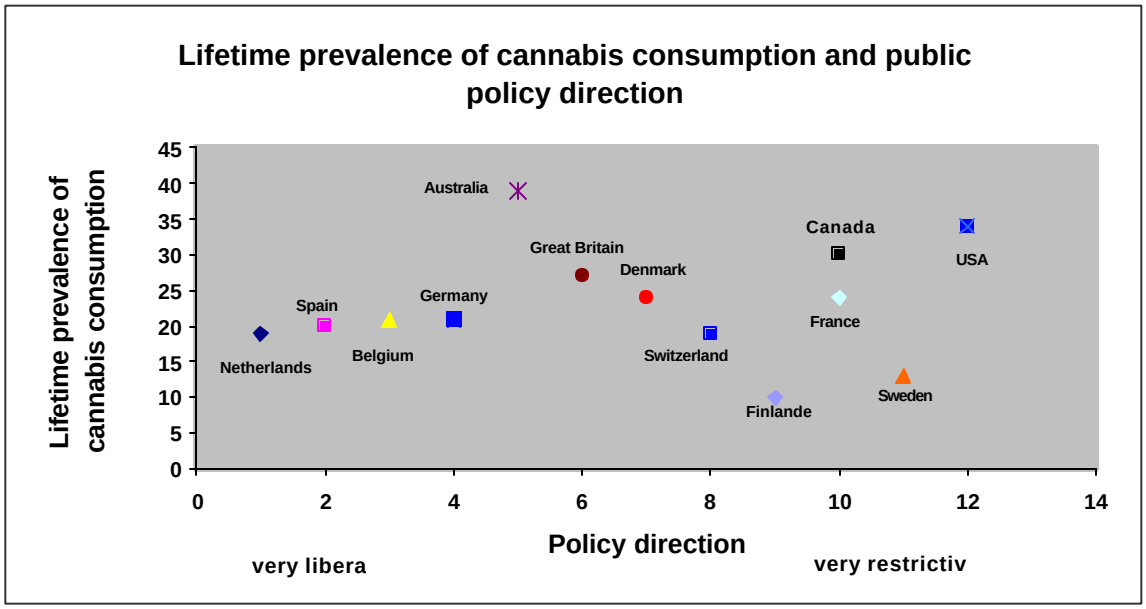
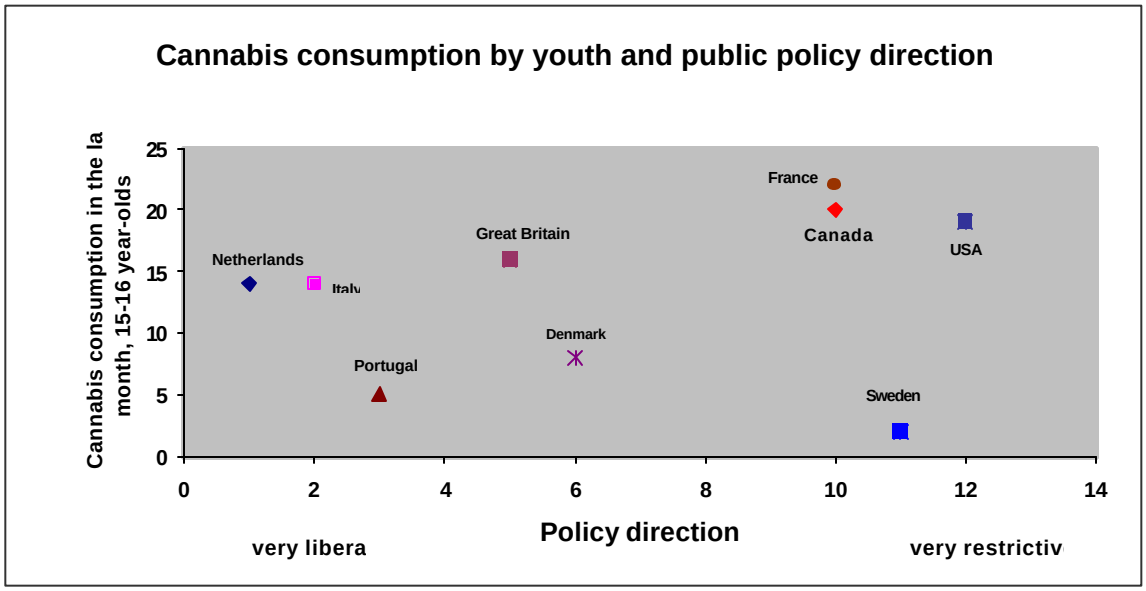
[3] Reuband, K., (1995) "Drug use and drug policy in Western Europe." *European Addiction Research*, vol. 1, 32-41.

[4] Cesoni, L.L. (1999) *Usage et actes préparatoires de l'usage des drogues illicites : les choix en matière d'ncrimination. Analyse comparative de l'usage de drogues illicites de sept législations européennes. In Conseil fédéral suisse*, op.cit., page 3560.

[5] *Conseil fédéral Suisse* (2001) *Message concernant la révision de la loi sur les stupéfiants*, page 3560.

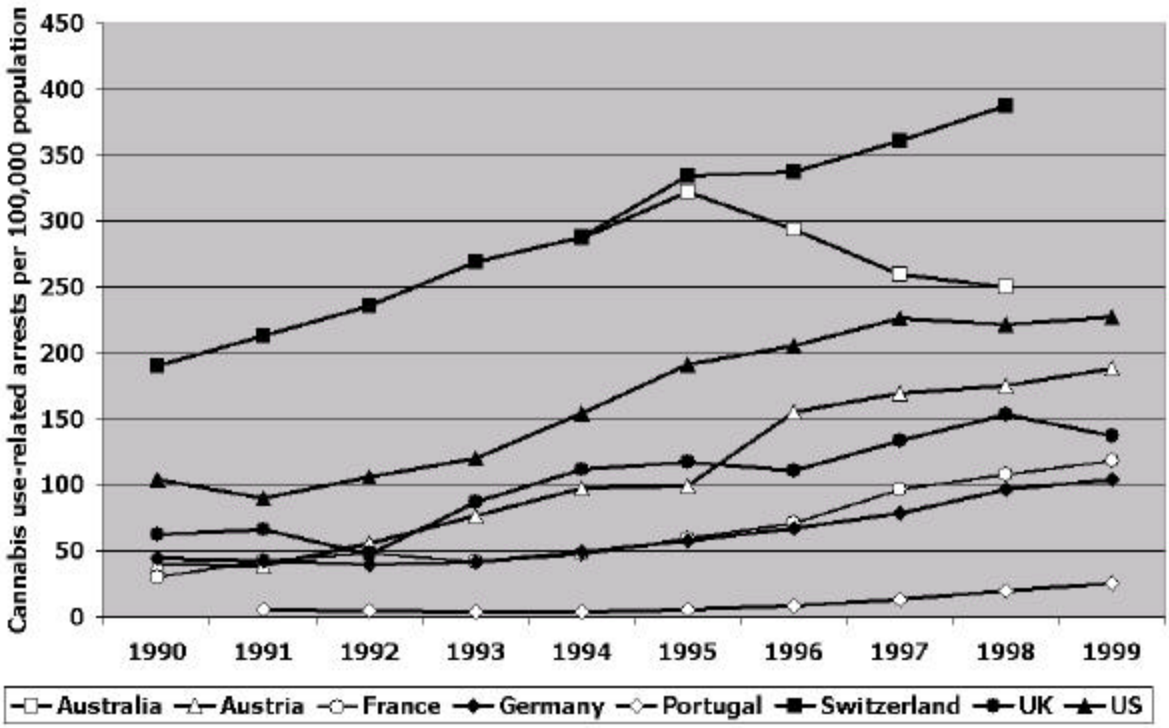




The charts show no direct relationship between consumption levels and public policy direction. Very liberal countries show low rates (Spain, the Netherlands, Portugal), whereas countries that have very restrictive policies show high rates (USA, Canada, France). Of course this may be explained by the fact that these are static statistical data not a time series, and are thus little influenced by variations from year to year. Another possible explanation is that, as few users are arrested, there is a strong inconsistency between words and action. The following section looks at this issue.

Cannabis consumption and arrests

A number of authors have looked at the relationship between arrest levels and delinquent behaviour in general, and in drug consumption in particular. One recent study was conducted by Kilmer[6] within the context of the International Scientific Conference on Cannabis. The following graph is from that study.



The graph shows that, in all countries, the number of arrests per inhabitant for simple possession of cannabis increased during the 1990s, with Australia the only exception. Switzerland, currently considered relatively moderate, has the highest level of arrests per inhabitant, followed by the USA, Austria, the United Kingdom, France, and Germany.

Here again there appears to be no direct relationship between direction of public policy and arrests. Switzerland and Australia, both of which have far more moderate policies than the USA, arrest proportionally larger numbers of people than that country, although Switzerland's consumption rate is far lower than that of the USA, and Australia's is virtually the same.

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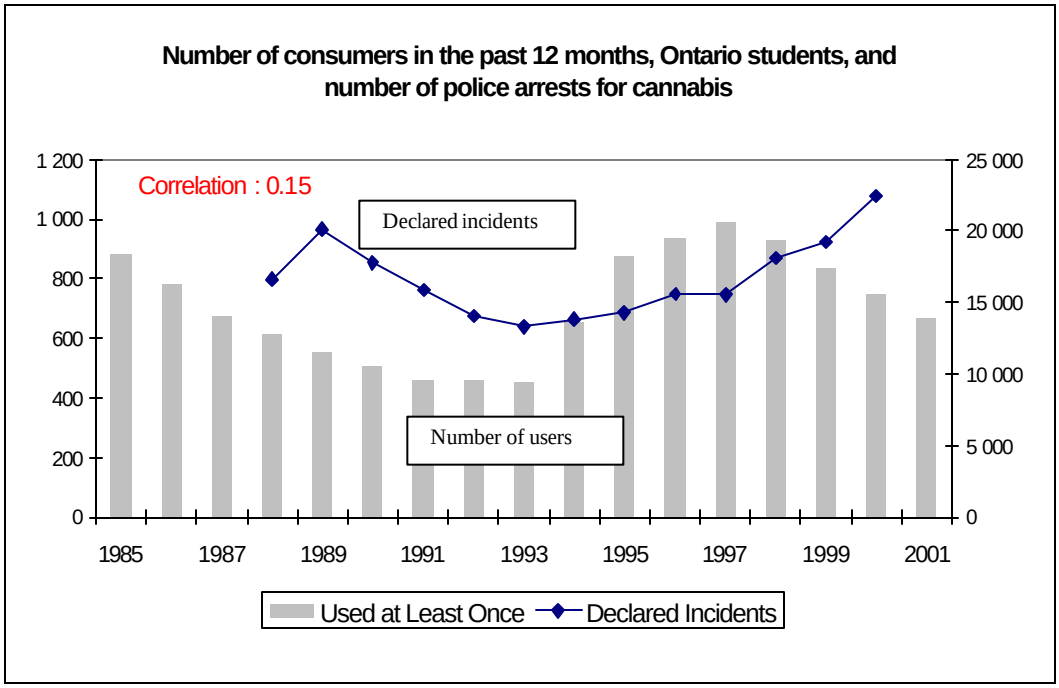
6 Kilmer, B., (2002) "Do cannabis possession laws influence cannabis use?" in Pelc, I. (dir.) International Scientific Conference on Cannabis. Brussels.

The variation in rates of arrest cannot be explained by the number of police officers per inhabitant. France has far more officers than does the USA or England, but arrests far fewer people than the USA and fewer than the UK for simple possession.

We created a graph charting the relationship between the number of users among high school youth in Ontario in the past twelve months and incidents declared by the police of cannabis-related offences in the same year in Ontario. We chose Ontario because it is the only province that produces continuous time series on consumption levels, and the Ontario figures are almost identical to the Canadian mean (Chapter 14). The results are shown below.



The graph shows a very weak statistical relationship (0.15) between police activity and cannabis use. In other words, police activity has no dissuasive effect on cannabis experimentation by young students.

Criminology teaches that probability of arrest carries far more dissuasive weight than severity of sentence. As the following table shows, the probability of arrest is very low for cannabis possession offences.

Probability of being arrested for cannabis possession[7]

	1995	1996	1997	1998	1999
Germany			2.7%		
Australia	3.7%			2.1%	
Austria	1.7%		1.7%		2.0%
Canada	1.8%				
United States	2.8%	3.0%	3.1%	3.2%	3.2%
France					2.0%
United Kingdom		2.1%			
Sweden			2.4%	2.9%	

Public spending

While none of the preceding factors appears related to consumption levels, can a case be made for public spending?

There is danger in trying to estimate the overall cost of public policy on drugs. Even for a budget item as seemingly well-defined as law enforcement, estimates are unreliable. As we saw in Chapter 14, the cost of law enforcement ranges from $700 million to $1 billion. Figures on public expenditure related to treatment and prevention, even if we know that they are much smaller than those for law enforcement, are equally unreliable.[8]

Making international comparisons is even riskier. Services are organized differently, costs are not accounted for in the same way, and service orientation and overall government direction vary widely.

With these reservations, we will attempt the exercise based on data from a number of sources. To make the results a little more comparable, we restrict the comparison to law enforcement expenditures which, in any case, account for between 70% and 90% of public spending relating to illegal drugs. The following table summarizes the data. (Note that, for Canada, we have used the data from the CCSA study rather than our own estimates from Chapter 14. Our data show a cost estimate of law enforcement (police, courts, prisons) of approximately $1.5 billion or $50 per capita).

[7] Table reproduced from Kilmer, B., *op.cit*, page 108.

[8] See Kopp, P. and Fenoglio (2000) *Le coûts social des drogues licites (alcool et tabac) et illicites en France.* Paris: OFDT.

Costs of enforcing legislation in various countries

	Cost of enforcing legislation	Per capita costs
Germany, 1992 [9]	DM 6.3 billion	
Australia, 1992 [10]	A$450 million	
Canada, 1992 [11]	US$300 million	US$10
United States [12]	US$12.3 billion	US$40
France, 1998 [13]	US$500 million	US$8
The Netherlands [14]	US$230 million	US$15

We note that countries in which consumption levels are average (Germany, the Netherlands) spend less than the USA, which has a high consumption rate; in addition, these countries, specifically, show law enforcement expenditures above those of two far more restrictive countries (France and Canada).

In short, here again cannabis consumption levels appear unaffected by public policy that aims to reduce demand by cracking down on use.

Impact on supply

Does public policy affect drug availability or price? The available data suggest not.

In spite of sustained efforts to exert national and international control, battle drug trafficking (macro and micro, local and international), the availability of drugs, and cannabis in particular, has not fallen. Price has fallen significantly (e.g., heroin, cocaine) or remained relatively stable (e.g., cannabis and derivatives).[15] The relative price increase for some grades of cannabis is at least as closely linked to attempts to improve

[9] Source: Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Brief presented to the Special Senate Committee on Illegal Drugs, page 13.

[10] Source: Rehm, J., (2001) *The Costs of public policies to fight illegal drugs.* Brief presented to the Special Senate Committee on Illegal Drugs, page 13.

[11] Single, E., et. al., *op. cit.*

[12] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[13] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[14] Source: Kopp, P. and C. Palle (1999) *"Économistes cherchent politique publique efficace."* in Faugeron, C., (ed.) *Les drogues en France.* Paris: Georg, page 261.

[15] See above, in the United States, one of the most complete studies on the question: Abt Associates (2001) *The price of illicit drugs: 1981 through the second quarter of 2000.* Washington, DC: Office of National Drug Control Policy.

"quality" (e.g., THC content, organic cultivation) and the large profit margin earned by producers and traffickers, as it is to the efforts of law enforcement agencies.

Conclusion

The title of this section includes our conclusion: **if the aim of public policy is to diminish consumption and supply of drugs, specifically cannabis, all signs indicate complete failure. We agree with the conclusions from the Swiss studies that prohibiting cannabis use through the application of criminal law appears to have little, if any, influence on levels of use.**

One may think the situation would be worse if not for current anti-drug action. This may be so. Conversely, one may also think that the negative impact of anti-drug programs that are currently centre stage are greater than the positive effect, specifically non-compliance with laws inconsistent with majority attitudes and behaviour.

One of the reasons for this failure is the excessive emphasis placed on criminal law in a context where prohibition of use and a drug-free society appear to remain the omnipresent and determining direction of current public policies.

Does this mean nothing can be done? We do not believe so. Does it mean market forces should be allowed to rule as if drugs were goods like any other commodity, a solution suggested by some free-market advocates?[16] Certainly not. Psychoactive substances, including cannabis, alcohol, and medications, are not ordinary commodities. Although cannabis (see Chapter 7) does not have the deleterious effects that some people claim and is in some respects a less harmful substance than tobacco, it must be the subject of regulation and government intervention.

The question raised by the patent and costly failure in human, social, and economic terms of Canada's public policy direction to date, is what should be the direction and components of public policy on cannabis and, as a corollary, the role and direction of legislation. This is what is discussed in the following sections.

GENERAL ECONOMY OF A PUBLIC POLICY ON CANNABIS

We are fully aware of the somewhat artificial distinction imposed by our mandate between cannabis and its derivatives and other psychoactive substances. Different substances lead to different types of uses. This is as true of cannabis as it is of alcohol, medications, cocaine, or ecstasy. The uses differ with the substance - cannabis consumption differs from consumption of medications or even alcohol. There is nonetheless a common basis to the non-medical uses of psychoactive substances, which are primarily seen as a source of pleasure, even a method of enhancing awareness and the senses. There are of course other forms of use: abuse, for example, is not based

[16] For example, economist Milton Friedman.

on pleasure but rather a physiological and psychological mechanism symptomatic of loss of control, even distress. Nevertheless, throughout history human beings have consumed psychoactive substances for reasons relating to self-liberation.

Uses also differ for a given substance. Cannabis use, originally associated with self-medication and religious rites, in twentieth century western societies became an expression of a counter culture and the hippie movement, before becoming a recreational drug. Although most cannabis use is self-regulated, in some cases, when associated with at-risk behaviour, use can lead to abuse.

For public policy on psychoactive substances to adequately encompass the common dimensions of substance use, it must be **integrated**, yet flexible enough to allow for **approaches that are adapted** to different substances.

An integrated public policy on drugs would be administered by a decision-making body capable of making links between the substances and their uses so as to propose a meaning to different drug uses. A public policy on drugs revolves around the varying uses made of drugs and not on the substances themselves. In other words, an approach more like that taken by France's *Mission interministérielle* instead of an approach by multiple decision-making bodies, each one operating in a functional silo, in competition with the others as in the States, or for that matter in Canada, where illegal drugs, tobacco and alcohol are handled by different agencies.

An adaptable policy would be able to propose, define and develop tools suited to the various substances. Abuse of cigarettes causes lung cancer, not death due to impaired driving. Some medications, however, do lead to fatal accidents. Cannabis may be associated with both problems: cancer related to combustion, and highway accidents related to psychomotor effects. We must be in the position to understand what is specific to a given substance and what is common to a variety of substances.

A public policy, both integrated and adaptable must aim for knowledge of the relationship between substances and methods and contexts of use, in order to define the determining factors that separate non-problematic self-regulated consumption, from at-risk behaviour, and excessive use and related problems. There are two broad types of problems: the first affect user health, the second the health and safety of others; they must be dealt with in different ways. Certain measures must be preventive - inform users of risks and, specifically, help individuals recognize the signs of at-risk behaviour that can lead to problems. Those who consistently smoke between three and five cigarettes a day, something very few tobacco consumers may be able to do, are probably at no greater risk of lung cancer than non-smokers. Learning to manage consumption, recognizing the dangers, and having the means and the tools to do so are key. Other methods are dissuasive in nature: where drinking and driving are involved for example. Finally, some measures are curative: whatever the substance, from simple aspirin to heroin, for all kinds of reasons that pre-date consumption of the substance itself, some individuals consume abusively in a way that leads to health problems. The tools for treatment and cure must be available.

Thus, and this is the third criterion, a public policy on psychoactive substances must primarily be a **public health policy**: prevention, abuse deterrence, and treatment are the three prongs of public health intervention. A public health policy does not attempt to oblige people to live healthy lives or to have the community decide individual behaviour for some elusive public good. What we envision is a public health policy that contributes to **reducing the risks relating** to the different uses of different substances. A public health policy on psychoactive substances is thus a risk reduction policy.

Harm reduction approaches have been associated with needle exchange or the prescription of methadone or heroin. Some think that harm reduction policies rely too heavily on a medical model, simply softening the negative effects of an otherwise prohibitionist regime.[17] Harm reduction has been described as a "*transition doctrine, contradictory and ambiguous, with the ambiguity enabling unlimited adaption*." [Translation][18] Even worse, according to American psychiatrist Thomas Szasz, it is a morally repugnant position reflecting government therapeutic paternalism.[19]

We believe that what is essential is recognition that (1) use of psychoactive substances cannot be eliminated, it is part of the human experience and not all use is abuse - whatever the substance - and (2) all substances can have negative consequences for both the user and society, making it advisable to contribute to individual and community well-being by providing information, abuse prevention tools and a treatment infrastructure. Recognition that an individual is no less a citizen, indeed no less a good citizen, because he chooses to smoke cannabis rather than drink alcohol, or chooses to use rather than abstain, but that individuals and societies, according to the circumstances and method of consumption, will have different needs is the key .

A public policy on drugs does not target users: its implementation embraces them. For too long, in any discussion of illegal drugs, including cannabis, the focus has been on understanding the characteristics specific to consumers, as if they had some feature distinguishing them fundamentally from users of tobacco, alcohol, or psychotropic medications for non-medical use. Although problem users may indeed have common characteristics, it is neither the substance nor being a user that is the question: other factors underlying development of at-risk behaviour should be given more attention.

Some people told us that harm and risk reduction policies, or for that matter decriminalizing cannabis, would "trivialize" its use. On the contrary, this is normalization, not trivialization. Excessive use of any substance is harmful: all substances may endanger user health, even coffee. Normalizing the use and the user does not mean trivializing them. A public policy on drugs aims to **normalize uses of psychoactive substances:** that implies not marginalizing users, while at the same time

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[17] For example, critical assessment in Caballero and Bisiou, pages 114-115.
[18] *Ibid.*, page *116.*
[19] *Ibid.*, page 120

not trivializing use and shrugging our shoulders, ignoring the dangers specific to various substances.

To summarize: a **public policy on psychoactive substances must be both integrated and adaptable, target at-risk uses and behaviours and abuses taking a public health approach that neither trivializes nor marginalizes users**. Implementation of such a policy must be multifaceted, as we will see now.

COMPONENTS OF A PUBLIC POLICY

The public policies described in the preceding chapter, as well as the policies of Denmark, Portugal, and Mexico, have a number of elements in common: they rely on a strong decision-making body, promote interconnection and multiple viewpoints, aim at national consensus on clear and measurable objectives, and rely on independent knowledge and assessment tools.

Strong decision-making body

One may disagree with the political orientation of the American Office of National Drug Control Policy (ONDCP); but no one can deny the office gives strong direction to American national policy on drugs. Although one may be critical of the structural rigidity of the French *Mission interministérielle* (MILDT), or its timidity with respect to legislative debate, however, one cannot help but agree that the MILDT has strongly influenced French policy and practice in the past five years. Each country covered in the preceding chapter has a highly visible, well-known decision-making body that has undeniable legitimacy and methods of action that meet expectations.

In our opinion, the question of drugs, inasmuch as it is broader than the jurisdiction of a single government department or level of government, inasmuch as it refers to our collective ways of relating to society and others, and especially inasmuch as it demands both integration and differentiation, must be governed by an agency that is not accountable to a particular department and can define direction for (not enforce diktats on) all players.

Interconnection

The policies on psychoactive substances are the concern of educators and therapists, police officers and anthropologists, diplomats and local associations and, of course, users. The ability to tie things together for knowledge and comprehension purposes supposes an ability to link specialties, administrations, individuals. This is the meaning of interconnection that a public policy must be capable of making.

A shared definition of shared objectives

In Chapters 11 and 18, we saw that federal policy on drugs, in addition to lacking rigour and clarity, means and infrastructures, is not a national policy. This does not mean there is no place for specific approaches by the provinces and territories that make up the Canadian mosaic. However, if a common culture on drugs is to emerge, if we are to better understand behaviours of use through geographic comparison, if players are to benefit from the experience of others, tools must be developed for the joint definition of shared objectives.

Moreover, the ability - and the will - to define objectives is the foundation of any future evaluation to determine whether or not the action taken is in sync with the objectives and is effective; in short, defining objectives is necessary because we must be able to assess the impact of what we do.

Information tools

A public policy must also rest on knowledge. Many witnesses, from all over, told us this. European Union member countries, the United States and Australia have developed powerful knowledge tools, specifically agencies that monitor drugs and drug addictions. These monitoring agencies, most of them independent of the government and political influence, are capable of measuring changing trends and forms of use of various substances, understanding emerging trends and new products, even assessing public policies. We are unable to see how Canada can fail to develop a national knowledge tool on psychoactive substance use.

LEGISLATIVE OPTIONS

So what do we do with the legislation? Legislation stems from public policy direction, which it supports and completes; it is a means, not an end.

Cannabis debates are highly contaminated by discussions on decriminalization, depenalization, legalization. The terms are frequently poorly understood, especially as they are not necessarily clear. This section defines each key term in the debate and suggests indicators that can be used to assess each option.

Clarification of terminology

Decriminalization or depenalization

The United Nations Drug Control Programme (UNDCP) glossary of terms on drugs gives the following definitions of the two terms.

> ***Decriminalization or depenalization***
> *Removal of penal controls and criminal sanctions in relation to an activity, which however remains prohibited and subject to non-penal regulations and sanctions (e.g., administrative sanctions such as the removal of driving licence).*
> *Under the "prohibition with civil penalties" option, the penalties for the possession of amounts of drugs deemed in law as being for personal use are still illegal but are dealt with by civil sanctions such as infringement notices which attract a monetary penalty, rather than by criminal sanctions such as a criminal record or imprisonment. Typically, the harsher criminal penalties still apply to the more serious offences of possession, supply, manufacture or cultivation of amounts of the drug deemed in law to be for trafficking or commercial purposes.* [20]

For Caballero and Bisiou, depenalization means essentially removing drugs from the field of criminal law. They distinguish between total depenalization and depenalization of use.[21] The first removes all control except free-market forces. This is a far cry from the UNDCP definition. Depenalization of use corresponds more closely to decriminalization as defined by UNDCP. It is also the definition given by the European Monitoring Centre for Drugs and Drug Addiction.

Possessing or holding cannabis for personal use has been decriminalized in Germany, Australia, Spain, Italy, Portugal, the Netherlands, and some American states. The resemblance ends there because each country has slightly different way of reaching the goal. In Australia and the American states where possession of cannabis has been decriminalized, possession remains illegal and subject to a fine. In Germany, the constitutional court has ruled that prosecution for possession of small quantities of cannabis contravenes basic rights and is unjustified. In Spain and Italy, possession of small amounts of cannabis is not an offence and consumption is authorized except in public places. However, as in Portugal, individual possession of cannabis is subject to an administrative penalty (fine in Spain and Portugal; suspended licence in Italy).[22] In the Netherlands, the possession offence has never been repealed, although use and certain types of sale (coffee shops) are tolerated.

In all cases, decriminalization is partial. It is sometimes *de jure* (Spain, Italy, Portugal) and sometimes *de facto* (the Netherlands, Denmark).

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[20] UN Office for Drug Control and Crime Prevention (2000) *Demand Reduction. A Glossary of Terms.* Vienna: author, page 18.

[21] Caballero and Bisiou, *op.cit*, page 117.

[22] See EMCDDA (2001) *Decriminalisation in Europe? Recent Developments in Legal Approaches to Drug Use.* Lisbon: author, available on line at www.emcdda.org

In Canada, some authors have written in favour of decriminalizing cannabis. One of the best known papers on this option may be that published by the policy committee of the Canadian Centre on Substance Abuse.[23] The authors identify four options for decriminalization:

- Fines under the *Controlled Drugs and Substances Act* (CDSA) excluding incarceration as a possible sanction. The option retains the illegality of cannabis possession and related criminal record consequences.
- Civil offence: here again the sanction is a fine, although the option differs from the first in that cannabis possession is no longer sanctioned under the CDSA, but subject to a sanction under the *Contraventions Act.*
- Alternative measures (or diversion): under this option, possession remains a punishable criminal offence, but sanctions are suspended if the offender agrees to another form of "treatment" or community service. Drug treatment courts are a form of alternative measure.
- Transfer to the provinces: under this approach, the provinces would be free to adopt the control measures they deem necessary (with the exception of criminal measures which are exclusively federal). However, it is difficult to understand the reasoning of the authors on this approach as it is more a form of legalization than decriminalization.

In Quebec, the *Comité permanent de lutte à la toxicomanie (*CPLT*)* has made a recommendation proposing diversion measures when deemed appropriate by the authorities.[24] The CPLT defines diversion as the "*exercise, by the Crown prosecutor, of a discretionary power enabling him to desist from prosecuting the offender and instead apply alternate measures*" [Translation].[25] However, diversion may be given a broader definition, in which the discretionary power is exercised by the police prior to a charge, giving a consumer a simple warning. The CPLT opinion notes the following.

- Cannabis related offences account for at least 60% of offences under the CDSA, with possession the most frequent.
- The number of offences for possession of cannabis is rising, whereas the proportion that lead to prosecution is falling, even though such prosecution remains in a majority (approximately 60% of 1997 cases).
- The practice of laying charges and applying alternative measures varies among regions of Canada and within Quebec.
- Most sentences handed down by the courts are fines.

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[23] Fischer et al., (1998) "Cannabis Use in Canada: Policy Options For Control.' *Policy Options.* October.
[24] *Comité permanent de lutte à la toxicomanie* (1999) *Avis sur la déjudiciarisation de la possession simple de cannabis.* Montreal: CPLT.
[25] *Ibid.*, page 2.

This timid recommendation refuses to take a systematic approach and even links cannabis consumption to delinquent or criminal activities, relating risk to consumption of products with a high THC concentration, as if consuming spirits should be subject to stronger measures than drinking wine.

The term "decriminalization" is obviously loaded with contradictions. Even though the term purports to remove it from the ambit of criminal law, cannabis consumption remains illegal. The sanction may be less severe, but a sanction still applies, one that, in some cases, can have the same impact as a criminal sanction and entail even greater discrimination: a young or disadvantaged person unable to pay the fine faces a far greater risk of ending up in prison than an adult or socially secure individual. As explained to the Committee by Dr. Kendall:

> *However, a cautionary note should be sounded. If Canada did adopt this recommendation, we should be concerned and thus take steps to avoid the situation in Australia, or to repeat that situation, where the imposition of a cannabis expiation program actually led to a net widening effect, because the police now ticketed individuals that they had previously ignored. Many of those so ticketed failed to appear to pay their fines, and subsequent numbers entered the criminal justice system for non-payment of fines and subsequently received criminal convictions. There was an unintended result in that the number of persons criminalized is as large, or perhaps larger, than before the measure was implemented.* [26]

In spite of its merits and success, the Dutch system of controlled cannabis sale, a form of *de facto* decriminalization, has no way of regulating production and distribution, which is still controlled at least in part by organized crime, or exercising quality control, specifically the concentration of THC.

In the opinion of some authors, decriminalization is in fact simply less severe prohibition.[27] In other words, in the guise of a socially responsible and rational measure, decriminalization in fact furthers a prohibitionist logic. Same grounds, different form. This model has no greater capacity for prevention or education than a strict prohibition model. Even worse, the prohibition model is based on clear and consistent theory, whereas the same cannot be said of decriminalization as an approach.

Some will say that decriminalization is a step in the right direction, one that gives society time to become accustomed to cannabis, to convince opponents that chaos will not result, to adopt effective preventive measures. We believe however that **this approach is in fact the worst-case scenario, depriving the State of a regulatory tool needed in dealing with the entire production, distribution, and consumption network, and delivering a rather hypocritical message at the same time.**

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[26] Dr. Perry Kendall, Medical Health Officer for the Government of British Columbia, testimony before the Special Senate Committee on Illegal Drugs, Senate of Canada, First session, Thirty-seventh Parliament, September 17, 2001, Issue 6, page: 40.

[27] MacCoun, R., Reuter, P. and T. Schelling (1996) "Assessing alternative drug control regimes." *Journal of Policy Analysis and Management.* Vol 15, no 3, page 332.

Legalization

The United Nations glossary of terms defines this term as follows.

Legalization

Removal of the prohibition over a previously illicit activity, e.g., non-medical trade or consumption of psychoactive substances. It does not necessarily imply the removal of all controls over such activity (e.g. restriction on sale to minors). [28]

The term "legalization" is equivalent to Caballero and Bisiou's concept of depenalization, although it does not rely solely on market forces but includes a form of regulation entailing some restrictions. To quote:

> *Controlled legalization is a system that aims to replace existing prohibition of drugs by regulation of their production, trade, and use with a view to restricting abuse that can damage society (…) unlike depenalization, penal law retains its role in preventing damage to third parties by users (drunkenness) or producers (contraband). [Translation]* [29]

No system for controlled legalization of cannabis currently exists. Switzerland comes close with its bill to amend the *Loi sur les stupéfiants*. This type of regulation is nothing new: colonial opium and kif regulatory bodies operated well into the first half of the twentieth century.

Conversely, legalized systems exist for the manufacture, distribution, sale and production of such products as alcohol, tobacco, and psychotropic medications. These could be used as a model for regulating the cannabis production chain.

Regulation

The United Nations glossary of terms defines regulation as follows:

Regulation

The rules governing all aspects of drug control promulgated pursuant to legislation. Violation of these rules may attract criminal or non-criminal penalties, such as fines and license suspension, depending on the seriousness and the intentional nature of the violation. [30]

Although one may play with words, regulation is in fact a necessary application of any form of control, whether within a system of prohibition or a system of legalisation. All consumer products, from the automobiles we drive to the food we eat, are subject to some form of regulation. Quality control, environmental standards, compliance with industrial standards, regulations on accessibility—all are forms of regulation essential

[28] UNDCP (2000) *op.cit*, page 41.
[29] Caballero and Bisiou, *op.cit*, page 132.
[30] UNDCP (2000) *op.cit*, page 63

for ensuring no one is poisoned by the food they eat, drives a defective vehicle, or plugs in a dangerous appliance.

Regulation is the most current form of government control; criminal law usually intervenes when the controls fail or mandatory standards are not met.

The same is true of the current international system for controlling narcotics. Canadian legislation deals with "controlled" substances. The control system may range from prohibition of all non-medical and non-scientific use (e.g., opium, cocaine, cannabis), to less severe control measures that allow accessibility to products deemed dangerous, under specific conditions.

Classification of legal policy systems

MacCoun, Reuter and Schilling examine various systems of legal policy, which they divide into three main types: prohibitionist, controlled access, and regulated access, each of which can be broken down further. Their classification system is reproduced below.[31]

Prohibitionist systems vary along a number of lines: based on the nature of prohibited activity (e.g., possession, use, use in public); based on the severity of sanctions (civil penalty, criminal penalty, imprisonment); based on the severity of enforcement (resources, priorities); and based on the capacity to exercise discretionary power (diversion, alternative measures). This makes it clearer why decriminalization remains in essence a prohibitionist approach, albeit a less severe one.

Controlled access systems are in a grey area somewhere between prohibition and regulation. In some ways, they are more like prohibition models, particularly by giving powers of decision to a physician or pharmacist rather than promoting individual user responsibility. This is the medical model criticized by Szasz, Caballero and, closer to home, Malherbe, in his discussion paper on the role of ethics and public health. One can see why harm reduction approaches belong in this grey area, somewhere between prohibition and regulation, with the prescription of methadone or heroine for treating addiction the perfect example of medical power.

The third type is the regulatory model that exercises various types of control on who (who may purchase, restrictions on minors), what (different accessibility levels for different substances), how (point of sale, location, requirement for producers and vendors) and when (time of day, days of the week).

[31] MacCoun and coll., *op. cit*, page 333. [1996 issue vol.15 not available]

Prohibitionnist	Pure prohibition : no use possible (i.e., cannabis)	Decreasing restriction ↓
↕ Controlled access	Prohibitionist prescription : medical and scientific purposes only	
	Treatment : prescription for the treatment of dependency (i.e., methadone)	
↕ Regulatory	Regulated prescription : auto administration under prescription to treat medical conditions (i.e, Valium)	
	Positive licensing : available to any adult with a licence to demonstrate his capacity to make responsible use	
	Negative licensing : accessible to any adult who has not violated some condition (i.e., criminal behaviour)	
	Free market for adults : similar to alcohol	
	Free market : no regulation (i.e., coffee).	

In our opinion, **there are basically only two systems:** a prohibition system and a legalization system. Both rest on regulation, and the nature and direction of this regulation determines their specific features.

Prohibitionist systems may be subdivided into criminal and medical prohibition. In the first case, sometimes referred to as outright prohibition, the justice system (police and the courts) is central. In the second, the physician is the key player. In both cases, the user is considered a "minor", a person in danger who must be protected from himself. Some call this legal paternalism. Both variations can be more or less strict, more or less severe, but rest on the concept that all use that poses a danger to the user and society and must be strictly controlled. In this scenario, **decriminalization of use is a weak variation of prohibition**, in the long run entailing more disadvantages than advantages. In addition to failing to affect the production chain and retaining the illegal aspect, it leaves no room for dispensing information to and promoting responsible behaviour by users, or for strong preventive measures. Conversely, **the harm**

reduction approach is a strong variation of a prohibition system. While this approach recognizes the impossibility of eliminating the damage done by market criminalization, it seeks nonetheless to reduce the negative effects of prohibition on users, who are the focus of its main thrust, by introducing education on drug content (for example, analysis of ecstasy consumed at raves).

Prohibition System

	Main player	Degree of prohibition	Severity
Criminal	Police / Justice	Prohibition of fabrication, cultivation, production, sale, trafficking, use and consumption Decriminalization of use with criminal process / diversion Civil offences	↓
Medical	Physician	Recognized therapeutic uses only Treatment for dependency General prescription by a physician	

A prohibition system, whether criminal or medical, calls for regulation derived from criminal law: any interaction with drugs that is not authorized under the medical model is punished by a criminal or quasi-criminal penalty.

The other type of system rests on legalization of cannabis. It can also take various forms.

Legalization System

	Main player	Accessibility level	Degree of control
State	Community	User licences Licence for production / distribution / sale	+ ↓
Market	User	Free market	-

Legalization systems range from issuing a user licence under certain conditions (e.g., no criminal record, no dependency problems), to permitting a completely uncontrolled free market.

Criteria for a legal policy on cannabis

Some studies have explored the question of the comparative effectiveness of public policy systems in cost/benefit terms, others in terms of social costs. The first type of analysis is impossible simply because no two strategies are different enough for purposes of comparison: there is no cannabis regulation model that can be compared to a prohibition model. The other approach is to consider the social costs incurred by drugs based on a "cost of illness" model in a "counter-factual" scenario: what would happen if there were no consumption of this drug? However, as we saw in Chapter 18, it is difficult to establish the real costs related to cannabis and the response of public policy to it, and impossible to determine real social costs.

> *The question is whether or not society would be better off if the use of one or more currently illegal drugs was authorized. The answer is only if public well-being is enhanced (or the social cost of drugs is reduced). No one knows the impact on social costs of legalization of illicit drugs. It is impossible to predict the impact of increased consumption, substitution of tobacco and alcohol for currently illegal drugs, the lower current negative impact attributable to drug illegality and, moreover, the combined impact of all these factors. The superiority of neither prohibition nor legalization is provable. [Translation]* [32]

The counter-factual scenario used in studies of the social costs of drugs is itself a formidable challenge, as it rests on the unproven concept of eradicating consumption of a drug. The model is drawn from the field of health, in which a counter-factual model may be legitimate because, in some cases, a disease can be completely or almost completely eradicated (e.g., childhood diseases). It does not apply to drugs, as the process is necessarily so hypothetical that one wonders if it is worth the effort. It is one thing to try and identify as accurately as possible the diversity of social and economic costs incurred by drugs and then reflect on public policy options; it is another to claim they can actually be measured.

MacCoun, Reuter, and Schelling propose two series of criteria, the first considering different applications to different substances, the second based on acceptable costs and consequences. Using a four-axis matrix, they distinguish:

- scope of consequences: community and user health; community and individual performance; public order and security;
- potential damage to each of the above;
- those affected by the damage (users, traffickers, family members, employers, neighbours, society); and

[32] Kopp, P., and P. Fenoglio (2000) *op.cit*, page 12.

- primary source of the damage (substance, legal status, legal intervention).

How do we make a choice? At the outset, it must be understood that, at the end of the line, the **decision is necessarily a political one**. Epidemiological data on levels of use and empirical data on effects and consequences are clear: cannabis is not as dangerous a substance as interdiction policies would like us to believe. Comparative data on public policies, although more limited, also make it clear that measures undertaken under prohibitionist regimes have not been effective. This much said, no one can predict what will happen under an alternative regime, such as the regulated access model we are proposing. This is why we insist that any comprehensive strategy on cannabis must be based on a public health model and involve tools to evaluate its implementation and effects.

Application to cannabis

We do not have all the empirical data required to make a decision with respect to all the potential consequences of different control systems. To produce such data, one would have to have experienced the different regimes of cannabis control. Since the early twentieth century, various degrees of prohibition are all there has been, however.

Be that as it may, we would hazard a guess that, even if we did have empirical data, in the final analysis the decisions would still be political in nature because they are basically public policy decisions which, as discussed in our chapter on guiding principles, are not defined on the basis of scientific knowledge alone.

Nonetheless, if we attempt to apply these criteria to cannabis, we believe that a **system of regulated access** is most likely to reduce the negative consequences for both users and society.

	Prohibition	Regulation
Consequences on:		
Health	- Use denied therefore no possible distinction between forms of use (use, at-risk use, abuse) - Difficulties adapting prevention to reality due to predominance of abstinence - Health costs due to lack of knowledge of forms of use - Absence of quality control may bring about problems - Difficult for users to recognize at-risk use and acknowledge possible dependency	- Possible increase in number of users - Enhanced recognition of use and ability to distinguish between forms of use - Ability to promote prevention not based on abstinence - Possible increase in health care for abusive users resulting from increase in number of users - Opportunity to control quality and THC content - Monitoring of at-risk behaviour and forms of non-penal treatment

Conduct of individuals and society	- Enhanced individual performance (e.g., school, professional) if prohibition totally successful and no substitute exists - Users potentially dealing with criminal networks - Human rights infringements - Theoretical decrease in availability of substance - Theoretical increase in price of substance	- Possibility of increased negative impact on users and their families if consumption increases - Legal access leading to normalizing and demystifying - Control over price and availability - Elimination of the negative consequences of criminalization and marginalization of users - Need to control impaired driving - Need to maintain restrictions regarding sale to minors
Public order and safety	- Increased organized crime - Significant illegal trafficking - Decreased respect for the law - Violence in criminal organizations	- Decrease in —not elimination of—organized crime - Increased control over illegal trafficking - Possible increase in the insecurity of people residing near points of sale

We are fully aware that our statements with respect to a regulatory system are wholly theoretical. We do think, however, that all the data we have collected on cannabis and its derivatives provide sufficient ground for our general conclusion that the **regulation of the production, distribution and consumption of cannabis, as part of an integrated and adaptable public policy, best responds to the principles of autonomy and governance that foster human responsibility and of the limitation of penal law to situations where there is demonstrable harm to others. A regulatory system for cannabis should permit, in particular, :**

- **more effective targeting of illegal traffic and a reduction in the role played by organized crime;**
- **prevention programs better adapted to the real world and better able to prevent and detect at-risk behaviour;**
- **enhanced monitoring of products, quality and properties;**
- **better user information and education;**
- **respect for individual and collective freedoms, and legislation more in tune with the behaviour of Canadians.**

In our opinion, Canadian society is ready for a responsible policy of cannabis regulation that honours these basic principles.

CONCLUSIONS AND RECOMMENDATIONS

The Senate Special Committee on Illegal Drugs' mandate was to examine Canada's public policy approach in relation to cannabis and assess its effectiveness and impact in light of the knowledge of the social and health-related effects of cannabis and the international context. Over the past two years, the Committee has heard from Canadian and foreign experts and reviewed an enormous amount of scientific research. The Committee has endeavoured to take the pulse of Canadian public opinion and attitudes and to consider the guiding principles that are likely to shape public policy on illegal drugs, particularly cannabis. Our report attempted to provide an update of the state of knowledge and of the key issues, and sets out a number of conclusions in each chapter.

This final section sets out the main conclusions that emerge from all this information and presents the resulting recommendations that derive from the thesis we have developed namely: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy insofar as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equivalence of others.***

LE DAIN – ALREADY THIRTY YEARS AGO

Thirty years ago, the Le Dain Commission released its report on cannabis. This Commission had far greater resources than did we. However, we had the benefit of a much more highly developed knowledge base and of thirty years' historical perspective.

The Commission concluded that the criminalization of cannabis had no scientific basis. Thirty years later, we can confirm this conclusion and add that continued criminalization of cannabis remains unjustified based on scientific data on the danger it poses.

The Commission heard and considered the same arguments on the dangers of using cannabis: apathy, loss of interest and concentration, learning difficulties. A majority of the Commissioners concluded that these concerns, while unsubstantiated, warranted a restrictive policy. Thirty years later, we can assert that the studies done in the meantime have not confirmed the existence of the so-called amotivational syndrome and add that most studies rule out this syndrome as a consequence of the use of cannabis.

The Commission concluded that not enough was known about the long-term and excessive use of cannabis. We can assert that these types of use exist and may present some health risks; excessive use, however, is limited to a minority of users. Public policy, we would add, must provide ways to prevent and screen for at-risk behaviour, something our policies have yet to do.

The Commission concluded that the effects of long-term use of cannabis on brain function, while largely exaggerated, could affect adolescent development. We concur, but point out that the long-term effects of cannabis use appear reversible in most cases. We not also that adolescents who are excessive users or become long-term users are a tiny minority of all users of cannabis. Once again, we would add that a public policy must prevent use at an early age and at-risk behaviour.

The Commission was concerned that the use of cannabis would lead to the use of other drugs. Thirty years' experience in the Netherlands disproves this very clearly, as do the liberal policies of Spain, Italy and Portugal. And here in Canada, despite the growing increase in cannabis users, we have not had a proportionate increase in users of hard drugs.

The Commission was also concerned that legalization would mean increased use, among the young, in particular. We have not legalized cannabis, and we have one of the highest rates in the world. Countries adopting a more liberal policy have, for the most part, rates of usage lower than ours, which stabilized after a short period of growth.

Thirty years later, we note that:

- **Billions of dollars have been sunk into enforcement without any greater effect: there are more consumers, more regular users and more regular adolescent users;**
- **Billions of dollars have been poured into enforcement in an effort to reduce supply, without any greater effect: cannabis is more available than ever, it is cultivated on a large scale, even exported, swelling coffers and making organized crime more powerful; and**
- **There have been tens of thousands of arrests and convictions for the possession of cannabis and thousands of people have been incarcerated; however, use trends remain totally unaffected and the gap the Commission noted between the law and public compliance continues to widen.**

It is time to recognize what is patently obvious: our policies have been ineffective, because they are poor policies.

INEFFECTIVENESS OF THE CURRENT APPROACH

No clearly defined federal or national strategy exists. Some provinces have developed strategies while others have not. There has been a lot of talk but little significant action. In the absence of clear indicators accepted by all stakeholders to assess the effectiveness of Canadian public policy, it is difficult to determine whether action that has been taken is effective. Given that policy is geared to reducing demand (i.e. drug-use rates) and supply (by reducing the availability of drugs and pushing up drug prices), both these indicators may be used.

A look at trends in cannabis use, both among adults and young people, **forces us to admit that current policies are ineffective**. In chapter 6, we saw that trends in drug-use are on the increase. If our estimates do indeed reflect reality, no fewer that 2 million Canadians aged between 18 and 65 have used cannabis at least once over the past 12 months, while at least 750,000 young people between the ages of 14 and 17 use cannabis at least once per month; one third of them on a daily basis. This proportion appears, at least in the four most highly-populated provinces, to be increasing. Statistics suggest that both use and at-risk use is increasing.

Of course, we must clearly establish whether the ultimate objective is a drug-free society, at least one free of cannabis, or whether the goal is to reduce at-risk behaviour and abuse. This is an area of great confusion, since Canadian public policy continues to use vague terminology and has failed to establish whether it focuses on substance abuse as the English terminology used in several documents seems to suggest or on drug-addiction as indicated by the French terminology.

It is all very well to criticize the "trivialization" of cannabis in Canada to "explain" increases in use but it must also be established why, if this is indeed the case, this trivialization has occurred. It is also important to identify the root cause of this trivialization against a backdrop of mainly anti-drug statements. The courts and their lenient attitude might be blamed for this. Perhaps the judiciary is at the forefront of those responsible for cannabis policies and the enforcement of the law. It must also be determined whether sentences are really as lenient as some maintain. A major issue to be addressed is whether harsher sentences would indeed be an effective deterrent given that the possibility of being caught by the police is known to be a much greater deterrent. Every year, over 20,000 Canadians are arrested for cannabis possession. This figure might be as high as 50,000 depending on how the statistics are interpreted. This is too high a number for this type of conduct. However, it is laughable number when compared to the three million people who have used cannabis over the past 12 months. We should not think that the number of arrests might be significantly increased even if billions of extra dollars were allocated to police enforcement. Indeed, such a move should not even be considered.

A look at the availability and price of drugs, **forces us to admit that supply-reduction policies are ineffective**. Throughout Canada, above all in British Columbia and Québec, the cannabis industry is growing, flooding local markets, irritating the

United States and lining the pockets of criminal society. Drug prices have not fallen but quality has improved, especially in terms of THC content – even if we are sceptical of the reported scale of this improvement. Yet, police organizations already have greater powers and latitude – especially since the September 11, 2001 tragedy – in relation to drugs than in any other criminal matter. In addition, enforcement now accounts for over 90% of all illegal drug-related spending. To what extent do we want to go further down this road?

Clearly, current approaches are ineffective and inefficient – it is throwing taxpayers' money down the drain on a crusade that is not warranted by the danger posed by the substance. It has been maintained that drugs, including cannabis, are not dangerous because they are illegal but rather illegal because they are dangerous. This is perhaps true of other types of drugs, but not cannabis. We should state this clearly once and for all, for public good, stop our crusade.

PUBLIC POLICY BASED ON GUIDING PRINCIPLES

However much we might wish good health and happiness for everyone, we all know how fragile both are. Above all, we realize that health and happiness cannot be forced on a person, especially not by criminal law based on a specific concept of what is morally right. No matter how attractive calls for a drug-free society might be, and even if some people might want others to stop smoking, drinking alcohol, or smoking joints, we all realize that these activities are well and truly part of social reality and the history of humankind.

Consequently, what role should the State play? It should neither abdicate responsibility and allow drug markets to run rife, nor should it impose a particular way of life on people. Instead, we have opted for a concept whereby public policy **promotes and supports freedom for individuals and society as a whole**. For some, this would undoubtedly mean avoiding drug use. However, for others, the road to freedom might be via drug use. For society as a whole, this concept means a State that does not dictate what should be consumed and under what form. Support for freedom necessarily means flexibility and adaptability. It is for this reason that public policy on cannabis has to be clear while at the same time tolerant, to serve as a guide while at the same time avoiding imposing a single standard. This concept of the role of the State is based on the **principle of autonomy and individual and societal responsibility.** Indeed, it is much more difficult to allow people to make their own decisions because there is less of an illusion of control. It is just that: an illusion. We are all aware of that. It is perhaps sometimes comforting, but is likely to lead to abuse and unnecessary suffering. An ethic of responsibility teaches social expectations (not to use drugs in public or sell to children), responsible behaviour (recognizing at-risk behaviour and

being able to use moderately) and supports people facing hardship (providing a range of treatment).

From this concept of government action ensues a limited role for criminal law. As far as cannabis is concerned, **only behaviour causing demonstrable harm to others shall be prohibited**: illegal trafficking, selling to minors, impaired driving.

Public policy shall also draw on available knowledge and scientific research but without expecting science to provide the answers to political issues. Indeed, scientific knowledge does have a major role to play as a **support tool in decision-making,** at both an individual and government level. Indeed, science should play no greater role. It is for this reason that the Committee considers that a drug and dependency observatory and a research program should be set up: to help those decision makers that will come after us.

A CLEAR AND COHERENT FEDERAL STRATEGY

Although the Committee has focused on cannabis, we have nevertheless observed inherent shortcomings in the federal drug strategy. Quite obviously, there is no real strategy or focused action. Behind the supposed leadership provided by Health Canada emerges a lack of necessary tools for action, a patchwork of ad hoc approaches from one substance to another and piecemeal action by various departments. Of course, co-ordinating bodies do exist, but without real tools and clear objectives, each focuses its action according to its own particular priorities. This has resulted in a whole series of funded programs developed without any tangible cohesion.

Many stakeholders have expressed their frustration to the Committee at the jig-saw of seemingly evanescent pieces and at the whole gamut of incoherent decisions, which cause major friction on the front lines. Various foreign observers also expressed their surprise that a country as rich as Canada, which is not immune to psychoactive substance-related problems, did not have a “champion”, a spokesperson or a figure of authority able to fully grasp the real issues while at the same time obtaining genuine collaboration of all stakeholders.

It is for this reason that we are recommending the creation of the position of National Advisor on Psychoactive Substances and Dependency to be attached to the Privy Council. We do not envisage this as a super body responsible for managing psychoactive substance-related budgets and action. In fact, we favour an approach similar to that of the *Mission interministérielle à la drogue et à la toxicomanie* in France over one modelled on the United States’ Office of National Drug Control Policy. The Advisor would have a small dedicated staff, with the majority of staff loaned from the various federal departments and bodies concerned by the drugs issue.

The Advisor would be responsible: for advising the Cabinet and the Prime Minister on national and international psychoactive substance-related issues; for

ensuring co-ordination between federal departments and agencies; for overseeing the development of federal government psychoactive substance-related objectives and ensuring these objectives are satisfied; and to serve as a Canadian Government spokes-person on psychoactive substance-related issues at an international level.

Recommendation 1
The Committee recommends that the position of National Advisor on Psychoactive Substances and Dependency be created within the Privy Council Office; that the Advisor be supported by a small secretariat and that federal departments and agencies concerned by psychoactive substances second, upon request, the necessary staff.

NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESSOURCES AND TOOLS

A federal policy and strategy do not in themselves make a national strategy. Provinces, territories, municipalities, community organizations and even the private sector all have a role to play in accordance with their jurisdiction and priorities. This is necessary and this diversity is worth encouraging. However, some harmonization and meaningful discussion on practices and pitfalls, on progress and setbacks, and on knowledge, are to be encouraged. Apart from the resource-starved piecemeal action of the Canadian Centre on Substance Abuse, there are all too few opportunities and schemes to promote exchanges of this type. **The current and future scale of drug and dependency-related issues warrants the Canadian Government earmarking the resources and developing the tools with which to develop fair, equitable and well-thought out policies**.

Like the majority of Canadian and foreign observers of the drug situation, we were struck by the relative lack of tools and measures for determining and following up on the objectives of public psychoactive substance policy. One might not agree with the numbers-focused goals set out by the Office of National Drug Control Policy for the reduction of drug use or for the number of drug treatment programs set up and evaluated. However, we have to admit that at least these figures serve as guidelines for all stakeholders and as benchmarks against which to measure success.

Similarly, one might not feel totally comfortable with the complex Australian goal-definition process, whereby the whole range of partners from the various levels of government, organizations and associations meet at a conference every five years. However, at least those goals agreed upon by the various stakeholders constitute a clear reference framework and enable better harmonization of action.

The European monitoring system with its focal points in each European Union country under the European Monitoring Centre for Drugs and Drug Addiction umbrella might seem cumbersome; and the American system of conducting various annual epidemiological studies might appear expensive. We might even acknowledge that there are problems with epidemiological studies, which are far from providing a perfect picture of the psychoactive substance-use phenomena. However, at least these tools, referred to and used throughout the Western world, enable the development of a solid information base, with which to analyse historical trends, identify new drug-use phenomena and react rapidly. In addition, it allows for an assessment of the relevance and effectiveness of action taken. No system of this type exists in Canada, which is the only industrialized Western country not to have such a knowledge structure.

It is for these reasons that the Committee recommends that the Government of Canada support various initiatives to develop a genuine national strategy. Firstly, the Government should call a national conference of the whole range of partners with a view to setting out goals and priorities for action over a five-year period. This conference should also identify indicators to be used in measuring progress at the end of the five-year period. Secondly, the Canadian Centre on Substance Abuse needs to be renewed. Not only does this body lack resources but it is also subject to the vagaries of political will of the Minister of Health. The Centre should have a budget in proportion with the scale of the psychoactive substance problem and should have the independence required to address this issue. Lastly, a Canadian Monitoring Agency on Drugs and Dependency should be created within the Centre.

Recommendation 2

The Committee recommends that the Government of Canada mandate the National Advisor on Psychoactive Substances and Dependency to call a high-level conference of key stakeholders from the provinces, territories, municipalities and associations in 2003, to set goals and priorities for action on psychoactive substances over a five-year period.

Recommendation 3

The Committee recommends that the Government of Canada amend the Canadian Centre on Substance Abuse enabling legislation to change the Centre's name to the *Canadian Centre on Psychoactive Substances and Dependency*; make the Centre reportable to Parliament; provide the Centre with an annual basic operating budget of 15 million dollars, to be increased annually; require the Centre to table an annual report on actions taken, the key issues, research and

trends in the federal Parliament and provincial and territorial assemblies and legislatures; mandate the Centre to ensure national co-ordination of research on psychoactive substances and dependency, and to conduct studies into specific issues; and mandate the Centre to undertake an assessment of the national strategy on psychoactive substance and dependency every five years.

Recommendation 4
The Committee recommends that in the legislation creating the Canadian Centre on Psychoactive Substances and Dependency, the Government of Canada specifically include provision for the setting up of a Monitoring Agency on Psychoactive Substances and Dependency within the Centre; provide that the Monitoring Agency be mandated to conduct studies every two years, in co-operation with relevant bodies, on drug-use trends and dependency problems in the adult population; work with the provinces and territories towards increased harmonization of studies of the student population and to ensure they are carried out every two years; conduct ad hoc studies on specific issues; and table a bi-annual report on drug-use trends and emerging problems.

A PUBLIC HEALTH POLICY

When cannabis was listed as a prohibited substance in 1923, no public debate or discussion was held on the known effects of the drug. In fact, opinions expressed were disproportionate to the dangers of the substance. Half a century later, the Le Dain Royal Commission of Inquiry on the Non-Medical Use of Drugs held a slightly more rational debate on cannabis and took stock of what was known about the drug. Commissioners were divided not so much over the nature and effects of the drug but rather over the role to be played by the State and criminal law in addressing public health-related goals. Thirty years after the Le Dain Commission report, we are able to categorically state that, **used in moderation, cannabis in itself poses very little danger to users and to society as a whole, but specific types of use represent risks for users**.

In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed in a discriminatorily fashion to the risk of arrest and to the criminal justice system; society sees organized crime

enhance their power and wealth by benefiting from prohibition; and governments see their ability to conduct prevention of at-risk use diminished.

We would add that, **even if cannabis were to have serious harmful effects, one would have to question the relevance of using the criminal law to limit these effects**. We have demonstrated that criminal law is not an appropriate governance tool for matters relating to personal choice and that prohibition is known to result in harm which often outweighs the desired positive effects. However, current scientific knowledge on cannabis, its effects and consequences are such that this issue is not relevant to our discussion.

Indeed available data indicate that the scale of the cannabis use phenomenon can no longer be ignored. Chapter 6 indicated that no fewer than 30% of Canadians (12 to 64 years old) have experimented with cannabis at least once in their lifetime. In all probability, this is an underestimation. We have seen that approximately 50% of high school students have used cannabis within the past year. Nevertheless, a high percentage of them stop using and the vast majority of those who experiment do not go on to become regular users. Even among regular users, only a small proportion develop problems related to excessive use, which may include some level of psychological dependency. Consumption patterns among cannabis users do not inevitably follow an upward curve but rather a series of peaks and lulls. Regular users also tend to have a high consumption rate in their early twenties, which then either drops off or stabilizes, and in the vast majority of cases, ceases altogether in their thirties.

All of this does not in any way mean, however, that cannabis use should be encouraged or left totally unregulated. Clearly, it is a psychoactive substance with some effects on cognitive and motor functions. When smoked, cannabis can have harmful effects on the respiratory airways and is potentially cancerous. Some vulnerable people should be prevented, as much as possible, from using cannabis. This is the case for young people under 16 years of age and those people with particular conditions that might make them vulnerable (for example those with psychotic predispositions). As with alcohol, adult users should be encouraged to use cannabis in moderation. Given that, as for any substance, at-risk use does exist, preventive measures and detection tools should be established and treatment initiatives must be developed for those who use the drug excessively. Lastly, it goes without saying that education initiatives and severe criminal penalties must be used to deter people from operating vehicles under the influence of cannabis.

As for any other substance, there is at-risk use and excessive use. There is no universally accepted criterion for determining the line between regular use, at-risk use and excessive use. The context in which use occurs, the age at which users were introduced to cannabis, substance quality and quantity are all factors that play a role in the passage from one type of use to another. Chapters 6 and 7 identified various criteria, which we have collated in table form below.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport…) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

If **cannabis itself poses very little danger to the user and to society as a whole, some types of use involve risks**. It is time for our public policy to recognize this and to **focus on preventing at-risk use and on providing treatment for excessive cannabis users**.

Recommendation 5

The Committee recommends that the Government of Canada adopt an integrated *policy on the risks and harmful effects of psychoactive substances* covering the whole range of substances (medication, alcohol, tobacco and illegal drugs). With respect to cannabis, this policy shall focus on educating users, detecting and preventing at-risk use and treating excessive use.

A REGULATORY APPROACH TO CANNABIS

The **prohibition of cannabis does not bring about the desired reduction in cannabis consumption or problem use**. However, this approach does have a whole series of harmful consequences. Users are marginalized and over 20,000 Canadians are arrested each year for cannabis possession. Young people in schools no longer enjoy the same constitutional and civil protection of their rights as others. Organized crime benefits from prohibition and the criminalization of cannabis enhances their power and wealth. It is a well-known fact that society will never be able to stamp out drug use – particularly cannabis use.

Some might believe that an alternative policy signifies abandoning ship and giving up on promoting well-being for Canadians. Some might maintain that a regulatory approach would fly in the face of the fundamental values of our society. We believe, however, that the continued prohibition of cannabis jeopardizes the health and well-being of Canadians much more than the regulated marketing of the substance. In addition, we believe that the continued criminalization of cannabis undermines the fundamental values set out in the *Canadian Charter of Rights and Freedoms* and borne out by the history of a country based on diversity and tolerance.

We do not want to see cannabis use increase, especially among young people. Of note, the data from other countries that we compared in Chapters 6 and 20 indicate that countries such as the Netherlands, Australia or Switzerland, which have put in place a more liberal approach, have not seen their long-term levels of cannabis use rise. The same data also clearly indicate that countries with a very restrictive approach, such as Sweden and the United States, are poles apart in terms of cannabis use levels, and that countries with similar liberal approaches such as the Netherlands and Portugal are also at opposite ends of the spectrum, falling somewhere between Sweden and the United States. We have concluded that public policy itself has little effect on cannabis use trends and that other more complex and poorly-understood factors play a greater role in explaining the variations.

An exemption regime making cannabis available to those over the age of 16 would probably lead to an increase in cannabis use for a certain period. Use rates would then level out as interest wanes and as effective prevention programs are set up. This would then be followed by a roller-coaster pattern of highs and lows, as has been the case in most other countries.

This approach is neither one of total abdication nor a sign of giving up but rather a vision of the role of the State and criminal law as **developing and promoting but not controlling human action** and as **stipulating only necessary prohibitions** relating to the fundamental principle of respect for life, others and a harmonious community, and as **supporting and assisting others and not** judging and condemning difference.

We might wish for a drug-free world, fewer tobacco smokers or alcoholics or less prescription drug dependency, but we all know that we shall never be able to eliminate

these problems. More importantly, we should not opt to criminalize them. The Committee believes that the same healthy and respectful approach and attitude should be applied to cannabis.

It is for this reason that the Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme for the production and sale of cannabis under the authority of a licence. Licensing and the production and sale of cannabis would be subject to specific conditions, that the Committee has endeavoured to specify. For clarity's sake, these conditions have been compiled at the end of this section. It should be noted at the outset that the Committee suggests that cigarette manufacturers be prohibited from producing and selling cannabis.

Recommendation 6
The Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme. This legislation should stipulate the conditions for obtaining licences as well as for producing and selling cannabis; criminal penalties for illegal trafficking and export; and the preservation of criminal penalties for all activities falling outside the scope of the exemption scheme.

Recommendation 7
The Committee recommends that the Government of Canada declare an amnesty for any person convicted of possession of cannabis under current or past legislation.

A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE

In Chapter 9, we noted that cannabis has not been approved as a medicinal drug in the pharmacological sense of the word. In addition to the inherent difficulties in conducting studies on the therapeutic applications of cannabis, there are issues arising from the current legal environment and the undoubtedly high cost to governments of conducting such clinical studies.

Nevertheless, we do not doubt that, for some medical conditions and for certain people, cannabis is indeed effective and useful therapy. Is it more effective than other types of medication? Perhaps not. Can physicians currently prescribe cannabis at a known dosage? Undoubtedly not. Should persons suffering from certain physical

conditions diagnosed by qualified practitioners be permitted to use cannabis if they wish to do so? Of this, we are convinced.

Regulations made in 2001 by the Health Canada, even though they are a step in the right direction, are fundamentally unsatisfactory. They do not facilitate access to therapeutic cannabis. They do not consider the experience and expertise available in compassion clubs. These regulations only govern marijuana and do not include cannabis derivatives such as hashish and cannabis oils.

It is for these reasons that the Committee recommends that Health Canada amend the *Marihuana Medical Access Regulations* in order to allow compassionate access to cannabis and its derivatives. As in the previous chapter, proposed rules have been compiled at the end of this chapter.

Recommendation 8
The Committee recommends that the *Marihuana Medical Access Regulations* be amended to provide new rules regarding eligibility, production and distribution of cannabis for therapeutic purposes. In addition, research on cannabis for therapeutic purposes is essential.

PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS

In chapter 8, we discussed the fact that research has not clearly established the effects of cannabis when taken alone on a person's ability to operate a vehicle. Nevertheless, there is enough evidence to suggest that operating a vehicle while under the influence of cannabis alters motor functions and effects a person's ability to remain in his or her lane. We have also established that the combined effects of cannabis and alcohol impair faculties even more than alcohol taken alone. Epidemiological studies have shown that a certain number of cannabis users do drive under the influence of the substance and that a large proportion of these people, mainly the young, appear to believe that cannabis does not impair their ability to drive.

This chapter also indicated that no reliable and non-intrusive road-side detection tools exist. Saliva-based equipment is a promising development but for the time being, provide random results. We have also established that a visual recognition system, which has mainly been developed and assessed in the United States, is a reliable way of detecting drug-induced impaired driving faculties.

Recommendation 9
The Committee recommends that the Criminal Code be amended to lower permitted alcohol levels to 40 milligrams of alcohol per 100 millilitres of blood, in the presence of other drugs, especially, but not exclusively cannabis; and to admit evidence from expert police officers trained in detecting persons operating vehicles under the influence of drugs.

RESEARCH

Research on psychoactive substances, and particularly on cannabis, has undergone a boom over the past 20 years. The Committee was able to fully grasp the actual extent of this increase, since we faced the challenge of summarizing it. Not all research is of the same quality and the current political and legal climate governing cannabis hampers thorough and objective studies. Nevertheless, a solid fact base was available to the Committee, on which to base its foregoing conclusions and recommendations.

However, more research needs to be done in a certain number of specific areas. In Chapter 6, we established that a lack of practical research on cannabis users has resulted in only a limited amount of information on contexts of use being available. It is also currently difficult to establish criteria on the various types of cannabis use in order to guide those responsible for prevention. The Committee suggests that cannabis use of over one gram per day constitutes excessive use and that between 0.1 and one gram per day equates to at-risk use. We also suggest that any use below 16 years of age is at-risk use. This is of course enlightened speculation, but speculation nevertheless, which remains to be explored.

In Chapters 16 and 17, we referred to the fact that we know very little about the most effective prevention practices and treatment. Here also, the current context hindered. As far as prevention is concerned, the more or less implicit "*just say no*" message and the focus on cannabis use prevention are strategies that have been dictated by the prohibition-based environment. In terms of treatment for problem users, abstinence-based models have long been the dominant approach and continue to sit very poorly with harm-reduction-based models. Thorough assessment studies are required.

The Canadian Centre on Psychoactive Substances and Dependency must play a key role in co-ordinating and publishing the results of studies. The Centre does not have to conduct research itself. This can and indeed must sometimes be carried out by academics. The Health Research Institutes are also natural players. However, it is important to clearly identify a single central body to collect research information. This will enable the information to be distributed as widely possible and, we hope, used.

Recommendation 10
The Committee recommends that the Government of Canada create a national fund for research on psychoactive substances and dependency to fund research on key issues - more particularly on various types of use, on the therapeutic applications of cannabis, on tools for detecting persons operating vehicles under the influence of drugs and on effective prevention and treatment programs; that the Government of Canada mandate the Canadian Centre on Psychoactive Substances and Dependency to co-ordinate national research and serve as a resource centre.

CANADA'S INTERNATIONAL POSITION

The Committee is well aware that were Canada to choose the rational approach to regulating cannabis that we have recommended, it would be in contravention of the provisions of the various international conventions and treaties governing drugs. We are also fully aware of the diplomatic implications of this approach, in particular in relation to the United States.

We are keen to avoid replicating, at the Canada-US border, the problems that marked relations between the Netherlands, France, Belgium and Germany over the issue of drugs-tourism between 1985 and 1995. This is one of the reasons that justifies restricting the distribution of cannabis for recreational purposes to Canadian residents.

We are aware of the fact that a significant proportion of the cannabis produced in Canada is exported, mainly to the United States. We are also aware that a considerable proportion of heroin and cocaine comes into Canada via the United States. We are particularly cognisant of the fact that Canadian cannabis does not explain the increase in cannabis use in the United States. It is up to each country to get its own house in order before criticizing its neighbour.

Internationally, Canada will either have to temporarily withdraw from the conventions and treaties or accept that it will be in temporary contravention until the international community accedes to its request to amend them. The Committee opts for the second approach, which seems to us to be more consistent with the tradition and spirit of Canadian foreign policy. In addition, we have seen that international treaties foster the imbalanced relationship between the Northern and Southern hemispheres by prohibiting access to plants, including cannabis, produced in the Southern hemisphere, while at the same time developing a regulatory system for medication manufactured by the pharmaceutical industry in the Northern hemisphere.

Canada could use this imbalanced situation to urge the international community to review existing treaties and conventions on psychoactive substances.

Canada can and indeed should provide leadership on drug policy. Developing a national information and action infrastructure would undoubtedly be key to this. **Canada must also play a leading role in the Americas**. We believe that Canada enjoys a favourable international reputation and that it can promote the development of fairer and more rational drug – in particular cannabis - policies. We also contend that Canada should strive for the creation of a European Observatory-style Drug and Dependency Observatory for the Americas within the Organization of American States.

Recommendation 11

The Committee recommends that the Government of Canada instruct the Minister of Foreign Affairs and International Trade to inform the appropriate United Nations authorities that Canada is requesting that conventions and treaties governing illegal drugs be amended; and that the development of a Drugs and Dependency Observatory for the Americas be supported by the Government of Canada.

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS

FOR THERAPEUTIC AND RECREATIONAL PURPOSES

Amendments to the *Marihuana Medical Access Regulations* (Production and sale of cannabis for therapeutic purposes)

A. Eligible person

A person affected by one of the following: wasting syndrome; chemotherapy treatment; fibromyalgia; epilepsy; multiple sclerosis; accident-induced chronic pain; and some physical condition including migraines and chronic headaches, whose physical state has been certified by a physician or an individual duly authorized by the competent medical association of the province or territory in question, may choose to buy cannabis and its derivatives for therapeutic purposes. The person shall be registered with an accredited distribution centre or with Health Canada.

B. Licence to distribute

A Canadian resident may obtain a licence to distribute cannabis and its derivatives for therapeutic purposes. The resident must undertake to only sell cannabis and its derivatives to eligible persons; to only sell cannabis and its derivatives purchased from producers duly licensed for this purpose; to keep detailed records on the medical conditions and their development, consumption and the noted effects on patients; to take all measures needed to ensure the safety of the cannabis products and to submit to departmental inspections.

C. Licence to produce

A Canada resident may obtain a licence to produce cannabis and its derivatives for therapeutic purposes. The resident must undertake: not to hold a licence to produce cannabis for non therapeutic purposes; to take the measures necessary to ensure the consistency, regularity and quality of crops; to take the measures necessary to ensure the security of production sites; to know and document the properties and concentrations of each harvest with respect to Delta 9 THC; to sell only to accredited distribution centres and to submit to departmental inspections.

D. Other proposals

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

- Establish a program of research into the therapeutic applications of cannabis, by providing sufficient funding; by mandating the ***Canadian Centre on Psychoactive Substances and Dependency*** to co-ordinate the research program; and by providing for the systematic study of clinical cases based on the documentation available in organizations currently distributing cannabis for therapeutic purposes and in future distribution centres; and
- Ensure that the advisory committee on the therapeutic use of cannabis represents all players, including distribution centres and users.

Amendment to the *Controlled Drugs and Substances Act* (CDSA) (Production and sale of cannabis for non therapeutic purposes)

A. General aims of the bill

- To reduce the injurious effects of the criminalization of the use and possession of cannabis and its derivatives;
- To permit persons over the age of 16 to procure cannabis and its derivatives at duly licensed distribution centres; and
- To recognize that cannabis and its derivatives are psychoactive substances that may present risks to physical and mental health and, to this end, to regulate the use and trade of these substances in order to prevent at-risk use and excessive use.

B. Licence to distribute

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA with respect to the distribution of cannabis. A Canadian resident could obtain a licence to distribute cannabis. The resident must undertake **not to distribute to persons under the age of 16; must never have been sentenced for a criminal offence, with the exception of offences related to the possession of cannabis, for which an amnesty will be declared**; and must agree to procure cannabis only from duly licensed producers. In addition, in accordance with the potential limits imposed by the *Canadian Charter of Rights and Freedoms*, licensed distributors shall not display products explicitly and shall not advertise in any manner.

C. Licence to produce

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA with respect to the production of cannabis. A Canadian resident could obtain a licence to produce cannabis. The resident must undertake to only sell to duly licensed distributors; to sell only marihuana and hashish with a

THC content of 13% or less; to limit production to the quantity specified in the licence; to take the measures needed to ensure the security of production sites; to keep detailed records of quantities produced, crops, levels of THC concentration and production conditions; and to submit to departmental inspections. No person charged with and sentenced for criminal offences, with the exception of the possession of cannabis, for which an amnesty will be declared, shall be granted a licence. No person or legal entity, directly or indirectly associated with the production, manufacture, promotion, marketing or other activity connected with tobacco products and derivatives shall be granted a licence. In accordance with the potential limits imposed by the *Canadian Charter of Rights and Freedoms*, cannabis products and their derivatives shall not be advertised in any manner.

D. Production for personal use

Amend the Act to create a criminal exemption scheme to the criminal offences provided in the CDSA in order to permit the personal production of cannabis so long as it is not sold for consideration or exchange in kind or other and not advertised or promoted in any other way. In addition, quantities shall be limited to ensure production is truly for personal consumption.

E. Consumption in public

Consumption in public places shall be prohibited.

F. International trade

All forms of international trade, except those explicitly permitted under the Act shall be subject to the penalties provided in the CDSA for illegal trafficking.

G. Other proposals

- Ensure the establishment of a National Cannabis Board with duly mandated representatives of the federal government and the governments of the provinces and territories. The Board would keep a national register on the production and sale of cannabis and its derivatives, set the amount and distribution of taxes taken on the sale of cannabis products and ensure the taxes collected on the production and sale of cannabis and derivatives are directed solely to prevention of at-risk use, treatment of excessive users, research and observation of trends and the fight against illegal trafficking.
- The provinces and territories would continue to develop prevention measures that should be directed at at-risk use, as a priority. The ***Canadian Centre on Psychoactive Substances and Dependency*** should be mandated

to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.

- The provinces and territories would continue to develop support and treatment measures that should be directed at excessive use, as a priority. The ***Canadian Centre on Psychoactive Substances and Dependency*** should be mandated to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.
- Increase resources available to police and customs to fight smuggling, export in all its forms and cross-border trafficking.

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II – WITNESSES QUOTED IN THE REPORT

Mohamed ben Amar, Professor, Pharmacology and Toxicology – University of Montreal, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Line Beauchesne, Professor, Department of Criminology – University of Ottawa, Second Session, Thirty-sixth Parliament, October 16, 2000, Issue nº 1.

Patricia Bégin, Director, Research and Evaluation – National Crime Prevention Centre, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Marie-Andrée Bertrand, Professor Emeritus of Criminology – University of Montreal, First Session, Thirty-seventh Parliament, April 23, 2001, Issue nº 1.

Hilary Black, Founder and Director – B.C. Compassion Club Society, First Session, Thirty-seventh Parliament, November 7, 2001, Issue nº 10.

Tim Boekhout van Solinge, Lecturer and Researcher in Criminology – Utrecht University, First Session, Thirty-seventh Parliament, November 7, 2001, Issue nº. 11.

Micheal J. Boyd, Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service – Canadian Association of Chiefs of Police, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Neil Boyd, Professor, Department of Criminology – Simon Fraser University, Second Session, Thirty-sixth Parliament, October 16, 2000, Issue nº 1.

Serge Brochu, Professor and Director of the International Center for Comparative Criminology – University of Montreal, First Session, Thirty-seventh Parliament, December 10, 2001, Issue nº 12.

Bill Campbell, President – Canadian Society on Addiction Medicine, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Mark Connolly, Director General, Contraband and Intelligence Services Directorate, Customs Branch – Canada Customs and Revenue Agency First Session, Thirty-seventh Parliament, October 29, 2001, Issue nº 8.

John Conroy, Barrister, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Jean-Michel Coste, Director – French Monitoring Centre for Drugs and Drug Addictions, First Session, Thirty-seventh Parliament, October 1st, 2001, Issue nº 7.

Patricia Erickson, Researcher – Centre for Addiction and Mental Health, First Session, Thirty-seventh Parliament, May 14, 2001, Issue nº 2.

Julian Fantino, Chief – Toronto Police Service, First Session, Thirty-seventh Parliament, September 10, 2001, Issue nº 5.

Benedikt Fischer, Professor, Department of Public Health Sciences – University of Toronto, First Session, Thirty-seventh Parliament, September 17, 2001, Issue nº 6.

David Griffin, Canadian Police Association, First Session, Thirty-seventh Parliament, May 28, 2001, Issue nº 3.

Henry Haddad, President – Canadian Medical Association, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

Health Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Kash Heed, Vice Drugs Section – Vancouver Police Service, First Session, Thirty-seventh Parliament, November 7, 2001, Issue nº 10

Gary E. Johnson, Governor, State of New Mexico, First Session, Thirty-seventh, November 5, 2001, Issue nº 9.

Cal Johnston, Chief – Regina Police Service, First Session, Thirty-seventh Parliament, May 13 2002, Issue nº 16.

Harold Kalant, Professor Emeritus – University of Toronto, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Perry Kendall, Health Officer – Province of British Columbia, First Session, Thirty-seventh Parliament, September 17, 2001, Issue nº 6.

Paul Kennedy, Senior Assistant Deputy Solicitor General, Policing and Security Branch – Solicitor General of Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Barry King, Former Chair of the Drug Abuse Committee and Chief of the Brockville Police Service – Canadian Association of Chiefs of Police, First Session, Thirty-seventh Parliament, March 11, 2002, Issue nº 14.

R.G. Lesser, Chief Superintendent – Royal Canadian Mounted Police, First Session, Thirty-seventh Parliament, October 29, 2001, Issue nº 8.

Gillian Lynch, Director General, Drug Strategy and Controlled Substances Programme – Health Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Mary Lynch, Director, Canadian Consortium for the Investigation of Cannabinoids – Dalhousie University, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Nicole Maestracci, President – Interministerial Mission for the Fight against Drugs and Drug Addiction, First Session, Thirty-seventh Parliament, October 1st, 2001, Issue nº 7.

Colin Mangham, Director – Prevention Source B.C., First Session, Thirty-seventh Parliament, September 17, 2001, Issue nº 6.

Céline Mercier, Associate Professor, Department of Psychiatry – McGill University, First Session, Thirty-seventh Parliament, December 10, 2001, Issue nº 12.

Croft Michaelson, Director and Senior General Counsel, Strategic Prosecution Policy Section – Justice Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

John P. Morgan, Professor of Pharmacology – City of New York Medical School, First Session, Thirty-seventh Parliament, June 11, 2001, Issue nº 4.

Dann Michols, Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch – Health Canada, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Dale Orban, Canadian Police Association, First Session, Thirty-seventh Parliament, May 28, 2001, Issue nº 3.

Michel Perron, Executive Director – Canadian Centre on Substance Abuse, First Session, Thirty-seventh Parliament, June 10, 2002, Issue nº 22.

Senate of Canada, Proceedings of the Senate Special Committee on Illegal Drugs, First Session, Thirty-seventh Parliament, March-April 2001, Issue nº 1.

Senate of Canada, Proceedings of the Senate Special Committee on Illegal Drugs, First Session, Thirty-seventh Parliament, May 28, 2001, Issue nº 3.

Eric Single, Professor, Department of Public Health Sciences – University of Toronto, First Session, Thirty-seventh Parliament, May 14, 2001, Issue nº 2.

Diane Steber Büchli, Head, International Drug Affairs Unit – Swiss Federal Office of Public Health, First Session, Thirty-seventh Parliament, February 24, 2002, Issue nº 13.

Art Steinman, Executive Director – Alcohol-Drug Education Service, First Session, Thirty-seventh Parliament, November 7, 2002, Issue nº 10.

Ambros Uchtenhagen, Retired Professor – Addiction Research Institute, First Session, Thirty-seventh Parliament, February 4, 2002, Issue nº 13.

Mark Ware, Assistant Professor – McGill University, First Session, Thirty-seventh Parliament, May 31st 2002, Issue nº 18.

Mark Zoccolillo, Professor, Department of Psychiatry – McGill University, Second Session, Thirty-sixth Parliament, October 16, 2000, Issue nº 1.

Senate Sénat

CANADA

CANNABIS :

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

VOLUME IV : APPENDICES

CHAIRMAN

PIERRE CLAUDE NOLIN

DEPUTY CHAIRMAN

COLIN KENNY

SEPTEMBER 2002

APPENDIX I

MEMBERS AND STAFF OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

1. MEMBERS OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

Honourable Pierre Claude Nolin
(Chair)

Honourable Colin Kenny
(Deputy Chair)

Honourable Tommy Banks

Honourable Eileen Rossiter

Honourable Shirley Maheu

Honourable John Lynch-Staunton *

Honourable Sharon Carstairs, P.C.* **

Honourable Noël A. Kinsella *

Honourable Fernand Robichaud *

2. OTHER SENATORS WHO PARTICIPATED IN THE PROCEEDINGS OF THE COMMITTEE

Honourable Michel Biron

Honourable Laurier LaPierre

Honourable Pat Carney, P.C.

Honourable Jean Lapointe

Honourable Thelma Chalifoux

Honourable Edward M. Lawson

Honourable Ione Christensen

Honourable Lorna Milne

Honourable Ethel M. Cochrane

Honourable Yves Morin

Honourable Pierre De Bané, P.C., Q.C.

Honourable Lucie Pépin **

Honourable Consiglio Di Nino

Honourable Marie-P. Poulin

Honourable Joyce Fairbairn, P.C.

Honourable Marcel Prud'homme, P.C.

Honourable Sheila Finestone, P.C.

Honourable Gerry St. Germain, P.C.

Honourable J. Michael Forrestall

Honourable Peter A. Stollery

Honourable Jerahmiel S. Grafstein, Q.C.

Honourable Terry Stratton

Honourable Mobina S.B. Jaffer

Honourable John Wiebe

Honourable Lois M. Wilson

* *Ex Officio* Members
** The Honourable Sharon Carstairs was a member of the Committee from April 2000 to October 2000
*** The Honourable Lucie Pépin was a member of the Committee from April 2000 to October 2000

3. STAFF OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

3.1 CLERKS

Blair Armitage
(Clerk)

Daniel Charbonneau
(Acting Clerk of the Committee)

Adam Thompson
(Acting Clerk of the Committee)

3.2 RESEARCH

Daniel Sansfaçon
(Director of Research)

Gérald Lafrenière
(Analyst – Library of Parliament)

Chantal Collin
(Analyst – Library of Parliament)

Lyne Casavant
(Library of Parliament)

Diane Leduc
(Library of Parliament)

Benjamin Dolin
(Library of Parliament)

Martine Leroux
(Office of Senator Shirley Maheu)

Nancy Miller Chenier
(Library of Parliament)

Robin MacKay
(Library of Parliament)

François Dubois
(Office of Senator Pierre Claude Nolin)

Jeffrey Myers
(Senate Special Committee on Illegal Drugs)

Mollie Dunsmuir
(Library of Parliament)

Sonya Norris
(Library of Parliament)

Daniel Dupras
(Library of Parliament)

Emmanuel Préville
(Library of Parliament)

David Goetz
(Library of Parliament)

Jay Sinha
(Library of Parliament)

Anthony Jackson
(Library of Parliament)

Leah Spicer
(Library of Parliament)

Rebecca Jesseman
(Senate Special Committee on Illegal Drugs)

Barbara B. Wheelock
(Office of Senator Eileen Rossiter)

3.3 ADMINISTRATION

Lise Bouchard
(Committees and Private Legislation Directorate of the Senate)

Nicole Bouchard
(Office of Senator Pierre Claude Nolin)

Martine de Launière
(Special Committee on Illegal Drugs)

Krista Durrell
(Committees and Private Legislation Directorate of the Senate)

Keli Hogan
(Committees and Private Legislation Directorate of the Senate)

Mireille Khouri
(Committees and Private Legislation Directorate of the Senate)

Nathalie Lemay-Paquette
(Committees and Private Legislation Directorate of the Senate)

Brigitte Martineau
(Committees and Private Legislation Directorate of the Senate)

Liliane Poiré
(Office of Senator Pierre Claude Nolin)

3.4 COMMUNICATIONS

Diane Boucher and her team
(Communications Directorate of the Senate)

Jean-Guy Desgagné
(Special Advisor – Senate Special Committee on Illegal Drugs)

David Newman
(Newman Communications)

3.5 REPORTERS, TRANSLATORS AND INTERPRETERS

Official Reporters of the Senate
(Debates and Publications Directorate of the Senate)

Translators
(Translation Bureau)

Interpreters
(Translation Bureau)

Thérèse Alier
(Private Text Editor)

APPENDIX II

LIST OF WITNESSES

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Cathy Airth	**Health Canada** Acting Director, Office of Canada's Drug Strategy, Health Environments and Consumer Safety Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Bruce Alexander	**Simon Fraser University** Professor, Department of Psychology (Victoria, British Columbia)	**April 23, 2001** **Ottawa, Ontario**
Lindsay Armitage	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Lyell Armitage	**Regina Health District** Former Director, Alcohol and Drug Services (Regina, Saskatchewan) **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
Guy Ati Dion	**University of Montreal** (Montreal, Quebec)	**October 29, 2001** **Ottawa, Ontario**
George Bailey	**As an individual**	**May 14, 2002** **Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Linda Barnes	**City of Richmond** City Councillor (Richmond, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Pat Baumet	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
David Beall	**Inter-American Drug Abuse Control Commission** Executive Secretary (Washington (D.C.), United States of America)	**March 18, 2002** **Ottawa, Ontario**
Line Beauchesne	**University of Ottawa** Professor, Department of Criminology (Ottawa, Ontario)	**October 16, 2000** **Ottawa, Ontario**
Denise Beaudoin	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Patricia Bégin	**National Crime Prevention Centre** Director, Research and Evaluation (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Mohamed Ben Amar	**University of Montreal** Professor, Pharmacology and Toxicology (Montreal, Quebec)	**June 11, 2001** **Ottawa, Ontario**
Chris Bennett	**As an individual**	**November 7, 2001 and May 14, 2002** **Vancouver and Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Marie-Andrée Bertrand	**University of Montreal** Professor Emeritus of Criminology **Town Hall Panelist (Montreal)**	**April 23, 2001 and May 30, 2002** **Ottawa, Ontario** **Montreal, Quebec**
Beverly Best	**Village of Salisbury** City Councillor (Salisbury, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**
Hilary Black	**B.C. Compassion Club Society** Founder and Director (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Bill Blanchard	**Royal Canadian Mounted Police** Sergeant (Regina, Saskatchewan) **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
Guillaume Blouin-Beaudoin	**As an individual**	**May 30, 2002** **Montreal Quebec**
Ron Bocking	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Tim Boekhout Van Solinge	**Utrecht University** Lecturer and Researcher in Criminology (Utrecht, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Renee Boje	**As an individual**	**May 14, 2002** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Stephen Bolton	**Department of Foreign affairs and International Trade** International Drug Officer, International Crime Division (Ottawa, Ontario)	**March 18, 2002** **Ottawa, Ontario**
Yvan Bombardier	**CACTUS** Intervener (Montreal, Quebec)	**May 30, 2002 and May 31st, 2002** **Montreal, Quebec**
Pierre-Charles Boudrias	**Dollard-Cormier Centre** (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
David Bourgeois	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Michael J. Boyd	**Canadian Association of Chiefs of Police** Chair of the Drug Abuse Committee and Deputy Chief of the Toronto Police Service (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Neil Boyd	**Simon Fraser University** Professor, Department of Criminology (Victoria, British Columbia)	**October 16, 2000** **Ottawa, Ontario**
Al Breau	**Village of Salisbury** Member of the Salisbury Municipal Drug Strategy (Salisbury, Nouveau-Brunswick) **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Serge Brochu	**University of Montreal** Professor and Director of the International Center for Comparative Criminology (Montreal, Quebec)	**December 10, 2001** **Ottawa, Ontario**
Nick Brusatore	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Perry Bulwer	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Fred Burford	**As an individual**	**September 10** **Toronto, Ontario**
Michele Burque	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Tracy Butler	**Salvation Army Harbour Light Addiction and Rehabilitation Treatment Centre, HCC St. John's** Program Director (St. John's, Newfoundland and Labrador)	**June 4, 2002** **St-John's, Newfoundland and Labrador**
Bill Campbell	**Canadian Society on Addiction Medicine** President (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Chris Carnell	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Nicolas Carrier	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
James Anthony Cavalier	**As an individual**	**September 10** **Toronto, Ontario**
Walter Cavalieri	**Toronto Harm Reduction Task Force** (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Jean-Pierre Chiasson	**Clinique du Nouveau Départ Inc.** Medical Director (Montreal, Quebec) **Town Hall Panelist**	**May 30, 2002** **Montreal, Quebec**
Ward Clapham	**Royal Canadian Mounted Police** Superintendent (Richmond, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Chantal Cloutier-Vautour	**Addiction Services, Health Region** Addiction Councillor (Moncton, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**
Pierre Cloutier	**As an individual**	**May 31, 2002** **Montreal, Quebec**
Peter Cohen	**University of Amsterdam** Professor (Amsterdam, Netherlands)	**May 28, 2001** **Ottawa, Ontario**
Émile Colas	**As an individual** **Town Hall Panelist**	**May 30, 2002** **Montreal, Quebec**
Mark Connolly	**Canada Customs and Revenue Agency** Director General, Contraband and Intelligence Services Directorate, Customs Branch (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
John W. Conroy	**As an individual** Barrister and Solicitor in *(R. v. Malmo-Levine and R. v. Caine)*	**March 11, 2002** **Ottawa, Ontario**
Randy Cormier	**Brentwood Recovery Home** Counsellor / Group Leader (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Terry Cormier	**Department of Foreign affairs and International Trade** Director, International Crime Division (Ottawa, Ontario)	**March 18, 2002** **Ottawa, Ontario**
Jean-Michel Coste	**French Monitoring Centre for Drugs and Drug Addictions** Director (Paris, France)	**October 1st, 2001** **Ottawa, Ontario**
Roland Côté	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Richard Cowan	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Michael Crichton	**Canada Customs and Revenue Agency** Chief, Intelligence and Operations Division, Contraband and Intelligence Services Directorate, Customs Branch (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Jean de Lavaltrie	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
France Desjardins	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Chuck Doucette	**Royal Canadian Mounted Police** (Vancouver, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Columbia**
Wally Dowhayko	**Royal Canadian Mounted Police** Sergeant, Windsor Drug Section (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Caroline Doyer	**Club Compassion de Montréal** President (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Toby Druce	**Seaton House** Program Supervisor (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Françoise Dubois-Arber	**Swiss Federal Commission for Drug Issues; University Institute for Social and Preventative Medicine** Member (Bern, Switzerland)	**February 4, 2002** **Ottawa, Ontario**
Georges Dulex	**Canton of Zurich, Criminal Police Department** Head (Zurich, Switzerland)	**February 4, 2002** **Ottawa, Ontario**
Johnny Dupuis	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Martin Earl	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Bill Elliot	**Canada Customs and Revenue Agency** Director, Windsor-St. Clair District (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Marc Emery	**B.C. Marijuana Party** (Vancouver, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Columbia**
Ron Enns	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Patricia Erickson	**Centre for Addiction and Mental Health** Researcher (Toronto, Ontario)	**May 14, 2001** **Ottawa, Ontario**
Julian Fantino	**Toronto Police Service** Chief (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Pat Fiacco	**City of Regina** Mayor (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Ross Findlater	**Regina Health District** Deputy Medical Health Officer, Alcohol and Drug Services (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Benedikt Fischer	**University of Toronto** Professor, Department of Public Health Sciences (Toronto, Ontario)	**September 17, 2001** **Ottawa, Ontario**
Jerry Fitzgerald	**Alcohol and Drug Services, Regina Health District** Manager (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Donald Fitzsimmons	**Alcohol and Drug Services, Regina Health District** Youth and Family Coordinator (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Mark Fortier	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Michel Frenette	**Royal Canadian Mounted Police** Drug Awareness Services Coordinator (Fredericton, New Brunswick) **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**
Thomas Fulgosi	**Seaton House** Shift Leader (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Nick Gallant	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Paul E. Garfinkel	**Centre for Addiction and Mental Health** President and C.E.O. (Toronto, Ontario)	**June 7, 2002** **Windsor, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Serge Gascon	**City of Montreal Police Service** Deputy Director (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Ryan Genie	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Michel Germain	**Comité permanent de lutte à la toxicomanie** Director General (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Rob Gillespie	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
John P. Gordon	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Hélène Goulet	**Health Canada** Director General, Tobacco Control Programme, Health Environments and Consumer Safety Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Caylie Graham	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Serge Granger	**University of Quebec in Montreal** Historian (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Brian Grant	**Correctional Service Canada** Director, Addictions Research Centre (Montague, Prince Edouard Island)	**June 10, 2002** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
David Griffin	**Canadian Police Association** Executive Officer (Ottawa, Ontario)	**May 28, 2001** **Ottawa, Ontario**
Peter Grin	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Derril W. Gudlaugson	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
André-Bernard Guévin	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Cathleen Guthrie	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Henry Haddad	**Canadian Medical Association** President (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Susan Hague	**Canada Customs and Revenue Agency** Senior Program Advisor, Contraband Operations Section, Contraband and Intelligence Services Directorate, Customs Branch (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Nichola Hall	**Grief to Action** Chairperson (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Ross Hall	**Grief to Action**	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Peter Hamel	**Club Compassion de Montréal** Executive Director (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
Tony Hammer	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Timothy Hampton	**NORML Saskatchewan** President, National Organization for Reform of Marijuana Laws (NORML) (Watrous, Saskatchewan) **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
Michael C. Hansen	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Andy Hathaway	**Centre for Addiction and Mental Health** Researcher (Toronto, Ontario)	**May 14, 2001** **Ottawa, Ontario**
Glen Hayden	**Canadian Police Association** Detective, Drug Control Section, Edmonton Police Service (Ottawa, Ontario)	**May 28, 2001** **Ottawa, Ontario**
Kenneth E. Hayes Jr.	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Kash Heed	**Vancouver Police Service** Drugs Section (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Sean Hunt	**As an individual**	**September 10, 2001** **Toronto, Ontario**
Thomas E. Hunter	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Alexis Jabarit	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Edward Jackson	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Gary E. Johnson	**State of New Mexico** Governor (Albuquerque, New Mexico – United States of America)	**November 5, 2001** **Ottawa, Ontario**
Cal Johnston	**Regina Police Service** Chief of Police (Regina, Saskatchewan)	**May 13, 2002** **Regina, Saskatchewan**
Hélène Jutras	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Harold Kalant	**University of Toronto** Professor Emeritus (Toronto, Ontario)	**June 11, 2001** **Ottawa, Ontario**
Sean Karl	**As an individual**	**May 14, 2002** **Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Robert Keizer	**Ministry of Health, Welfare and Sports of the Netherlands** Drug Policy Advisor (The Hague, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Jim Kelly	**Richmond Alcohol and Drug Action Team (RADAT)** Director (Richmond, British Colombia)	**May 14, 2002** **Richmond, British Columbia**
Perry Kendall	**As an individual** Health Officer (Victoria, British Columbia)	**September 17, 2001** **Ottawa, Ontario**
Paul E. Kennedy	**Solicitor General of Canada** Senior Assistant Deputy Solicitor General, Policing and Security Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Steven Kent	**City of Mount Pearl** Deputy Mayor (Mount Pearl, Newfoundland and Labrador)	**June 4, 2002** **Mount Pearl, Newfoundland and Labrador**
Barry King	**Canadian Association of Chiefs of Police** Former Chair of the Drug Abuse Committee and Chief of the Brockville Police Service (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Michel Kokoreff	**Lille University** (Lille, France)	**October 1st, 2001** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Dirk J. Korf	**University of Amsterdam** Professor (Amsterdam, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Michele Kubby	**As an individual**	**May 14, 2002** **Richmond, British Colombia**
Alain Labrousse	**Observatoire français des drogues et des toxicomanies** Chargé de mission (Paris, France)	**May 28, 2001** **Ottawa, Ontario**
C. Gwendolyn Landolt	**REAL Women of Canada** National Vice-President (Ottawa, Ontario) **Town Hall Panelist**	**June 6, 2002 and June 7, 2002** **Windsor, Ontario**
Michel Landry	**Dollard-Cormier Centre** Director of Professional Services and Research (Montreal, Quebec)	**December 10, 2001** **Ottawa, Ontario**
Julie Langlois	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Dana Larsen	**Cannabis Culture** (Vancouver, British Columbia) **Town Hall Panelist**	**November 7, 2001 and May 14, 2002** **Vancouver and Richmond, British Columbia**
Pierre Lauzon	**As an individual** **Town Hall Panelist**	**May 30, 2002** **Montreal, Quebec**
Marc-André Lavoie	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
James Leslie	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Robert G. Lesser	**Royal Canadian Mounted Police** Chief Superintendent (Ottawa, Ontario) **Canadian Association of Chiefs of Police** Vice Chair of the Drug Abuse Committee (Ottawa, Ontario)	**October 29, 2001 and March 11, 2002** **Ottawa, Ontario**
Mason Loh	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Dennis Long	**Breakaway** Executive Director (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Blair T. Longley	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Cynthia Low	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Phillippe Lucas	**Vancouver Island Compassion Society** Director (Victoria, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Gillian Lynch	**Health Canada** Director General, Drug Strategy and Controlled Substances Programme (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Mary Lynch	**Dalhousie University** Director, Canadian Consortium for the Investigation of Cannabinoids (Halifax, Nova Scotia)	**June 11, 2001** **Ottawa, Ontario**
Sandy MacDonald	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Edward J. MacEachern	**Royal Canadian Mounted Police** Sergeant (Fredericton, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**
David MacFarnam	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Chris MacLean	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Donald MacPherson	**City of Vancouver** Drug Policy Coordinator (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Nicole Maestracci	**Interministerial Mission for the Fight against Drugs and Drug Addiction** President (Paris, France)	**October 1st, 2001** **Ottawa, Ontario**
Achille Maillet	**Addiction Services, Health Region** Director (Moncton, New Brunswick)	**June 5, 2002** **Moncton, New Brunswick**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
David Malmo-Levine	**As an individual**	**November 7, 2001 and May 14, 2002** **Vancouver and Richmond, British Columbia**
Colin R. Mangham	**Prevention Source B.C.** Director (Vancouver, British Columbia)	**September 17, 2001** **Ottawa, Ontario**
Bill Marra	**Federation of Canadian Municipalities** Chair of the Standing Committee on Community Safety and Crime Prevention and City Councillor for the City of Windsor (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
Richard Mathias	**University of British Columbia** Professor, Health Care and Epidemiology Department (Vancouver, British Colombia)	**September 17, 2001** **Ottawa, Ontario**
Pierre Matteau	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
William B. McAllister	**University of Virginia** Professor (Charlottesville, Virginia, United States of America)	**March 18, 2002** **Ottawa, Ontario**
Michael McCoy	Touchtone Family Association (Richmond, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Colombia**
John McIntyre	**BC Civil Liberties Association** Member of the Board (Vancouver, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
W. Joe McKeown	**City of Regina** City Councillor **(Regina, Saskatchewan)** **Town Hall Panelist**	**May 13, 2002** **Regina, Saskatchewan**
William A. McKim	**Memorial University of Newfoundland** Acting Head, Department of Psychology (Mount Pearl, Newfoundland and Labrador) **Town Hall Panelist**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Ken McLennan	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Wanda McPherson	**Springboard** Diversion Coordinator (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Timothy Meehan	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Céline Mercier	**McGill University** Associate Professor, Department of Psychiatry (Montreal, Quebec)	**December 10, 2001** **Ottawa, Ontario**
Croft Michaelson	**Justice Canada** Director and Senior General Counsel, Strategic Prosecution Policy Section (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Dann Michols	**Health Canada** Assistant Deputy Minister, Healthy Environments and Consumer Safety Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Mike Moldovan	**As an individual**	**June 6, 2002** **Windsor, Ontario**
John P. Morgan	**City of New York Medical School** Professor of Pharmacology (City of New York, New York, United States of America)	**June 11, 2001** **Windsor, Ontario**
Tracy Mortensen	**As an individual**	**June 6, 2002** **Windsor, Ontario**
David Mossop	**Community Legal Assistance Society** (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Ethan Nadelman	**Lindesmith Centre** Executive Director (City of New York, New York, United States of America)	**November 5, 2001** **Ottawa, Ontario**
Janet Neves	**Federation of Canadian Municipalities** Policy Analyst (Ottawa, Ontario)	**March 11, 2002** **Ottawa, Ontario**
John Noddin	**New Brunswick Home and Schools Association** Former President **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**
Kathryn Noddin	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Dale Orban	**Canadian Police Association** Sergeant and Detective, Regina Police Service Executive Director, Regina Police Association (Ottawa, Canada)	**May 28, 2001** **Ottawa, Ontario**
Albert G. Ormiston	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Eugene Oscapella	**Canadian Foundation for Drug Policy** Executive Director (Ottawa, Ontario)	**October 16, 2000 and October 29, 2001** **Ottawa, Ontario**
Philip Owen	**City of Vancouver** Mayor (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Melanie Stephen Patriquen	**Marijuana Party of Canada** (Montreal, Quebec)	**June 5, 2002** **Moncton, New Brunswick**
Mike Patriquen	**Marijuana Party of Canada** (Montreal, Quebec) **Town Hall Panelist**	**June 5, 2002** **Moncton, New Brunswick**
Caroline Pelchat	**Royal Canadian Mounted Police** Researcher, Drug Awareness Service (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Michel Pelletier	**Royal Canadian Mounted Police** Sergeant and National Coordinator, Drug Awareness Service (Ottawa, Ontario)	**October 29, 2001** **Ottawa, Ontario**
Michel Perron	**Canadian Centre on Substance Abuse** Executive Director (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Martin Petit	**CACTUS** Community Worker (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Robert Pike	**Penitentiary Addictions Group** Classification Officer (St. John's, Newfoundland and Labrador)	**June 4, 2002** **Mount Pearl, Newfoundland and Labrador**
Jim Power	**Royal Canadian Mounted Police** Sergeant (Clarenville, Newfoundland and Labrador) **Town Hall Panelist**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Diane Power-Jeans	**Janeway Community Mental Health Division, HCC St. John's** Social Worker (St. John's, Newfoundland and Labrador)	**June 4, 2002** **Mount Pearl, Newfoundland and Labrador**
Fred Pritchard	**Marijuana Compassion Club of Windsor** Founder and Operator (**Windsor, Ontario)** **Town Hall Panelist**	**June 6, 2002** **Windsor, Ontario**
Norman Qworden	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Alan Randell	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Eleanor Randell	**As an individual**	**May 14, 2002** **Richmond, British Columbia**
Shauna Raycraft	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Jürgen Rehm	**University of Zurich** Professor (Zurich, Switzerland)	**May 14, 2001** **Ottawa, Ontario**
Rick Reimer	**As an individual**	**May 31, 2002** **Montreal, Quebec**
Dave Roberts	**Windsor Police Service** Inspector, Investigation Services (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Gerald Royce	**As an individual**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Jerome Sabourin	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Greg Schweitzer	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Darlene Simpson	**House of Sophrosyne** Director of Program (Windsor, Ontario)	**June 7, 2002** **Windsor, Ontario**
Eric Single	**University of Toronto** Professor, Department of Public Health Sciences (Toronto, Ontario)	**May 14, 2001** **Ottawa, Ontario**
Leon Smith	**As an individual**	**May 14, 2002** **Richmond, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Patrick Smith	**Centre for Addiction and Mental Health** Vice-President, Clinical Programs (Toronto, Ontario)	**June 7, 2002** **Windsor, Ontario**
Ted Smith	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Raf Souccar	**Royal Canadian Mounted Police** Superintendent (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Rob Spring	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Randall St. Jacques	**As an individual**	**June 6, 2002** **Windsor, Ontario**
Margaret Stanowski	**Springboard** Executive Director (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Paul St-Denis	**Justice Canada** Senior Counsel, Criminal Law Policy Section (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Diane Steber Büchli	**Swiss Federal Office of Public Health** Head, International Drug Affairs Unit (Bern, Switzerland)	**February 4, 2002** **Ottawa, Canada**
Art Steinmann	**Alcohol-Drug Education Service** Executive Director (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Marc-Boris St-Maurice	**Marijuana Party** Leader (Montreal, Quebec) **Town Hall Panelist**	**May 30, 2002 and May 31st** **Montreal, Quebec**
Ron Taverner	**Toronto Police Service** Sergeant, Superintendent (Toronto, Ontario)	**June 7, 2002** **Windsor, Ontario**
Rosaire Théorêt	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Rick Tipple	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Lilian To	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Ross Toller	**Correctional Service Canada** Deputy Commissioner, Prairie Region (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**
Chris Trenholm	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
John Turmel	**As an individual**	**May 30, 2002** **Montreal, Quebec**
Ray Turmel	**As an individual**	**May 30, 2002** **Montreal, Quebec**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Selene Tracy Tyndale	**Ontario Public Interest Research Group** Volunteer (Windsor, Ontario) **Town Hall Panelist**	**June 6, 2002** **Windsor, Ontario**
Mark Tyndall	**B.C. Centre for Excellence in HIV/AIDS** (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Ambros Uchtenhagen	**Addiction Research Institute** Retired Professor (Zurich, Suisse)	**February 4, 2002** **Ottawa, Ontario**
Steven Van Hoogstraten	**Ministry of Justice of the Netherlands** Director for International Criminal Affairs and Drugs Policy (The Hague, Netherlands)	**November 19, 2001** **Ottawa, Ontario**
Anne Vogel	**Gilwest Clinic** Manager (Richmond, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
John Walsh	**City of Mount Pearl** City Councillor (Mount Pearl, Newfoundland and Labrador) **Town Hall Panelist**	**June 3, 2002** **Mount Pearl, Newfoundland and Labrador**
Chuck Walter	**Royal Canadian Mounted Police** Officer in Charge, Operational Systems Policy Section, National Contract Policing Branch (Ottawa, Ontario)	**June 10, 2002** **Ottawa, Ontario**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Thia Walter	**As an individual**	**November 7, 2001** **Vancouver, British Columbia**
Mark A. Ware	**McGill University** Assistant Professor (Montreal, Quebec)	**May 31, 2002** **Montreal, Quebec**
David Weinberg	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Yves Wermelinger	**As an individual**	**June 5, 2002** **Moncton, New Brunswick**
Anna Marie White	**Focus on the Family** Policy Analyst (Vancouver, British Columbia)	**May 14, 2002** **Richmond, British Columbia**
Dean Wilson	**Vancouver Area Network of Drug Users (VANDU)** Executive Director (Vancouver, British Columbia)	**November 7, 2001** **Vancouver, British Columbia**
Cory Wint	**Inner Visions Recovery Society** (Vancouver, British Columbia) **Town Hall Panelist**	**May 14, 2002** **Richmond, British Columbia**
Brad Wolbaum	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**
Scott Wolbaum	**As an individual**	**May 13, 2002** **Regina, Saskatchewan**

NAME	ORGANIZATION	DATE AND LOCATION OF APPEARANCE
Danny Woods	**Windsor Police Service** Sergeant, Drug Enforcement Branch (Windsor, Ontario)	**June 7, 2002**
Alan Young	**As an individual** Associate Professor, Osgoode Hall Law School (Toronto, Ontario)	**September 10, 2001** **Toronto, Ontario**
Mark Zoccolillo	**McGill University** Professor, Department of Psychiatry (Montreal, Quebec)	**October 16, 2000** **Ottawa, Canada**

APPENDIX III

RESEARCH PAPERS *

A- RESEARCH PAPERS PREPARED BY THE PARLIAMENTARY RESEARCH BRANCH OF THE LIBRARY OF PARLIAMENT

AUTHORS	TITLE	DATE OF PUBLICATION
Lyne Casavant, Chantal Collin	**Illegal Drug Use and Crime : A Complex Relationship**	August 2001
Chantal Collin	**National Drug Policy: France**	August 2001
Chantal Collin	**National Drug Policy: Switzerland**	January 2002
Benjamin Dolin	**National Drug Policy: United States of America**	July 2001
Benjamin Dolin	**National Drug Policy: Netherlands**	August 2001
Daniel Dupras	**Canada's International Obligations Under the Leading International Conventions on the Control of Narcotics Drugs**	October 1998
David Goetz	**Drug Prohibition and the Constitution**	March 2001
Anthony Jackson	**The Costs of Drug Abuse and Drug Policy**	April 2002
Diane Leduc, Nancy Miller Chenier, Sonya Norris	**Inventory of Federal Research on Illegal Drugs and Related Issues**	October 2001

* All the research papers quoted in this appendix were produced at the request of the Senate Special Committee on Illegal Drugs and are available at: www.parl.gc.ca/illegal-drugs.asp

AUTHORS	TITLE	DATE OF PUBLICATION
Diane Leduc, Nancy Miller Chenier, Sonya Norris	**Inventory of Provincial and Territorial Research on Illegal Drugs and Related Issues**	May 2002
Gérald Lafrenière	**Police Powers and Drug-Related Offences**	March 2001
Gérald Lafrenière	**National Drug Policy: United Kingdom**	July 2001
Gérald Lafrenière	**National Drug Policy: Sweden**	April 2002
Gérald Lafrenière, Emmanuel Préville	**Reported Incidents, Convictions, Incarceration and Sentencing in Relation to Illegal Drugs in Canada**	May 2002
Gérald Lafrenière, Leah Spicer	**Illicit Drug Trends in Canada 1980-2001: A Review and Analysis of Enforcement Data**	June 2002
Robin MacKay	**National Drug Policy: Australia**	December 2001
Jay Sinha	**The History and Development of the Leading International Drug Control Conventions**	February 2001
Leah Spicer	**Historical and Cultural Uses of Cannabis and the Canadian "Marijuana Clash"**	April 2002

B- RESEARCH PAPERS ON GUIDING PRINCIPLES

AUTHORS	TITLE	DATE OF PUBLICATION
Thomas De Koninck **Laval University**	**The Role of Knowledge and Culture in Public Policy on Illegal Drugs**	June 2002
Roderick A. Macdonald **McGill University**	**The Governance of Human Agency**	May 2001
Jean-François Malherbe **University of Sherbrooke**	**The Contribution of Ethics in Defining Guiding Principles for a Public Drug Policy**	May 2002
Alvaro P. Pires **University of Ottawa**	**La politique législative et les crimes à « double face » : Éléments pour une théorie pluridimensionnelle de la loi criminelle**	June 2002

C- OTHER RESEARCH PAPERS

AUTHORS	TITLE	DATE OF PUBLICATION
François Dubois **Office of Senator Pierre Claude Nolin**	**The Federal Parliament and the Evolution of Canadian Legislation on Illegal Drugs**	June 2002
Léger Marketing **Montreal**	**An Exploratory Study Among Canadians About the Use of Cannabis**	June 2002
Diane Riley **University of Toronto**	**Drugs and Drug Control Policy: A Brief Review and Commentary**	November 1998
Barbara B. Wheelock **Office of Senator Eileen Rossiter**	**Physiological and Psychological Effects of Cannabis: Review of the Research Findings**	May 2002

APPENDIX IV

The Evolution of Canadian Drug Legislation (1908-1996): Offences, Penalties, Police Powers and Criminal Procedure*

Act	Offences	Penalties	Police Powers – Criminal Procedure
1908 – **Opium Act**	***Trafficking*** • **Importation for non-medical purposes and without the authorization of the Minister of Customs** • **Manufacture, sale or <u>possession, for the purpose of selling</u>, of raw or prepared opium** • **Manufacture, sale or <u>possession, for the purpose of selling</u>, opium prepared for the use of smokers**	**Indictment** • **Imprisonment for a term not exceeding 3 years; and / or** • **Fine of not less than $50 and not exceeding $1,000**	

*This chart is taken from the study prepared by François Dubois entitled *The Federal Parliament and the Evolution of Canadian Legislation on Illegal Drugs*. The study is available online at: www.parl.gc.ca/illegal-drugs.asp

Act	Offences	Penalties	Police Powers – Criminal Procedure
1911 – **Opium and Narcotic Drug Act**	***Trafficking***		***Police powers***
	• **Importation, transportation within Canada, manufacture, sale or offering for sale, <u>without lawful excuse</u>, of a drug for non-therapeutic or non-scientific purposes**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $500**	**Search warrants** • **Search warrant authorizing, on reasonable grounds:** ▪ **the search of the following places: dwelling houses, stores, boutiques, warehouses, gardens or ships; and** ▪ **the seizure of any drugs found there and of the containers in which they are found**
	• **Exportation, <u>without lawful excuse</u>, to a country that prohibits the importing of a drug**	**Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $500**	***Criminal procedure*** **Destruction of seized drugs** • **Order allowing the destruction of drugs and containers in which they were found after conviction of the accused** • **Order providing for the return of seized drugs if the accused is acquitted. If not claimed, they have to be destroyed within three months following the acquittal**
	Possession		
	• **Possession of a drug, <u>without lawful excuse</u>, for non-therapeutic or non-scientific purposes**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $500**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Possession of opium prepared for smokers or its use**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $50**	**Reverse onus** • **In a prosecution for trafficking or possession of drugs, the accused has to prove:** ▪ **the existence of a lawful excuse; or** ▪ **that the substances were used for therapeutic or scientific purposes**
	• **Being found, without lawful <u>excuse</u>, in a place where opium is smoked**	**Summary conviction** • **Imprisonment for a term not exceeding one month; and / or** • **Fine not exceeding $100**	**Writ of *certiorari*** • **Elimination of use of a writ of *certiorari***
	Legal trade in narcotic drugs **(Physicians)** • **Prescription of drugs for non-medical purposes particularly if they are not required for the treatment of illness**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $200**	**Reward** • **Possibility to use a portion of a fine paid by an offender to reward the person who filed the complaint against him**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	(Pharmacists)		
	• **Sale of drugs for medical purposes without prescription (in writing or by telephone) by a physician**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $200**	
	• **Refusal to keep a record of drug purchases and sales, the making of medications containing such substances and the renewal of prescriptions issued by a physician**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $200**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1920 – **Amendments to Act of 1911**	***Trafficking*** • **Exportation or importation, manufacture, transportation within Canada, sale and distribution of a drug <u>without a license</u>, or its importation at a port not designated by federal authorities** • **Exportation or importation, manufacture, transporting within Canada, sale and distribution of raw or prepared opium <u>without a license</u>**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	Possession • **Possession of drugs, <u>without a license</u>, for non-medical or non-scientific purposes**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal Trade in narcotic drugs		
	(Businesses)		
	• **Refusal to keep a record of activities, duly authorized by federal authorities, relating to the importing, exporting, manufacture, sale and distribution of drugs**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	(Physicians)		
	• **Refusal to provide information requested by federal authorities relating to the purchase, preparation or prescription of medications containing drugs**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	(Pharmacists)		
	• **Sale of drugs for medical purposes <u>without a prescription written and signed</u> by a physician**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $500 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Sale or administration of a product containing quantities of drugs exceeding the limits prescribed by the Act and without appropriate labelling to a child under 2 years of age**	**Summary conviction** • **Imprisonment for a term not exceeding one year; and / or** • **Fine of not less than $200 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1921 – **Amendments to Act of 1911**	***Trafficking*** • **Illegal activities as defined in the Act of 1920**	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months, to which may be added an additional period of 12 months for failure to pay a fine; and / or** • **Fine of not less than $200 and not exceeding $1,000**	***Criminal procedure*** **Forfeiture or return of seized drugs** • **Order providing for the forfeiture to the <u>Minister of Health</u> of seized drugs and the receptacles in which they were found following conviction of the accused** • **Order providing for the return of seized drugs if the accused was acquitted. If not claimed, they were forfeited to the <u>Minister of Health</u>, not later than two months following the acquittal, for disposal by the minister as he saw fit** **Reverse onus** • **Every person <u>possessing or occupying a place</u> (dwelling, store, boutique, warehouse, garden or ship) where a drug is found is deemed to possess such a substance where unable to prove that he:** ▪ **was in that place without his consent; or** ▪ **did not know that drugs were in that place.**
	• **Selling, giving or distributing drugs to a minor <u>without a license</u>**	**Indictment** • **Imprisonment for a term not exceeding 7 years**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • **Possession**	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months, to which may be added an additional period of 12 months for failure to pay a fine; and / or** • **Fine of not less than $200 and not exceeding $1,000**	**Where a person is charged with exporting, importing, making, transporting, selling, giving or distributing raw or prepared opium without first having obtained a license issued by federal authorities, he shall prove that he held such authorization.** **Certificate of a federal analyst** • **Admissibility in evidence of a certificate of a federal analyst respecting one or more drugs seized by police officers**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1922 – **Amendments to Act of 1911**	***Trafficking*** • **Illegal activities as defined in the Act of 1920, <u>with the exception of most offences involving raw or prepared opium without a license</u>** • **<u>Continuation of the offence regarding the exportation of raw or prepared opium</u>**	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months; and** • **Fine of not less than $200 and not exceeding $1,000** **(Deportation of immigrants upon completion of sentence)**	***Police powers*** **Search warrants** • **Authorization to conduct a search and seizure of drugs, <u>without a warrant,</u> in the following places: stores, boutiques, warehouses, gardens and ships** • **Authorization to to search a dwelling house, with a warrant, , where the police officer requesting such warrant has reasonable grounds to believe that such substances will be found there** ***Criminal procedure*** **Reverse onus** • **Repealed in the case of offences involving raw or prepared opium** • **Added for the offence of selling, giving or distributing a drug to a minor without a license**
	• **Selling, giving or distributing narcotic drugs to a minor, without a license**	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years** **(Whipping at court's discretion)** **(Deportation of immigrants upon completion of sentence)**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession		
	• **Possession**	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months; and** • **Fine of not less than $200 and not exceeding $1,000** **(Deportation of immigrants upon completion of sentence)**	
	• **Possession of pipes, lamps or any other equipment used to prepare or use opium, except where authorized by federal authorities**	**Summary conviction** • **Imprisonment for a term not exceeding one month; and / or** • **Fine not exceeding $100**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal trade in narcotic drugs		
	(Physicians)		
	• **Refusal to provide information requested by federal authorities relating to the purchase, preparation or prescription of medications containing drugs**	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of not less than $200 and not exceeding $1,000**	
	• **Prescription of drugs for non-medical purposes particularly if they are <u>not required for treatment of a disease</u>**	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine not exceeding $1,000**	
	(Pharmacists)		
	Sale of drugs for medical purposes <u>without a prescription written and signed</u> by a physician	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of not less than $200 and not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1923 – **Legislative Consolidation of the Act of 1911 and other amendments**	***Trafficking*** • **Exportation or importation, transportation within Canada, manufacture, sale, gift or distribution of drugs without a license, or its importation at a port not designated by federal authorities**	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years; and** • **Fine of not less than $200 and not exceeding $1,000** **Summary conviction** • **No amendment** **(The court may not impose a lesser sentence than that prescribed by the Act)**	***Police powers*** **Powers granted to police officers in 1911 and 1922 maintained** ***Criminal procedure*** **Criminal procedures adopted between 1911 and 1922 maintained, with the exception of:** • **Possibility to use a portion of a fine paid by an offender to reward the person who filed the complaint against him** ***New criminal procedures*** **Right of appeal** • **Right of appeal from a guilty verdict and/or from a sentence in the case of a conviction by way of summary conviction eliminated for the following offences:** ▪ **trafficking in or possession of drugs without a license** ▪ **selling, giving or distributing drugs to a minor without a license**
	• **Selling, giving or distributing narcotic drugs to a minor, without a license**	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years; and** • **Fine of not less than $200 and not exceeding $1,000** **(The court may not impose a lesser sentence than that prescribed by the Act)**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession		**Reverse onus**
	• **Possession**	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years; and** • **Fine of not less than $200 and not exceeding $1,000** **Summary conviction** • **No amendment** **(The court may not impose a lesser sentence than that prescribed by the Act)**	• **Procedure maintained for possession or trafficking without a license** • **Added in the case of offences of exporting or importing a drug without a license** • **Every physician charged with prescribing or administering a drug for non-therapeutic purposes is required to prove that the substance was used for medical purposes**
	• **Possession of pipes, lamps or any other equipment used to prepare or use opium, except where authorized by federal authorities**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $100**	**Fingerprints and criminal record** • **Provisions of the *Identification of Criminals Act* apply to persons convicted by way of summary conviction** **Certificate of the federal analyst** • **Authorization to file in evidence a certificate prepared by <u>a provincial analyst</u>**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Possession of opium prepared for smokers or its use**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $100**	
	• **Being found, without lawful excuse, in a place where opium is smoked**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding $100**	
	Legal trade in narcotic drugs **(Businesses)**		
	• **Refusal to keep a record of activities, duly authorized by federal authorities, relating to the importing, exporting, manufacture, sale and distribution of narcotic drugs**	**Summary conviction** • **No amendment**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	(Physicians)		
	• **Prescription of drugs for non-medical purposes particularly if they are not required for treatment of a disease**	**Summary conviction** • **No amendment**	
	(Pharmacists)		
	• **Sale of a drug for medical purposes without a prescription written and signed by a physician or <u>the multiple renewal of such prescription</u>**	**Summary conviction** • **No amendment**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1925 – **Amendments to Act of 1923**	***Trafficking*** • **Exportation or importation, transportation within Canada, manufacture, giving, selling and distributing a drug without a license, or its importation at a port not designated by a federal authority** ***Possession*** • **Possession**	**Indictment** • **No amendment** **Summary conviction** • **No amendment** **Indictment** • **No amendment** **Summary conviction** • **In addition to the other penalties provided for by the Act of 1923, the court may, at its discretion, impose a sentence of hard labour**	***Police powers*** **Searches** • **Authorization to seize, <u>without a warrant</u>, <u>a motor vehicle, boat, rowboat or any means of transportation in which a drug was found</u>** • **Addition of the power to search any person found on the premises of the search** ***Criminal procedure*** **Forfeiture of seized drugs** • **Order providing for the forfeiture to the Minister of Health of a motor vehicle, boat, rowboat or any other means of transportation <u>in which a drug was found</u>** **Defence arguments of physicians** • **Elimination of the defence allowing a physician to prescribe a drug to a sick person or drug addict so that he could administer it to himself**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal trade in narcotic drugs		**A physician may thus no longer use the defence that a patient who administers medication to himself is administering a therapeutic treatment authorized under the *Opium and Narcotic Drug Act***
	(Physicians)		
	• **Prescription of drugs for non-medical purposes, particularly if they are not required for the treatment of a disease, or which <u>is designed to treat a drug addict who has developed a dependency on such a substance as a result of abusing it</u>**	**Indictment** • **Imprisonment for a term of not less than 3 months and not exceeding 5 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of not less than $200 and not exceeding $1,000** • **The court may, at its discretion, impose a sentence of hard labour**	
	(Pharmacists)		
	Sale of a drug for medical purposes without a prescription written and signed by a physician and <u>without authenticating the signature</u>, or renewal of such a prescription on a number of occasions	**Summary conviction** • **No amendment**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1929 – **Legislative Consolidation of Act of 1923 and other amendments**	***Trafficking*** • **Exporting or importing, transporting within Canada, preparing, giving, selling and distributing without a license, importation at a port not designated by federal authorities, <u>a drug or substance the owner of which falsely claims is a drug</u>** • **Drug trafficking by mail**	**Indictment** • **No amendment** **Summary conviction** • **No amendment** **(In addition to the other penalties provided for by the Act of 1923, the court may, at its discretion, impose a sentence of whipping)** **Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years; and** • **Fine of not less than $200 and not exceeding $1,000** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months; and / or** • **Fine of not less than $200 and not exceeding $1,000**	***Police powers*** **Writ of assistance** • **Possibility of obtaining a writ of assistance in the context of a police operation conducted under the *Opium and Narcotic Drug Act*** **This new provision made it possible to circumvent the obligation to obtain a warrant to search a dwelling house** **Seizure and forfeiture** • **Expanded powers of seizure and forfeiture previously provided in the Act with respect to pipes, lamps and any other equipment or <u>the various parts thereof</u> used to prepare or use opium** • **Extended powers of seizure and forfeiture previously provided for in the Act with respect to money used to purchase drugs** • **Authorization to resort to force, if necessary, to conduct a search. Police officers can also be assisted by other persons**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • **Possession of drugs (or of a substance the owner of which falsely claims is a drug), without a license, for non-therapeutic purposes**	**(In addition to the other penalties provided for by the Acts of 1923 and 1925, the court may, at its discretion, impose a sentence of whipping)** **Indictment** • **No amendment** **Summary conviction** • **No amendment** **(In addition to the other penalties provided for by the Acts of 1923 and 1925, the court may, at its discretion, impose a sentence of whipping)**	• **Expansion of the power to seize and confiscate a motor vehicle, boat, rowboat or any other means of transportation <u>used by a trafficker convicted of an offence under the Act, regardless of whether it contained drugs</u>** *Criminal procedure* **Reverse onus** • **In any case involving trafficking in, or unlawful possession of, a drug or substance in which the owner falsely claims is a drug, Crown prosecutor is not required to establish that the accused did not have authorization duly issued by federal authorities to commit one of the offences with which he was charged** • **If the accused alleged that he had such authorization, the burden of proof was on him**
	• **Possession of pipes, lamps, any other equipment or <u>the various parts thereof</u> used to prepare or use opium, except where authorized by federal authorities** • **Possession of opium prepared for**	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding <u>$50</u>**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	smokers or its use	**Summary conviction** • **Imprisonment for a term not exceeding 3 months; and / or** • **Fine not exceeding <u>$50</u>**	**Certificate of the federal analyst** • **Amendments to the procedure for admissibility in evidence of the certificate of the federal or provincial analyst, stipulating that, henceforth, that document would constitute *prima facie* and peremptory evidence of the status of the person giving or issuing it** • **In the circumstances, proof of the appointment of that analyst or authentication of his signature was not necessary**
	• **Obtaining drugs from two physicians**	**Summary conviction** • **Fine not exceeding $500 to which may be added a term of imprisonment not exceeding 12 months for failure to pay**	**Writ of *certiorari*** • **Repeal of the provision eliminating recourse to a writ of *certiorari***
	Legal trade in narcotic drugs **(Physicians)** **Prescription of drugs for non-medical purposes, particularly if they are not required for the treatment of a disease, or which is designed <u>to treat a drug addict who has developed a dependency on such a substance as a result of abusing it</u>** **(Pharmacists)**	**Summary conviction** **(No amendment)** **(The court may not impose a lesser sentence than that prescribed by the Act)**	**Right of appeal** • **Expanded the prohibition against appealing from a guilty verdict and/or sentence in the case of a <u>summary conviction</u> for the following offence:** ▪ **<u>possession of, or trafficking in, a substance the owner of which falsely claims is a drug</u>**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• Selling or administering a product containing quantities of drugs exceeding the limits prescribed by the Act and without appropriate labelling to a child less than 2 years of age	Summary conviction (First offence) • Fine not exceeding $100 (Subsequent offences) • Imprisonment for a term not exceeding 3 months; and / or • Fine not exceeding $100	
	• Refusal to keep a record of drug purchases and sales, the making of medications containing such substances and the renewal of prescriptions issued by a physician	Summary conviction • Imprisonment for a term not exceeding 18 months; and / or • Fine of not less than $200 and not exceeding $1,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1932 – **Amendments to Act of 1929**	***No amendment***	***No amendment***	***Criminal procedure*** **Right of appeal** • **Significant expansion of the prohibition from appealing of a guilty verdict and/or a sentence in the case of a <u>summary conviction</u> for the following offences:** ▪ **Prescribing of a drug for non-medical purposes, particularly if they are not required for the treatment of a disease, or which is intended to treat a drug addict who has developed a dependency to such a substance as a result of abusing it (physicians);** ▪ **refusal to provide information required by federal authorities relating to the purpose, preparation of prescription of medications containing drugs (physicians);** ▪ **obtaining drugs from two physicians;**

Act	Offences	Penalties	Police Powers – Criminal Procedure
			▪ **selling or administering a product containing quantities of drugs exceeding the limits prescribed by the Act and without appropriate labelling to a child under 2 years of age (pharmacists);** ▪ **refusal to keep a record of drug purchases and sales, the preparation of medications containing such substances and the renewals of prescriptions issued by a physician (pharmacists);** ▪ **unlawful possession of pipes, lamps and any other equipment or <u>the various parts thereof</u> used to prepare or use opium; and** ▪ **drug trafficking by mail**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1938 – **Amendments to Act of 1929**	***Trafficking*** • **Cultivation of the opium poppy or cannabis sativa without a licence** ***Possession*** **No amendment** ***Legal trade in narcotic drugs*** **No amendment**	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years** • **Fine of not less than $200 and not exceeding $1,000** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months** • **Fine of not less than $200 and not exceeding $1,000** **(Deportation of immigrants – whipping)**	***Criminal procedure*** **Right of appeal** ▪ **Repeal the prohibition against appealing from a guilty verdict and/or sentence in the case of a <u>summary conviction</u> for the following offence:** ▪ **obtaining drugs from two physicians**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1946 – **Amendments to Act of 1929**	***Trafficking*** • **Selling, giving, <u>illegally administering</u> or distributing drugs to a minor (1921)**	**No amendment**	***Criminal procedure*** **Reverse onus** • **Applicable to the offence of cultivation of cannabis sativa or the opium poppy without a licence**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1954 – **Amendments to Act of 1929**	***Trafficking***	***(Repealed sentence of forced labour)*** ***(Repealed provisions respecting the deportation of immigrants . They were transferred to the Immigration Act in 1952, but still applied to drug offences)***	***Police powers*** **Seizure and forfeiture** • **Amended powers of seizure and forfeiture to exclude the equipment used to prepare or smoke opium (offences repealed)** ***Criminal procedure***
	• **Importation, exportation, manufacture, sale, administering, transportation, delivery and distribution of a drug or substance the owner of which claims is a narcotic drug**	**Indictment** • **Imprisonment for a term not exceeding 14 years** • **Whipping (at court's discretion)**	**Reverse onus** • **Possession for the purpose of trafficking** ▪ **In every criminal prosecution involving possession for the purpose of trafficking, Crown prosecutor was required to prove that the accused had been illegally in possession of the drug. Otherwise, he was acquitted** ▪ **In the contrary case, the respondent had to prove that he did not possess the substance for the purpose of trafficking. If he did so, he was convicted of possession, otherwise of trafficking**
	• **Possession for the purpose of trafficking**	**Indictment** • **Imprisonment for a term not exceeding 14 years** • **Whipping (at court's discretion)**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Cultivation of the opium poppy or cannabis sativa without a license** ***(Repeal of the offence of selling, giving or administering a drug to a minor)*** ***(Repeal of the offence of drug trafficking by mail)***	**No amendment**	
	Possession		
	Possession	**Indictment** • **Imprisonment for a term of not less than 6 months and not exceeding 7 years** **Summary conviction** • **Imprisonment for a term of not less than 6 months and not exceeding 18 months** **(Whipping (at court's discretion))** ***(The court may not impose a lesser sentence than the minimum prescribed by the Act)***	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	(Repeal of the offence of possessing opium prepared for smokers or use of such a substance) ***(Repeal of the offence of being found in a place where opium is smoked)*** ***(Repeal of the offence of possession of pipes, lamps or any other equipment and the various parts thereof used to prepare or use opium)*** ***Legal trade in narcotic drugs*** • **No amendment**		

Act	Offences	Penalties	Police Powers – Criminal Procedure
1961 – **Narcotic Control Act**	***Trafficking*** • **Illegal activities defined in the Act of 1954, with the exception of the offences of importing and exporting** • **As was the case in the former acts, this offence was extended to include substances falsely presented by a trafficker as being scheduled drugs** • **Exporting and importing** • **Possession for the purpose of trafficking**	***(Repeal of sentence of whipping)*** **Indictment** • **Imprisonment for a term not exceeding 25 years (life)** **Indictment** • **Imprisonment for a term of not less than 7 years and not exceeding 25 years (life)** **Indictment** • **Imprisonment for a term not exceeding 25 years (life)**	***Police powers*** **Writ of assistance** • **Provision maintained without amendment** **Searches** • **Continuation of provisions authorizing searches <u>without a warrant</u> of any place and of persons found there (with the exception of a dwelling house) where police officers have reasonable grounds to believe there are drugs or equipment used to make or use them** • **Continuation of provisions authorizing the use of force, if necessary, to conduct a search, stipulating that a police officer may force entry, break in a wall or ceiling or break objects that might contain drugs**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Cultivation the opium poppy or cannabis sativa without a licence**	**Indictment** • **Imprisonment for a term not exceeding 7 years**	• **Continuation of the procedure providing that a police officer may obtain the assistance of a person whom he designates to carry a search**
	Possession		
	Possession	**Indictment** • **Imprisonment for a term not exceeding 7 years**	***Criminal procedure*** **Reverse onus** • **Continuation of the procedure adopted in 1954 in the case of the offence of possession for the purpose of trafficking, with a few amendments to clarify the procedure and guarantee greater compliance with the principle of the presumption of innocence**
	Legal trade in narcotic drugs		
	• **Transfer to the regulations of the statutory provisions enacted between 1911 and 1946 respecting the legal trade in drugs** • **Regulations made by the Governor in Council respecting the legitimate activities of businesses, physicians and pharmacists involving sale, production, distribution, administration, prescription, record keeping and offences**	**Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $500**	• **Continuation of the procedure providing that an accused must prove that he acted lawfully, for therapeutic or scientific reasons <u>under a government authorization</u>** **Certificate of a federal or provincial analyst** • **Continuation of this provision, with the stipulation that the analyst would be appointed under the *Food and Drugs Act*.**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Preventive detention • **For offences of trafficking, possession for the purpose of trafficking, exporting or importing drugs, the court may order the accused placed in preventive detention for an indeterminate period of time, in lieu of any other sentence that might be imposed** **(This provision was never proclaimed in force)** ***Treatment*** • **In the case of the offences regarding possession, trafficking, possession for the purpose of trafficking and importing or exporting drugs, the court, may, upon application by the Crown prosecutor, remand the accused to custody for examination to determine whether he is eligible for an addiction treatment program** • **If such is the case, the accused shall be sentenced to custody for treatment for an indeterminate period of time in lieu of any other sentence provided for by the Act**		**Forfeiture** • **Continuation of the forfeiture to the Minister of Health and Welfare of drugs, syringes, needles, equipment and money used to use, make or purchase such substance following an offence of possession, trafficking, possession for the purpose of trafficking or import/export *(The minister may dispose of the substances in the manner provided for by regulation)*** • **Continuation of the procedure allowing forfeiture of any motor vehicle, aircraft, ship or other means of transportation used for the purpose of trafficking, exporting or importing drugs** **Restitution** • **Continuation of the system providing for an order to restore drugs or objects related to the making or use of drugs prior to their forfeiture to the Minister of Health and Welfare** **But, certain criteria apply before a court orders restitution:**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• In the case of a first offence, preventive detention may not exceed 10 years • The accused has a right of appeal, is subject to the *Parole Act* and, at any time, may be referred to preventive detention if he uses drugs during his probation period • Where a province adopts a preventive detention policy and an addiction treatment program (in cases not involving an offence under the Act), the federal government may enter into an agreement with the competent provincial authorities to transfer addicts to specialized federal institutions. (These provisions were never proclaimed in force)		▪ Application must be made to the court not later than two months after the seizure; ▪ If it is satisfied that the applicant is not involved in the offence and if it is satisfied that they will not be necessary to the prosecution of an investigation or criminal case, the court shall immediately return the drugs or objects seized, ▪ However, where the court decides otherwise, they will not be restored until the end of the trial or upon expiry of a period of four months if no prosecution is commenced against the accused The applicant has a right of appeal Application by third parties • Creation of a system authorizing a third party (a person who have not been involved in the offence) to apply to the court for an order to restore an aircraft, motor vehicle, ship or any other means of transportation.

Act	Offences	Penalties	Police Powers – Criminal Procedure
			The procedures that applied for the issuing of such an order were similar to those described above for the return of seized objects. **The third party had a right of appeal** **Right of appeal** • **Repeal of the prohibition to appeal from a guilty verdict or a sentence for certain offences** **Fingerprints and criminal record** • **Repeal of the provision making the *Identification of Criminals Act* applicable to persons convicted by summary conviction (1923)**

Act	Offences	Penalties	Police Powers – Criminal Procedure
1961 – **Food and Drugs Act**	***Addition of Part III to the Food and Drugs Act – Barbiturates and amphetamines*** **(Controlled drugs – Schedule G)** ***Trafficking*** • **Manufacture, sale, transportation, exportation, importation or delivery of a controlled drug without the authorization of federal authorities** ***(Exclusion of the administration or distribution of such substances)*** ***Possession for the purpose of trafficking*** • **Possession for the purpose of trafficking**	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months** **Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	***Police powers*** • **Police powers similar to those provided for by the *Narcotic Control Act* of 1961, which, however, <u>do not apply to possession of controlled drugs</u>** ***Criminal procedure*** • **Criminal procedures similar to those provided for by the *Narcotic Control Act* of 1961, which, however, <u>do not apply to the possession of controlled drugs</u>**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • **<u>Possession is not an offence</u>**		
	Legal trade in controlled drugs • **Regulations made by the Governor in Council**	**Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $500**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1969 – **Food and Drugs Act**	***Addition of Part IV to the Food and Drugs Act – Hallucinogenics*** **(Restricted drugs – Schedule J)** ***Trafficking*** • **Manufacture, sale, transportation, exportation, importation or delivery of a restricted drug without the authorization of federal authorities** ***(Exclusion of administration or distribution of such substances)*** ***Possession for the purpose of trafficking*** • **Possession for the purpose of trafficking**	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months** **Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	***Police powers*** • **Police powers similar to those provided for in Part III. <u>Unlike those provided for in that part, they also apply to possession of restricted drugs</u>** ***Criminal procedure*** • **Criminal procedures similar to those provided for by Part III. <u>Unlike those provided for in that part, they also apply to possession of restricted drugs</u>** **Certificate of the federal or provincial analyst** • **Amendment to the procedure for admissibility of the certificate of a federal or provincial analyst at trial** **Under the Act of 1961, a court could admit into evidence the certificate of the analyst appointed under the *Food and Drugs Act.* That document constituted *prima facie* and peremptory evidence of the status of the person who gave or issued it.**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • **Possession**	**Indictment** • **Imprisonment for a term not exceeding 3 years; or** • **Fine of $5,000** **Summary conviction** ***First offence*** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** ***Subsequent offences*** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	**In the circumstances, it was neither necessary to prove the appointment of that person or to authenticate his signature.** **In 1969, this procedure was amended to enable Crown prosecutor to prove that status orally under oath, by affidavit or by solemn declaration of the person who signed the certificate. That person did not have to appear in court** **However, a judge could require the analyst to appear before him to be examined or cross-examined so as to better assess the information contained in the affidavit or solemn declaration**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Legal trade in restricted drugs		
	• **Regulations made by the Governor in Council**	**Summary conviction** • **Imprisonment for a term not exceeding 18 months; and / or** • **Fine of $500**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1969 – **Amendments to Narcotic Control Act**	***Possession***	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** ***First offence*** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** ***Subsequent offences*** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	***Criminal procedure*** **Certificate of the analyst** • **Amendments identical to those made to the *Food and Drugs Act***

Act	Offences	Penalties	Police Powers – Criminal Procedure
Act of 1985 – **Amendments to Act of 1961**	***Possession*** • **Disclosure of previous prescriptions to a physician** ***(This new offence was designed to prevent a person from consulting two physicians at the same time to obtain drugs. It is similar to the provision introduced in the Opium and Narcotic Drug Act in 1929 prohibiting anyone from obtaining drugs from two physicians)***	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; or** • **Fine not exceeding $1,000** **(Second offence)** • **Imprisonment for a term not exceeding one year; or** • **Fine not exceeding $2,000**	***Police powers*** **Searches** • **Abolition of the writ of assistance** ***Criminal procedure*** • **Repeal of the reverse onus provision for the offence of possession of drugs for the purpose of trafficking**

Act	Offences	Penalties	Police Powers – Criminal Procedure
Act of 1988 – **Amendments to Act of 1961**	***Trafficking*** **Exporting and importing**	**Indictment** • **Imprisonment for a term not exceeding 25 years (life)** ***(In 1987, the Supreme Court of Canada ruled in R. v. Smith that it was unconstitutional to impose a sentence of imprisonment for a term of not less than 7 years)***	***Police powers*** **The *Criminal Code* provisions concerning search, seizure and detention powers relating to the offences of possession of property obtained through drug trafficking and laundering the proceeds of crime also apply to the *Narcotic Control Act*** ***Criminal procedure*** **The *Criminal Code* provisions concerning forfeiture and restoration, third party applications and the management of property seized in relation to the offences of possession of property obtained through drug trafficking and laundering the proceeds of crime also apply to the *Narcotic Control Act***
	• **Possessions of property obtained through drug trafficking** ***(This new offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)***	**(Value of more than $1,000)** **Indictment** • **Imprisonment for a term not exceeding 10 years** • **(Value of less of than $1,000)** **Indictment** • **Imprisonment for a term not exceeding 2 years**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		Summary conviction • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	
	• **Laundering the proceeds of crime** ***(This new offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)***	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
1996 – **Controlled Drugs and Substances Act**	**Schedule I: Opiates (opium, morphine, heroin, codeine, cocaine, morphinans, etc.)** **Schedule II: Cannabis (marijuana), hashish, cannabinol, etc.** **Schedule III: Amphetamines and hallucinogenics (mescaline, LSD, DET, PCP)** **Schedule IV: Barbiturates, benzodiazepines (Seconal, Luminal, Valium and Librium) and anabolic steroids** **Schedule V: Other substances giving rise to abuse** **Schedule VI: Precursors (simili-drugs and designer drugs)** **Schedule VII: Cannabis trafficking** • **Under 3 kg of cannabis (marijuana) or hashish** **Schedule VIII: Cannabis possession** **Under:** • **1 gram of hashish; or** • **30 grams of cannabis**		***Police powers*** **Search and seizure** • **Repeal of the right to conduct searches and seizures without a warrant** • **Search or seizure <u>without a warrant</u> allowed in exigent circumstancts** • **Continuation of procedures for the seizure of a means of transportation, an object or a designated substance with the use of force, if necessary, or assistance of persons other than police officers** **However, following a search or seizure with or without a warrant, police officers are required to send a report to the justice of the peace and to the Minister of Health stating:** ▪ **the place of the search;** ▪ **the designated substance; and** ▪ **the place where that substance was stored**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Trafficking or possession for the purpose of trafficking • **Administration, gift, transportation, dispatch, and delivery of a designated substance, or any other activity outside the regulatory framework** ***(Designated substance includes: natural and synthetic drugs, any other substance the owner of which falsely claims is a drug and objects used to use, make or store a drug)***		• **Extension of powers of search already provided for by the *Narcotic Control Act* to:** ▪ **real property and those modified for criminal purposes (premises of criminal organizations); and** ▪ **where police officers have reasonable grounds, to any other object which might establish evidence of an offence**
	Schedules I and II	**Indictment** • **Imprisonment for a term not exceeding 25 years (life)**	• **Validity of a search warrant in a province other than the one where it was given** **Policy immunity**
	Schedule III	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	• **In 1996, the *Controlled Drugs and Substances Act* allowed the Governor in Council to authorize by regulations police officers to possess and traffic in designated substances sting operations** ***(Currently, sections 4, 5, 6, 7, 8 and 9 of the CDSA prohibit possession, possession for the purpose of trafficking, importing, exporting, producing narcotics, possession of***

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule IV	**Indictment** • **Imprisonment for a term not exceeding 3 years** **Summary conviction** • **Imprisonment for a term not exceeding one year**	***property obtained by criminal activity and laundering of proceeds of crime.*** ***However, section 3 of the Narcotic Control Regulations authorizes inspectors and police officers to possess drugs for the purposes of or in relation to their duties. This provision existed in the regulations relating to the Narcotic Control Act to prevent a police officer from being charged with possession following a search)*** ***In addition, the police enforcement regulations made under the Controlled Drugs and Substances Act provides for an exemption for peace officers from the application of sections 4, 5, 6, 7 8 and 9 of the Act. In that case, the persons concerned by that provision must at all times be active members of a police force and must be found in the performance of their duties during the investigation in question)***
	Schedule VII • **Cultivation or production**	**Indictment** • **Imprisonment for a term not exceeding 5 years less a day**	
	Schedules I and II (except cannabis)	**Indictment** • **Imprisonment for a term not exceeding 25 years (life)**	
	Cannabis	**Indictment** • **Imprisonment for a term not exceeding 7 years**	• **In December 2001, the *Criminal Code* was amended (Bill C-24) to grant police officers, on certain conditions, legal immunity when required to commit an indictable**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule III	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 18 months**	**offence in the course of an investigation or operation to infiltrate a criminal or terrorist organization. However, they are granted no legal immunity if they commit the following offences: murder, manslaughter, bodily harm, obstructing the administration of justice and sexual assault.**
	Schedule IV	**Indictment** • **Imprisonment for a term not exceeding 3 years** **Summary conviction** • **Imprisonment for a term not exceeding one year**	***Criminal procedure*** **Sentencing** • **Definition of guiding principles for sentencing (compliance with the Act, maintaining a just and peaceful society, social reintegration, treatment and reparation of harm caused to victims)** • **Definition of aggravating circumstances:** ▪ **use of a weapon;** ▪ **resorting to violence;** ▪ **trafficking in a substance designated under Schedules I, II, III and IV with a minor or on a school ground**
	▪ **Exporting and importing** **Schedules I and II**	**Indictment** • **Imprisonment for life (25 years)**	
	Schedules III and VI	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		• Imprisonment for a term not exceeding 18 months	▪ prior convictions under the Act; ▪ and use of a minor to commit an offence
	Schedules IV or V	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction • Imprisonment for a term not exceeding one year	• Any court that decides not to impose a sentence of imprisonment in cases involving aggravating circumstances must give reasons for that decision Forfeiture • Continuation of the provision allowing forfeiture of: ▪ designated substances; ▪ means of transportation and property acquired by drug trafficking (expands powers to include ordinary real property or real property modified for criminal purposes); and ▪ proceeds of crime • Continuation of the procedure regarding applications by third parties, stipulating, however, that the application must be made by Crown prosecutor. He must prove that the property is necessary to

Act	Offences	Penalties	Police Powers – Criminal Procedure
	• **Possession of property obtained through trafficking in designated substances** ***(This offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens)***	**(Value of more than $1,000)** **Indictment** • **Imprisonment for a term not exceeding 10 years** **(Value of less of than $1,000)** **Indictment** • **Imprisonment for a term not exceeding 2 years** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	**that the property is necessary to the investigation and prosecution. Otherwise, property is automatically returned to the owner** • **Creation of a restraint order in respect of offence-related property, real property and proceeds of crime** • **Creation of a separate procedure for restoring or disposing of designated substances in order to clarify the provisions of the *Narcotic Control Act* in this respect** • **Possibility that property or proceeds of crime may be forfeited to the Minister of Public Works and Government Services Canada or the <u>Solicitor General of a province.</u>**
	• **Laundering of the proceeds of crime** ***(This n offence applies to the illegal activities of cultivating, trafficking in, exporting and importing drugs in Canada or in a foreign country where those offences are committed by Canadian citizens and is more particularly aimed at money laundering)***	**Indictment** • **Imprisonment for a term not exceeding 10 years** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $2,000**	**Federal inspectors** • **Definition of the powers of inspectors appointed by the federal government to enforce regulations governing legal trade of designated substances.** **Inspectors may:**

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Possession • **Possession** **Schedule I** **Schedule II**	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** **Indictment** • **Imprisonment for a term not exceeding 5 years less a day** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000**	▪ **enter (with the consent of one of the occupants), examine and search, <u>without a warrant</u> any place, equipment or receptacle used to produce or store a designated substance or precursor;** ▪ **search any dwelling house, <u>with a warrant</u> used to produce or store a designated substance or precursor;** ▪ **take away any computer hardware used to store information on designated substances or precursors;** ▪ **seize such substances if necessary and return them in accordance with the regulations; and** ▪ **use force or be accompanied by a police officer to execute their warrant** **Arbitration and designated regulations** • **Creation of a special procedure - the Governor in Council may designate regulations – known as "designated regulations" – the**

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • Imprisonment for a term not exceeding one year; and / or • Fine not exceeding $2,000	contravention of which is dealt with under special administrative orders • Creates an arbitration mechanism enabling pharmacists, physicians and businesses to dispute orders made under designated regulations by the Department of Health and following an investigation by an investigator into offences under the designated regulations
	Schedule VIII	Summary conviction • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	
	Schedule III	Indictment • Imprisonment for a term not exceeding 3 years Summary conviction (First offence) • Imprisonment for a term not exceeding 6 months; and / or • Fine not exceeding $1,000	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding of $2,000**	
	• **Disclosure of previous prescriptions to a physician (1985)**		
	Schedule I	**Indictment** • **Imprisonment for a term not exceeding 7 years** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** **(Subsequent offences)** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
	Schedule II	**Indictment** • **Imprisonment for a term not exceeding 5 years less a day** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** **(Subsequent offences)** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	
	Schedule III	**Indictment** • **Imprisonment for a term not exceeding 3 years**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		Summary conviction **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000** **(Subsequent offences)** • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	
	Schedule IV	**Indictment** • **Imprisonment for a term not exceeding 18 months** **Summary conviction** **(First offence)** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000**	

Act	Offences	Penalties	Police Powers – Criminal Procedure
		(Subsequent offences) • **Imprisonment for a term not exceeding one year; and / or** • **Fine not exceeding $2,000**	
	Legal trade in narcotic drugs • **Regulations made by the Governor in Council**	**Indictment** • **Imprisonment for a term not exceeding 3 years; and / or** • **Fine not exceeding $5,000** **Summary conviction** • **Imprisonment for a term not exceeding 6 months; and / or** • **Fine not exceeding $1,000**	
	Therapeutic use of cannabis • **Authorization to use this designated substance for therapeutic or scientific purposes** **Under section 56 of the Act, the Minister of Health may on such terms and conditions as he may**		

Act	Offences	Penalties	Police Powers – Criminal Procedure
	set, exempt from the application of all or any part of the Act any person or class of persons or any designated substance referred to in a schedule to the Act **In July 2000, this procedure was ruled unconstitutional by the Ontario Court of Appeal in *R. v. Parker*. At the time, the court held that the minister's power to grant an exemption to allow the use of marijuana or other drugs for therapeutic purposes was too broad and contrary to section 7 of the *Canadian Charter of Rights and Freedoms* (liberty and security of the person, fundamental justice)** **To correct the situation, the federal government made regulations in July 2001 allowing the therapeutic use of cannabis** ***Preventive detention (1961)*** • **Provision repealed** ***Detention for treatment (1961)*** • **Provision repealed**		

Sénat Senate

CANADA

CANNABIS:

OUR POSITION FOR A CANADIAN PUBLIC POLICY

REPORT OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

SUMMARY REPORT

CHAIR

PIERRE CLAUDE NOLIN

DEPUTY CHAIR

COLIN KENNY

SEPTEMBER 2002

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GLOSSARY OF KEY TERMS

Abuse
Vague term with a variety of meanings depending on the social, medical and legal contexts. Some equate any use of illicit drugs to abuse: for example, the international conventions consider that any use of drugs other than for medical or scientific purposes is abuse. The Diagnosis and Statistical Manual of the American Psychiatric Association defines abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as defined by one or more of four criteria (see Chapter 7). In the Report, we prefer the term excessive use (or harmful use).

Acute effects
Refers to effects resulting from the administration of any drug and specifically to its short term effects. These effects are distinguished between central (cerebral functions) and peripheral (nervous system). Effects are dose-related.

Addiction
General term referring to the concepts of tolerance and dependency. According to WHO addiction is the repeated use of a psychoactive substance to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain the substance by almost any means. Some authors prefer the term addiction to dependence, because the former also refers to the evolutive process preceding dependence.

Agonist
A substance that acts on receptor sites to produce certain responses.

Anandamide
Agonist neurotransmitter of the endogenous cannabinoid system. Although not yet fully understood in research, these neurotransmitters seem to act as modulators as THC increases, the liberation of dopamine in nucleus accumbens and in the cerebral cortex.

At-risk use
Use behaviour which makes users at risk of developing dependence to the substance.

Cannabinoids
Endogenous receptors of the active cannabis molecules, particularly Delta 9-THC. Two endogenous receptors have been identified: CB1 densely concentrated in the hippacampus, basal ganglia, cerebellum and cerebral cortex, and CB2, particularly abundant in the immune system. The central effects of cannabis appear to be related only to CB1.

Cannabis
Three varieties of the cannabis plant exist: *cannabis sativa*, *cannabis indica*, and *cannabis ruredalis*. *Cannabis sativa* is the most commonly found, growing in almost any soil condition. The cannabis plant has been known in China for about 6000 years. The flowering tops and leaves are used to produce the smoked cannabis. Common terms used to refer to cannabis are pot, marijuana, dope, ganja, hemp. Hashish is produced from the extracted resin. Classified as a psychotropic drug, cannabis is a modulator of the central nervous system. It contains over 460 known chemicals, of which 60 are cannabinoids. Delta-9-tétrahydrocannabinol, referred to as THC, is

the principal active ingredient of cannabis. Other components such delta-8-tétrahydrocannabinol, cannabinol and cannabidiol are present in smaller quantities and have no significant impacts on behaviour or perception. However, they may modulate the overall effects of the substance.

Commission on narcotic drugs (CND)
The Commission on Narcotic Drugs (CND) was established in 1946 by the Economic and Social Council of the United Nations. It is the central policy-making body within the UN system for dealing with all drug-related matters. The Commission analyses the world drug abuse situation and develops proposals to strengthen international drug control.

Chronic effects
Refers to effects which are delayed or develop after repeated use. In the report we prefer to use the term consequences of repeated use rather than chronic effects.

Decriminalization
Removal of a behaviour or activity from the scope of the criminal justice system. A distinction is usually made between *de jure* decriminalization, which entails an amendment to criminal legislation, and *de facto* decriminalization, which involves an administrative decision not to prosecute acts that nonetheless remain against the law. Decriminalization concerns only criminal legislation, and does not mean that the legal system has no further jurisdiction of any kind in this regard. Other, non-criminal, laws may regulate the behaviour or activity that has been decriminalized (civil or regulatory offences, etc.).

Diversion
The use of measures other than prosecution or a criminal conviction for an act that nonetheless remains against the law. Diversion can take place before a charge is formally laid, for example if the accused person agrees to undergo treatment. It can also occur at the time of sentencing, when community service or treatment may be imposed rather than incarceration.

Depenalization
Modification of the sentences provided in criminal legislation for a particular behaviour In the case of cannabis, it generally refers to the removal of custodial sentences.

Dependence
State where the user continues its use of the substance despite significant health, psychological, relational, familial or social problems. Dependence is a complex phenomenon which may have genetic components. Psychological dependence refers to the psychological symptoms associated with craving and physical dependence to tolerance and the adaptation of the organism to chronic use. The American Psychiatric Association has proposed seven criteria (see Chapter 7).

Dopamine
Neuromediator involved in the mechanisms of pleasure.

Drug
Any chemical agent that alters the biochemical or physiological processes of tissues or organisms. In this sense, the term drug refers better to any substance which is principally used for its psychoactive effects. Also used to refer to illicit rather than licit (such as nicotine, alcohol or medicines) substances.

European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
The European Monitoring Centre was created in 1993 to provide member states within the EU objective, reliable and comparable information on drugs, drug addictions and their consequences. Statistical information, documents and techniques developed in the EMCDDA are designed to give a broad perspective on drug issues in Europe. The Centre only deals with information. It relies on national focal points in each of the Member States.

Fat soluble
Characteristic of a substance to irrigate the tissues quickly. THC is highly fat-soluble.

Gateway / Gateway Theory
Theory suggesting a sequential pattern in involvement in drug use from nicotine to alcohol, to cannabis and then to "hard" drugs. In regard to cannabis, the theory rests on a statistical association between the use of hard drugs and the fact that these users have generally used cannabis as their first illicit drug. This theory has not been validated by empirical research and is considered outdated.

Half-life
Time needed for the concentration of a particular drug in blood to decline to half its maximum level. The half-life of THC is 4.3 days on average but is faster in regular users than in occasional users. Because it is highly fat soluble, THC is stored in fatty tissues, thus increasing its half-life to as much as 7 to 12 days. Prolonged use of cannabis increases the period of time needed to eliminate it from the system. Even one week after use, THC metabolites may remain in the system. They are gradually metabolised in the urine (one third) and in feces (two thirds). Traces of inactive THC metabolites can be detected as long as 30 days after use.

Hashish
Resinous extract from the flowering tops of the cannabis plant transformed into a paste.

International conventions
Various international conventions have been adopted by the international community since 1912, first under the League of Nations, then under the United Nations, to regulate the possession, use, production, distribution, sale, etc., of various psychotropic substances. Currently, the three main conventions in force are the 1961 Single Convention, the 1971 Convention on Psychotropic Substance and the 1988 Convention against Illicit Traffic. Canada is a signatory to all three conventions. Subject to countries' national constitutions, these conventions establish a system of regulation where only medical and scientific uses are permitted. This system is based on the prohibition of source plants (coca, opium and cannabis) and the regulation of synthetic chemicals produced by pharmaceutical companies.

International Narcotics Control Board (INCB)
The Board is an independent, quasi-judicial organization responsible for monitoring the implementation of the UN conventions on drugs. It was created in 1968 as a follow up to the 1961 Single Convention, but had predecessors as early as the 1930s. The Board makes recommendations to the UN Commission on Narcotics with respect to additions or deletions in the appendices of the conventions.

Intoxication
Disturbance of the physiological and psychological systems through substance use. Pharmacology generally distinguishes four levels of intoxication: light, moderate, serious and fatal.

Joint
Cigarette of marijuana or hashish with or without tobacco. Because joints are never identical, scientific analyses of the effects of THC in their use are more difficult, especially to determine the therapeutic benefits of cannabis and to examine its effects on driving.

League of Nations
International organisation organization of Sstates until in existence until 1938; now the United Nations.

Legalization
Legislating under a regulatory system the culture, production, marketing, sale and use of substances. Although no such provision currently exist in relation to "street-drugs" (as opposed to alcohol or tobacco which are regulated products), a legalization system could take two forms: free of state control (free markets) and with state controls (regulatory regime).

Marijuana
Mexican term originally referring to a cigarette of poor quality. Has now become a synonym for cannabis in popular language usage.

Narcotic
Substance which can induce stupor or artificial sleep. Usually restricted to opiates. Sometimes used incorrectly to refer to all drugs capable of inducing dependence.

Office of National Drug Control Policy (ONDCP) USA
Created in 1984 under the Reagan administration, the Office is under the direct authority of the White House. It coordinates US policy on drugs. Its budget is currently US $18 billion.

Opiates
Substance derived from the opium poppy. The term opiate excludes synthetic opioids such as heroin and methadone.

Prohibition
Historically, the term most often refers to the period of national interdiction of alcohol sales in the United States between 1919 and 1933. By analogy, the term is now used to describe UN and State policies aiming for a drug-free society. Prohibition is based on the interdiction to cultivate, produce, fabricate, sell, possess, use, etc., some substances except for medical and scientific purposes.

Psychoactive substance
Substance which alters mental processes such as thinking or emotions. We prefer to use this term as it is more neutral than the term “drug” and does not refer to the legal status of the substance.

Psychotropic substance (see also psychoactive)
Used synonymously with psychoactive substance, however the term refers to drugs primarily used in the treatment of mental disorders, such as anxiolytics, sedatives, neuroleptics, etc. More specifically,the term refers to the substances covered in the 1971 Convention on Psychotropic Substances.

Regulation
System of control specifying the conditions under which the cultivation, production, marketing, prescription, sales, possession or use of a substance are allowed. Regulatory approaches may rest on interdiction (as for illegal drugs) or controlled access (as for medical drugs or alcohol). Our proposal of an exemption regime under the current legislation is a regulatory regime.

Tetrahydrocannabinol (Δ9-THC)
Main active component of cannabis, Δ9-THC is highly fat-soluble and has a lengthy half-life. Its psychoactive effects are modulated by other active components in cannabis. In its natural state, cannabis contains between 0.5% to 5% THC. Sophisticated cultivation methods and plant selection, especially female plants, lead to higher levels of THC concentration.

Tolerance
Reduced response of an organism and increased capacity to support the effects of a substance after a more or less lengthy period of use. Tolerance levels are extremely variable between substances, and tolerance to cannabis is believed to be lower than for most other drugs,including tobacco and alcohol.

Toxicity
Characteristic of a substance which induces intoxication, i.e., "poisoning". Many substances, including some common foods, have some level of toxicity. Cannabis presents almost no toxicity and cannot lead to an overdose.

United Nations Drug Control Program (UNDCP)
Established in 1991, the Program works to educate the world about the dangers of drug abuse. The Program aims to strengthen international action against drug production, trafficking and drug-related crime through alternative development projects, crop monitoring and anti-money laundering programs. UNDCP also provides accurate statistics through the Global Assessment Programme (GAP) and helps to draft legislation and train judicial officials as part of its Legal Assistance Programme. UNDCP is part of the UN Office for Drug Control and the Prevention of Crime.

World Health Organization (WHO) The World Health Organization, the United Nations' specialized agency for health, was established on April 7, 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

INTRODUCTION

The **Senate Special Committee on Illegal Drugs** addressed the question of drugs just as everyone else does, with the same preconceptions, attitudes, fears and anxieties we all share. Of course, we had at our disposal the 1996 study our colleagues conducted on government legislation dealing with illegal drugs, which had enabled them to hear a number of witnesses over several months. We also knew at the outset that research expertise would be available to us, but it is still difficult to overcome attitudes and opinions that we have long taken for granted. Whether one is in favour of enhanced enforcement or, on the contrary, greater liberalization, opinions often resist the facts and in a field such as this the production of facts, even through scientific research, is not necessarily a neutral undertaking. We, like you, have our prejudices and preconceptions. Together we must make the effort to go beyond such predispositions. That is one of the objectives of this report.

The public policy regime we propose expresses the fundamental premise underlying our report: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy as far as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equality of others.***

We are aware, as much now as we were at the start of our work, that there is no pre-established consensus in Canadian society on public policy choices in the area of drugs. In fact, our research has shown us that there are few societies where there is a broadly shared consensus among the general public, let alone between the public and experts. We are well aware, perhaps more so than at the outset, that the question of illegal drugs, viewed from the standpoint of public policy, has a broad international context and that we cannot think or act in isolation. We know our proposals are provocative, that they will meet with resistance. However, we are also convinced that Canadian society has the maturity and openness to welcome an informed debate.

PART I – GENERAL ORIENTATION

CHAPTER 1 – OUR MANDATE

"That a special committee of the Senate be struck to examine:

- *the approach taken by Canada to cannabis, its preparations, derivatives and similar synthetic preparations, in context;*
- *the effectiveness of this approach, the means used to implement it and the monitoring of its application;*
- *the related official policies adopted by other countries;*
- *Canada's international role and obligations under United Nations agreements and conventions on narcotics, in connection with cannabis, the Universal Declaration of Human Rights and other related treaties; and*
- *the social and health impacts of cannabis and the possible consequences of different policies;*

That the special committee consist of five senators, three of whom shall constitute a quorum;
That the Honourable Senators Banks, Kenny, Nolin, Rossiter and (a fifth Senator to be named by the Chief Government Whip) be named to the committee;
That the committee be authorized to send for persons, papers and records, to hear witnesses, to report from time to time, and to print from day to day such papers and evidence as may be ordered by it;
That the briefs and evidence heard during consideration of Bill C-8, An Act respecting the control of certain drugs, their precursors and other substances and to amend certain other Acts and repeal the Narcotic Control Act in consequence thereof, by the Standing Senate Committee on Legal and Constitutional Affairs during the 2nd Session of the 35th Parliament be referred to the committee;
That the documents and evidence compiled on this matter and the work accomplished by the Special Senate Committee on Illegal Drugs during the 2nd Session of the 36th Parliament be referred to the committee;
That the committee be empowered to authorize, if deemed appropriate, the broadcasting on radio and/or television and the coverage via electronic media of all or part of its proceedings and the information it holds;
That the committee present its final report no later than August 31, 2002; and that the committee retain the powers necessary to publicize its findings for distribution of the study contained in its final report for 30 days after the tabling of that report;
That the committee be authorized, notwithstanding customary practice, to table its report to the Clerk of the Senate if the Senate is not sitting, and that a report so tabled be deemed to have been tabled in the Senate."

The Committee's mandate is a continuation of the evolution of drug legislation passed by the Parliament of Canada in 1996, the *Controlled Drugs and Substances Act*. While this legislation was being studied by the Sub-Committee on Bill C-7 of the Standing Committee on Health of the House of Commons in 1994 and 1995, the vast majority of witnesses were highly critical of the bill. The most common criticisms concerned three points: first, the lack of basic principles or an expressed statement as to the purpose of the act; second, the fact that the bill perpetuated the prohibition system of the 1920s, and third, the absence of any emphasis on harm reduction and prevention criteria. Despite the amendments made by the Sub-Committee of the House, the testimony heard by the Senate Committee was equally critical. Witnesses noted that the Act did not categorize drugs on the basis of the dangers they represented, that it did not contain any specific, rational criteria and that it was impossible, particularly in view of the Act's complexity, to determine how it would be implemented in practice. All of these criticisms led that Senate Committee to "*propose energetically*" the creation of a Joint Committee of the House of Commons and the Senate that would review all Canadian drug legislation, policies and programs. However, the 1997 federal election intervened. Senator Nolin, convinced of the need for action and faced with the inaction of the House of Commons, tabled his first motion in 1999 - that a Senate Committee be struck and given a mandate to examine the legislation, policies and programs on illegal drugs in Canada. The motion was adopted by the Senate in April 2000.

However, that Committee was dissolved by general election of October 2000, and was restruck on March 15, 2001, with an amended mandate: the scope of its work was now restricted to cannabis "in its context". We chose to interpret this sentence broadly.

CHAPTER 2 – OUR WORK

At the Committee's public hearings, the Chair presented the research program as follows:

> *"In order to fully satisfy the mandate conferred upon the committee, the committee has adopted an action plan. This plan centres around three challenges. The first challenge is that of knowledge. We will be hearing from a wide variety of experts, both from Canada and afar, from academic settings, the police, legal specialists, medical specialists, the government sector and social workers. (…)*
> *The second challenge, surely the most noble challenge, is that of sharing knowledge. The committee hopes that Canadians from coast to coast will be able to learn and share the information that we will have collected. In order to meet this challenge, we will work to distribute this knowledge and make it accessible to all. We would also like to hear the opinions of Canadians on this topic and in order to do so, we will be holding public hearings in the spring of 2000 throughout Canada.*
> *And finally, the third challenge for this committee will be to examine and identify the guiding principles on which Canada's public policy on drugs should be based."*

In view of our mandate, including an obligation to provide Canadians with objective and rigorous information, we have emphasized rigour and openness throughout the entire process, an approach that was all the more important as opinions on all sides of the illegal drugs issue are strong and often categorical. But rigour is not enough. For the information to reach Canadians, we could not reserve it for our exclusive use, hence the second principle that guided us: openness. From the outset, we insisted that all our work be made available as soon as possible on our Web site and we entered into direct dialogue with our fellow citizens as well as with experts.

The Committee approved a research program divided into five major axes of knowledge, sub-dividing each one into specific issues:

- the socio-historical, geopolitical, anthropological, criminological and economic issues of the use and regulation of cannabis;
- the medical and pharmacological aspects of the consumption, use and regulation of cannabis;
- the legal aspects from a national perspective;
- the legal and political issues in an international perspective; and
- the ethical issues and Canadians' moral and behavioural standards.

In an attempt to answer these questions in the most effective and economical manner possible, the Committee agreed to perform two tasks concurrently: conduct a research program and hear expert witnesses–complementary activities. We asked the Parliamentary Research Branch and other researchers to produce syntheses and analyses of the relevant literature. In all, the Committee received 23 reports and benefited from summaries of work conducted in other countries, including attendance at international conferences. In all, the Committee held more than 40 days of public hearings in Ottawa and 10 other Canadian communities, hearing more than 100 witnesses from all backgrounds, from across Canada and abroad.

The second component of our program of work was to examine public opinion. That meant we had two closely related responsibilities. The first was a duty to inform, indeed, to educate. We hope those who are offended by that term will pardon our presumption, but we are convinced that on public policy topics that are societal issues, it is the duty of political leaders to transmit information that educates, not merely convinces. The level of knowledge about drugs, even about cannabis, perhaps the best known drug, is often limited and clouded by myth. Our second responsibility in taking public opinion into account was to go out and discover it. We did so in three ways. We publicized our work as widely and as openly as possible to enable everyone to learn about it and react to it. Many chose to write us, although they were relatively few compared with the number of people in this country. We commissioned a qualitative public opinion study. The focus groups conducted across the country as part of that study are described in detail in Chapter 10. We also held public hearings in eight

communities across the country, enabling citizens to come and tell us what they thought, what they knew and what they had experienced.

In order to be able to interpret all this knowledge and come to conclusions and recommendations, the third component of our work focussed on guiding principles.

CHAPTER 3 – GUIDING PRINCIPLES

It has now been thirty years since the Royal Commission of Inquiry on the Non-Medical Use of Drugs, the Le Dain Commission, studied issues similar to those we are studying today. Its report on cannabis, whose scientific conclusions on the effects of the drug were generally accepted by all members of the Commission, led to three reports: a majority report by three of the members, and two minority reports. Each expressed a different concept of the role of the State and of criminal law, and the roles of science and ethics in the choices that had to be made. Having examined each of these subjects, we have elected to set down the guiding principles that clarify the concept we have of the roles that the state, criminal law, science and ethics must play in the development of a public policy on cannabis.

Ethical considerations take us through what is, that is the realm of facts, to the realm of what should be, what would be desirable, moving from recognized facts to standards, then more importantly to values and finally to the means of passing on and above all implementing these values. This is why ethics was our first subject. As a guideline, we have adopted the principle that an ethical public policy on illegal drugs, and on cannabis in particular, must **promote reciprocal autonomy built through a constant exchange of dialogue within the community.**

We always find ourselves in paradoxical situations where, to a certain degree, each person has the free will to make decisions and makes free decisions for himself, while at the same time rules are established in order to regulate interaction with others, a complex and more or less formal, but appropriate approach. The goal of governance is freedom, and not control. It is a question of defining the goals of society through policies and programs of action that are then implemented through systems and processes and upheld by those who govern that permits the encouragement and affirmation of those goals for human action. The law, as a vehicle of choice of governance, does not merely express rules or limitations passed for the benefit of and on behalf of citizens, but seeks a reciprocal process of building social relationships through which people, citizens and governments, can constantly adjust their expectations of behaviour. We therefore accept as a guiding principle for governance that **all of the means the State has at its disposal must work towards facilitating human action, particularly the processes allowing for the building of arrangements between government of the citizenry and governance of the self.**

On the whole, the legal basis of the criminal law is weak where the prescribed standard first, does not concern a relationship with others and where the characteristics of the relationship do not establish a victim and a perpetrator able to recognize his/her

actions; second, has to find its justification outside fundamental social relationships; and third, results in the form of enforcement, the harmful effects of which undermine and challenge the very legitimacy of the law. Where criminal law is involved in these issues, the very standard prescribed by the law turns the perpetrator into the victim and tries to protect him from himself, something it can do only by producing a never-ending stream of knowledge that remains constantly out of his reach. In this context **only offences involving significant direct danger to others should be matters of criminal law**.

The Committee's Report - especially the second part - puts great emphasis on research-based knowledge. This focus is an attempt to do justice to the knowledge that has been developed over the past few decades. We considered it important and indeed necessary to give it detailed consideration. Indeed, the Committee recommends that the drive to acquire knowledge on specific issues we deem important be continued. We do not claim, however, to have answered the fundamental question of why people consume psychoactive substances, such as alcohol, drugs or medication. We were indeed surprised, given the quantity of studies conducted each year on drugs, that this area has not been covered. It is almost as if the quest for answers to technical questions has caused science to lose sight of the basic issue!

Scientific knowledge cannot replace either personal reflection or the political decision-making process. It supports those processes, science's greatest contribution to public drug policy. Our guiding principle is that **science, which must continue to explore specific areas of key issues and reflect on overarching questions, supports the public policy development process.**

These principles have guided our interpretation of the available information as well as our choice of recommendations; the reader should always keep them in mind when reading our report.

CHAPTER 4 – A CHANGING CONTEXT

This chapter puts the Committee's work in context. In recent years, in fact, in the past few months, events of some significance have taken place; some directly linked to illegal drugs, others far removed from them. Obviously, September 11 comes to mind. In social and political terms, the claims of medical users, of recreational users, within the changing context of drug use and, more generally, inter-generational conflict, have to be taken into account. Legislation passed in the aftermath of September 11, some provisions of which could affect police drug investigations, the fight against organized crime and the trial of the Hells Angels in Quebec, must also be taken into account. In legal terms, court decisions have had a direct effect on medical use and a decision will be rendered in the next few months by the Supreme Court on recreational use. In international terms, the fragility of the UNDCP and the development of a continental drug policy for the Americas are relevant to an understanding of certain issues that may even overdetermine national policy. Finally, globalization and the more extreme forms

of economic liberalism have been factors too, primarily in western societies but worldwide as well, in the increase of addictive behaviours, be they the use of drugs or other substitutes for social life.

PART II – CANNABIS: EFFECTS, TYPES OF USE, ATTITUDES

CHAPTER 5 – CANNABIS: FROM PLANT TO JOINT

This chapter first describes the cannabis plant and the various forms in which it becomes a consumer drug. We then take a brief look at the geographical origin of the cannabis plant and the routes along which it circulates in the modern world, noting at the same time current modes of production (soil-based and hydroponic) that have developed in certain regions of Canada. We then describe the pharmacokinetics of the cannabis plant, in particular its main active ingredients, and their metabolism in the body.

Available information on cannabis markets is weak and contradictory. Since 1997, the RCMP's annual reports on drugs suggest that 800 tons of cannabis circulate in Canada each year. Yet, many people told us that cannabis production has increased significantly and that cannabis has become more available than ever in this country. Data on the economic value of the cannabis market are no more reliable. We noted that:

- The size of the national production has significantly increased, and it is estimated that 50% of cannabis available in Canada is now produced in the country;
- The main producer provinces are British Columbia, Ontario and Quebec;
- Estimates of the monetary value of the cannabis market are unreliable. For example, if 400 tons are grown yearly in Canada, at a street value of $225 per ounce, the total value of the Canadian production would be less than $6 billion per year, less than the often quoted value of the BC market alone;
- An unknown proportion of national production is exported to the United States; and
- A portion of production is controlled by organized crime elements.

We heard many alarmist comments on the increased level of active ingredient (THC) in cannabis, however, it is currently impossible to estimate the average content of cannabis available in the market. More sophisticated growing methods have likely contributed to increasing the THC concentration. We observed that:

- In its natural state, cannabis contains between 0.5% and 3% THC. Sophisticated growing methods and genetic progress have made it possible to increase THC content in recent years, but it is impossible to estimate the average content of cannabis available in the market; it is reasonable to consider that content varies between 6% and 31%.

- THC is fat soluble and readily spreads in the innervated tissues of the brain; it reaches a peak in the blood plasma in less than nine minutes and falls to approximately 5% after one hour.
- The body is slow to eliminate THC and inactive THC metabolites can be detected in urine up to 27 days after use in the case of regular users.
- Psychoactive effects generally last two to three hours and may last as many as five to seven hours after use.

CHAPTER 6 – USERS AND USES: FORM, PRACTICE, CONTEXT

Who uses cannabis? How do the patterns of use in Canada compare to those in other countries? In what context is cannabis used? Why? What populations are most vulnerable? What are the social consequences of cannabis, specifically on delinquency and criminal behaviour? Most important, what trajectories do cannabis users follow, specifically with respect to consumption of other drugs?

At the very least, partial answers to these questions are prerequisite to establishing policy on a substance. In Canada, knowledge of patterns and contexts of cannabis use verges on the abysmal. In the early 1980s, the USA, the United Kingdom, and Australia introduced monitoring systems for the general population and the student population. In the last five years, a number of European countries have introduced data collection systems as part of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Canada, by contrast, has carried out only two epidemiological general population surveys specific to drugs (in 1989 and 1994), and only some provinces conduct surveys of the student population, using different methods and instruments that preclude data comparison. Furthermore, few sociological or anthropological studies are conducted on the circumstances or context of illegal drug use, specifically for cannabis. The result is that our pool of knowledge on users and characteristics of use is sorely lacking.

We have no explanation for this situation, at least no satisfactory explanation. In the 1970s, following up on the work done by the Le Dain Commission, Canada could have set up a trend monitoring system. In the 1980s, when Canada's Anti-Drug Strategy was adopted, to which the federal government allocated $210M over five years, a data collection system could well have been created. The fact that it was not could be due to an absence of leadership or vision, a fear of knowing, the division of powers among levels of government, or the absence of a socio-legal research tradition within the departments responsible for justice and health. In fact, all of the above are probable factors. Whatever the case, it is our contention that this situation, unacceptable by definition, requires timely remedial action. We must resign ourselves to working with the scarce Canadian data available, and, more significantly, the virtually non-existent comparable data. We will also look at studies and data from other countries.

The chapter is divided into four sections. The first covers consumption patterns in the population as a whole, then specifically in the 12-18 year age group and compares the patterns in various countries. In the adult population we observed that:

- The epidemiological data available indicates that close to 30% of the population (12 to 64 years old) has used cannabis at least once;
- Approximately 2 million Canadians over age 18 have used cannabis during the previous 12 months, approximately 600,000 have used it during the past month, and approximately 100,000 use it daily. Approximately 10% used cannabis during the previous year; and
- Use is highest between the ages of 16 and 24.

For youth in the 12-17 age group, we observed that:

- Canada would appear to have one of the highest rates of cannabis use among youths;
- Approximately 1 million would appear to have used cannabis in the previous 12 months, 750,000 in the last month and 225,000 would appear make daily use; and
- The average age of introduction to cannabis is 15.

The second section looks at what we know about reasons for and details on use, including origins and cultural differences. The third section deals specifically with cannabis user trajectories, including escalation. We have observed the following:

- Most experimenters stop using cannabis;
- Regular users were generally introduced to cannabis at a younger age. Long-term users most often have a trajectory in which use rises and falls;
- Long-term regular users experience a period of heavy use in their early 20s;
- Most long-term users integrate their use into their family, social and occupational activities; and
- Cannabis itself is not a cause of other drug use. In this sense, we reject the gateway theory.

The fourth and last section covers the relationship between cannabis use and delinquency and crime. Based on research evidence, we concluded that:

- Cannabis itself is not a cause of delinquency and crime; and
- Cannabis is not a cause of violence.

CHAPTER 7 – CANNABIS: EFFECTS AND CONSEQUENCES

When it comes to cannabis, one hears anything and its opposite. While in some areas more research is needed and in others research results are contradictory, there exists nevertheless a strong basis of information contradicting many of the myths that continue to be perpetuated.

This chapter is divided into five sections. The first is a collection of statements on the presumed effects of marijuana that the Committee heard or became aware of through its research. The following three sections examine the acute effects of cannabis, followed in turn by the physiological and neurological consequences, the psychological consequences and the social consequences. Then, because of its significance and the central place it holds in social and political concerns, we turn our attention specifically to the question of any possible dependence arising from prolonged use of cannabis.

With respect to the effects of cannabis, the Committee observed that:

- The immediate effects of cannabis are characterized by feelings of euphoria, relaxation and sociability; they are accompanied by impairment of short-term memory, concentration and some psychomotor skills; and
- Long term effects on cognitive functions have not been established in research.

The Committee has distinguished between use, at-risk use and excessive use. Quantities used, psychosocial characteristics of the users and factors related to use contexts and quality of the substance all come into play to explain the passage from one category to the other. On at-risk use, the Committee observed that:

- Most users are not at-risk users insofar as their use is regulated, irregular and temporary, rarely beyond 30 years of age;
- For users above 16, at-risk use is defined as using between 0.1 to 1 gram per day; and
- Available epidemiological data suggests that approximately 100,000 Canadians might be at-risk users.
- The Committee feels that, because of its potential effects on the endogenous cannabinoid system and cognitive and psychosocial functions, any use in those under age 16 is at-risk use.

With respect to excessive use we observed that:

- More than one gram per day over a long period of time is heavy use, which can have certain negative consequences on the physical, psychological and social well-being of the user. According to the epidemiological data available, there is reason to believe that approximately 80,000 Canadians above age 16 could be excessive users;
- For those between the ages of 16 and 18, heavy use is not necessarily daily use but use in the morning, alone or during school activities;
- Heavy use can have negative consequences for physical health, in particular for the respiratory system (chronic bronchitis, cancer of the upper respiratory tract);
- Heavy use of cannabis can result in negative psychological consequences for users, in particular impaired concentration and learning and, in rare cases and with people already predisposed, psychotic and schizophrenic episodes;
- Heavy use of cannabis can result in consequences for a user's social well-being, in particular their occupational and social situation and their ability to perform tasks; and

- Heavy use of cannabis can result in dependence requiring treatment; however, dependence caused by cannabis is less severe and less frequent than dependence on other psychotropic substances, including alcohol and tobacco.

CHAPTER 8 – DRIVING UNDER THE INFLUENCE OF CANNABIS

If there is one issue, other than the effects of cannabis use on young people or the effects of substance abuse, that is likely to be of concern to society and governments, then it is certainly the effect of the use of cannabis on the ability to drive a vehicle. We are already familiar with the effects of alcohol on driving and the many accidents involving injuries or deaths to young people. In spite of the decreases in use noted in recent years, one fatal accident caused by the use of a substance is one accident too many.

Next to alcohol, cannabis is the most widely used psychoactive substance, particularly among young people in the 16-25 age group. Casual use occurs most often in a festive setting, at weekend parties, often accompanied by alcohol. People in this age group are also the most likely to have a car accident and are also susceptible to having an accident while impaired.

Cannabis affects psychomotor skills for up to five hours after use. The psychoactive effects of cannabis are also dependent on the amount used, the concentration of THC and the morphology, experience and expectations of users. But what are the specific effects of cannabis on the ability to drive motor vehicles? What are the effects of alcohol and cannabis combined? And what tools are available to detect the presence of a concentration of THC that is likely to significantly affect the psychomotor skills involved in vehicle operation?

This chapter is divided into three sections. The first considers the ways of testing for the presence of cannabinoids in the body. The second analyzes studies on the known prevalence of impaired driving, in both accident and non-accident contexts. The third and last summarizes what is known about the effects of cannabis on driving based on both laboratory and field studies. As in the other chapters, the Committee then draw its own conclusions.

The Committee feels it is quite likely that cannabis makes users more cautious, partly because they are aware of their deficiencies and compensate by reducing speed and taking fewer risks. However, because what we are dealing with is no longer the consequences on the users themselves, but the possible consequences of their behaviour on others, the Committee feels that it is important to **opt for the greatest possible caution** with respect to the issue of driving under the influence of cannabis.

Given what we have seen, we conclude the following:

- Between 5% and 12% of drivers may drive under the influence of cannabis; this percentage increases to over 20% for young men under 25 years of age;
- Cannabis alone, particularly in low doses, has little effect on the skills involved in automobile driving. Cannabis leads to a more cautious style of driving. However it has a negative impact on decision time and trajectory. This in itself does not mean that drivers under the influence of cannabis represent a traffic safety risk;
- A significant percentage of impaired drivers test positive for cannabis and alcohol together. The effects of cannabis when combined with alcohol are more significant than is the case for alcohol alone;
- Despite recent progress, there does not yet exist a reliable and non intrusive rapid roadside testing method;
- Blood remains the best medium for detecting the presence of cannabinoids;
- Urine cannot screen for recent use;
- Saliva is promising, but rapid commercial tests are not yet reliable enough;
- The visual recognition method used by police officers has yielded satisfactory results; and
- It is essential to conduct studies in order to develop a rapid testing tool and learn more about the driving habits of cannabis users.

CHAPTER 9 - USE OF MARIJUANA FOR THERAPEUTIC PURPOSES

There has been renewed interest in the issue of the use of marijuana for therapeutic purposes in recent years, particularly in Canada. In the wake of an Ontario Court of Appeal ruling which found the provisions of the *Controlled Drugs and Substances Act* to be unconstitutional pertaining to the therapeutic use of marijuana, the federal Minister of Health made new regulations in July 2001 that give people with specified medical problems access to marijuana under certain conditions.

However, the scientific community, the medical community in particular, is divided on the real therapeutic effectiveness of marijuana. Some are quick to say that opening the door to medical marijuana would be a step toward outright legalization of the substance.

But none of that should matter to physicians or scientists. It is not a question of defending general public policy on marijuana or even all illegal drugs. It is not a question of sending a symbolic message about “drugs”. It is not a question of being afraid that young people will use marijuana if it is approved as a medicine. The question, and the only question, for physicians as professionals is whether, to what extent and in what circumstances, marijuana serves a therapeutic purpose. Physicians should have to determine whether people with certain diseases would benefit from marijuana use and weigh the side effects against the benefits. If they do decide the patient should use marijuana, they then have to consider how he or she might get it.

This chapter is devoted to the history of the use of marijuana for therapeutic purposes and the status of contemporary knowledge of marijuana and synthetic cannabinoids. We then give a brief account of compassion clubs and other organizations that supply marijuana for therapeutic use, as well as various public policy regimes. We conclude with our views on medical use of marijuana. In a later chapter, we discuss which public policy regime would be most appropriate given the status of medical use of marijuana

We observed that:

- There are clear, though non-definitive indications of the therapeutic benefits of marijuana in the following conditions: analgesic for chronic pain, antispasm for multiple sclerosis, anticonvulsive for epilepsy, antiemetic for chemotherapy and appetite stimulant for cachexi;
- There are less clear indications regarding the effect of marijuana on glaucoma and other medical conditions;
- Marijuana has not been established as a drug through rigorous, controlled studies;
- The quality and effectiveness of marijuana, primarily smoked marijuana, have not been determined in clinical studies;
- There have been some studies of synthetic compounds, but the knowledge base is still too small to determine effectiveness and safety;
- Generally, the effects of smoked marijuana are more specific and occur faster than the effects of synthetic compounds;
- The absence of certain cannabinoids in synthetic compounds can lead to harmful side effects, such as panic attacks and cannabinoid psychoses;
- Smoked marijuana is potentially harmful to the respiratory system;
- People who smoke marijuana for therapeutic purposes self-regulate their use depending on their physical condition and do not really seek the psychoactive effect;
- People who smoke marijuana for therapeutic purposes prefer to have a choice as to methods of use;
- Measures should be taken to support and encourage the development of alternative practices, such as the establishment of compassion clubs;
- The practices of these organizations are in line with the therapeutic indications arising from clinical studies and meet the strict rules on quality and safety;
- The studies that have already been approved by Health Canada must be conducted as quickly as possible;
- The qualities of the marijuana used in those studies must meet the standards of current practice in compassion clubs, not NIDA standards;
- The studies should focus on applications and the specific doses for various medical conditions; and
- Health Canada should, at the earliest possible opportunity, undertake a clinical study in cooperation with Canadian compassion clubs.

CHAPTER 10 - CANADIANS' OPINIONS AND ATTITUDES

It is always difficult to gauge the public's opinions, attitudes and concerns. The traditional method of surveying a representative sample of the population was too expensive for our resources. Surveys also have limits that we discuss in more detail. However, we did commission a qualitative study using focus groups, the results of which are presented in this chapter. We also report the results of other surveys that we researched and considered. As well, many Canadians wrote to us or sent us e-mails, and others came out to our public hearings to participate. Obviously we cannot draw solid conclusions from this. The people who wrote to us were probably those to whom the issue is very important, regardless of which way they may lean. Some are cited in our Report but we must reiterate that no conclusion should be drawn from these opinions in terms of representativeness. No account of Canadians' opinions on and attitudes toward drugs in general would be complete without an examination of the role of the media in shaping those opinions and attitudes. In recent years, as a result of this Committee's work and other initiatives, various Canadian newspapers and magazines have run stories or have written editorials on the issue. These are the focus of the first part of the chapter. The next part presents the results of surveys and polls, including the survey we commissioned and surveys conducted in different provinces. The last part covers our understanding of what Canadians told us.

We observed the following:

- Public opinion on marijuana is more liberal than it was 10 years ago;
- There is a tendency to think that marijuana use is more widespread and that marijuana is more available than it used to be;
- There is a tendency to think that marijuana is not a dangerous drug;
- The concern about organized crime is significant;
- Support for medical use of marijuana is strong;
- There is a tendency to favour decriminalization or, to a lesser degree, legalization;
- People criticize enforcement of the legislation in regards to simple possession of marijuana; and
- There is a concern for youth and children.

PART III -- POLICIES AND PRACTICES IN CANADA

CHAPTER 11 - A NATIONAL DRUG STRATEGY?

Based on the importance of the subject, it would probably surprise many Canadians to learn that only from 1987 to 1993 did Canada have a fully funded national drug strategy. It is true that Canada has had legislation dealing with the use of psychoactive substances since the passage of the *Opium Act* in 1908. This Act was followed by several pieces of criminal legislation over the years that increased federal

enforcement powers over psychoactive substances and expanded the list of illicit substances. These pieces of legislation have historically focused on the supply of psychoactive substances, adopting a prohibitionist approach to use. It is widely acknowledged now, however, that a more balanced approach is required if one is to deal effectively with those who abuse psychoactive substances.

This chapter recounts the development and implementation of the 1987 National Drug Strategy, which had as an objective the promotion of a balanced approach to the problem of psychoactive substance abuse. This is followed by a discussion of what became of the national strategy and what goals have been achieved.

We observed the following:

- Canada urgently needs a comprehensive and coordinated national drug strategy for which the federal government provides sound leadership;
- Any future national drug strategy should incorporate all psychoactive substances, including alcohol and tobacco;
- To be successful, a national drug strategy must involve true partnerships with all levels of government and with non-governmental organizations;
- Over the years, the intermittency of funding has diminished the ability to coordinate and implement the strategy; adequate resources and a long-term commitment to funding are needed if the strategy is to be successful;
- Clear objectives for the strategy must be set out, and comprehensive evaluations of these objectives and the results are required;
- At the developmental stage, there is a need to identify clear and shared criteria for "success";
- The core funding for the Canadian Centre on Substance Abuse (CCSA) has been insufficient for it to carry out its mandate; proper funding for the CCSA is essential;
- There is a need for an independent organization – the CCSA – to conduct national surveys at least every second year; there is also a need to achieve some level of consistency, comparability and similar time frames for provincially-based school surveys;
- Coordination at the federal level should be given to a body that is not an integral part of one of the partner departments; and
- Canada's Drug Strategy's should adopt a balanced approach – 90% of federal expenditures are currently allocated to the supply reduction.

CHAPTER 12 - THE NATIONAL LEGISLATIVE CONTEXT

Drugs have been prohibited for fewer than a hundred years; cannabis for slightly more than 75 years. It is tempting to think that the decisions made over the years to use criminal law to fight the production and use of certain drugs are in keeping with social progress and the advancement of scientific knowledge about drugs. But is this really the case? The history of legislation governing illegal drugs in Canada, like the analysis in Chapter 19 of the structure of international conventions, suggests that it is highly

doubtful. To what extent is such reasoning really rational? Is the rationale of the system of controls acceptable in the eyes of civil society, users as well as abstainers? What criteria motivated legislator decisions? Indeed, were there criteria? What motivated parliamentarians from Canada and elsewhere to prohibit certain substances, to control access to certain others, and to permit still others to be sold over the counter?

Knowing where we have been helps in understanding where we are going. That is the goal of this chapter, retracing the evolution of Canadian drug laws from 1908 to the present day. We have identified three legislative periods. The first, and longest, spans 1908 to 1960, the period of hysteria. We were told that drugs were made criminal because they are dangerous. Analysis of debates in Parliament and in media accounts clearly shows how far this is from truth. When cannabis was introduced in the legislation on narcotics in 1923, there was no debate, no justification, in fact many members did not even know what cannabis was.

The second period, much shorter, runs from 1961 to 1975, the search for lost reason. Following the explosion in drug use in the early 1960s and demands for reform from various sectors of society, governments appointed a commission of inquiry in Canada, the Le Dain Commission. Last comes the contemporary period at the beginning of the 1980s. Reform is not on the policy agenda any more and anti-drug policies have forged ahead.

In summary, we observed that:

- Early drug legislation was largely based on a moral panic, racist sentiment and a notorious absence of debate;
- Drug legislation often contained particularly severe provisions, such as reverse onus and cruel and unusual sentences; and
- The work of the Le Dain Commission laid the foundation for a more rational approach to illegal drug policy by attempting to rely on research data. The Le Dain Commission's work had no legislative outcome until 1996 in certain provisions of the *Controlled Drugs and Substances Act*, particularly with regard to cannabis.

CHAPTER 13 - REGULATING THERAPEUTIC USE OF CANNABIS

Cannabis has an extremely long history of therapeutic use, going back several thousands of years. It was often used for the same medical conditions it is used for today. With the development of the pharmaceutical industry in the last century, the medical community has gradually discontinued its use. Various factors may explain this. Developments in the pharmaceutical industry provided the medical community with more stable and better tested medication. The practice of medicine itself has changed and so has our conception of health. Then, at the turn of the 20th century, the plants from which opium, cocaine and cannabis are derived were banned by the international community, except for medical and scientific purposes. In the case of cannabis, no rigorous study had been done until recently.

Further to the social rediscovery of cannabis and the identification of its molecular composition and chemical elements in the 1960s, renewed interest in the therapeutic applications of cannabis grew in the early 1970s. More people began using the plant for its therapeutic benefits and many demanded a relaxation of the prohibitionist rules governing cannabis.

Partly because its safety and effectiveness have yet to be reviewed in clinical trials, cannabis has not been approved for sale in Canada as a medical product. Despite this lack of approval, many use cannabis for its therapeutic purposes without legal authorization. In addition, because of the many claims regarding its therapeutic benefit, a growing number of people have called for a less restrictive approach and are demanding access to cannabis for people who could benefit from its use.

This chapter reviews the events that prompted the recent enactment of the *Marihuana Medical Access Regulations*. One of the objectives of the regulations is to provide a compassionate framework of access to marijuana for seriously ill Canadians while research regarding its therapeutic application continues. Also discussed is the implementation of these regulations, which came into force on 30 July 2001.

We have observed the following:

- The MMAR are not providing a compassionate framework for access to marijuana for therapeutic purposes and are unduly restricting the availability of marijuana to patients who may receive health benefits from its use;
- The refusal of the medical community to act as gatekeepers and the lack of access to legal sources of cannabis appear to make the current regulatory scheme an "illusory" legislative exemption and raises serious Charter implications;
- In almost one year, only 255 people have been authorized to possess marijuana for therapeutic purposes under the MMAR and only 498 applications have been received – this low participation rate is of concern;
- Changes are urgently needed with regard to who is eligible to use cannabis for therapeutic purposes and how such people gain access to cannabis;
- Research on the safety and efficacy of cannabis has not commenced in Canada because researchers are unable to obtain the product needed to conduct their trials;
- No attempt has been made in Health Canada's current research plan to acknowledge the considerable expertise currently residing in the compassion clubs;
- The development of a Canadian source of research-grade marijuana has been a failure.

CHAPTER 14 - POLICE PRACTICES

Views on police priorities regarding enforcement of laws on illicit drugs are, at the very least, inconsistent, if not contradictory. Some believe that too much police time, effort and resources are spent in investigating illicit drug offences and, more specifically, possession offences, even more specifically, cannabis possession offences. Others, including the police themselves, claim that police priorities are already focused

on traffickers and producers, and that possession charges are laid as a result of police presence to deal with other criminal activity. Thus, they maintain that the vast majority of cannabis possession charges are incidental to other police responsibilities.

This chapter reviews the key organizations that are responsible for enforcing Canada's current illicit drugs legislation, the *Controlled Drugs and Substances Act* (CDSA). It includes a discussion of the powers they have been granted, and the investigative techniques used, in relation to illicit drug investigations. Finally, key police-related statistics are explored. This information should help clarify some of the misconceptions related to enforcement of laws on illicit drugs.

The Committee found that:

- The annual cost of drug enforcement in Canada is estimated to be between $700 million and $1 billion;
- Reduced law enforcement activities resulting from amendments to the drug legislation on cannabis could produce substantial savings or a significant reallocation of funds by police forces to other priorities;
- Due to the consensual nature of drug offences, police have been granted substantial enforcement powers and have adopted highly intrusive investigative techniques; these powers are not unlimited, however, and are subject to review by Canadian courts;
- Over 90,000 drug-related incidents are reported annually by police; more than three-quarters of these incidents relate to cannabis and over 50% of all drug-related incidents involve possession of cannabis;
- From 1991 to 2001, the percentage change in rate per 100,000 people for cannabis-related offences is +91.5 – thus, the rate of reported cannabis-related offences has almost doubled in the past decade;
- The number of reported incidents related to the cultivation of cannabis increased dramatically in the past decade;
- Reported incident rates vary widely from province to province;
- Cannabis was involved in 70% of the approximately 50,000 drug-related charges in 1999. In 43% of cases (21,381), the charge was for possession of cannabis.;
- The rate of charges laid for drug offences vary significantly from province to province;
- The uneven application of the law is of great concern and may lead to discriminatory enforcement, alienation of certain groups within society, and creation of an atmosphere of disrespect for the law; in general, it raises the issue of fairness and justice; and
- Statistics on seizure seem to confirm an increase in cannabis cultivation in Canada and also a shift in police priorities regarding this offence.

CHAPTER 15 - THE CRIMINAL JUSTICE SYSTEM

The previous chapter examined how people first come into contact with the criminal justice system through the enforcement of criminal legislation. Several questions remain, however. What happens once a person has been charged with a drug offence? Who is responsible for prosecuting drug cases? What type of punishment do people receive? Who ends up with a criminal record? Have there been any challenges to the constitutional validity of drug legislation? These issues and others related to the criminal justice system are reviewed in this chapter

We have observed the following:

- The cost of prosecuting drug offences in 2000-2001 was $57 million with approximately $5 million or roughly 10% of the total budget relating to prosecuting cannabis possession offences;
- In 1999, it was estimated that Canadian criminal courts heard 34,000 drug cases, which involved more than 400,000 court appearances;
- The Drug Treatment Court initiatives seem very encouraging, although comprehensive evaluations are needed to ensure such programs are effective;
- Disposition and sentencing data with respect to drug-related offences are incomplete and there is an urgent need to correct this situation;
- Correctional Service Canada spends an estimated $169 million annually to address illicit drugs through incarceration, substance abuse programs, treatment programs and security measures; expenditures on substance abuse programs are unreasonably low, given the number of inmates who have substance-abuse dependence problems;
- A criminal conviction can negatively affect a person's financial situation, career opportunities and restrict travel. In addition, it can be an important factor in future dealings with the criminal justice system; and
- Provincial courts of appeal have so far maintained the constitutionality of cannabis prohibition. They have found that because there is some evidence of harm caused by marijuana use that is neither trivial nor insignificant, Parliament has a rational basis to act as it has done, and the marijuana prohibition is therefore consistent with the principles of fundamental justice in section 7 of the Charter. These decisions have been appealed, and the Supreme Court of Canada will soon decide whether cannabis prohibition is constitutionally sound.

CHAPTER 16 - PREVENTION

Viewed in theory, at least, as a public health issue, a policy on illegal drugs should call for a strong prevention strategy. Nothing, however, is more fluid, vague, or even controversial, than prevention. When it comes to illegal drugs, the legal and political context makes the issue of prevention even harder to clarify and actions even harder to define. The national legal context surrounding illegal drugs and the interpretation of international drug policies are such that because they are defined *a priori* as harmful

substances, illegal drugs must not be used. Another way of putting it is that any use is abuse. If use is abuse, if individuals or organizations involved in prevention are unable to make distinctions that are essential in setting objectives and devising preventive measures, what hope is there of establishing successful prevention programs? There are, as this chapter will show, many prevention programs that are not aimed solely or even particularly at the prevention of use, but rather the prevention of at-risk behaviour. Harm reduction, for example, is not only a general strategy for dealing with psychoactive substances, but is also a preventive approach that seeks to lower the risks associated with drugs and drug control without requiring abstinence. However, harm reduction is the subject of much controversy and criticism because it is based on the premise that use of drugs is a social reality. Addressing the issue of prevention means considering at the same time government policies on illegal drugs. Any discussion of prevention entails discussion of the limits of government intervention and of how one conceives of human action. How far should government interventions go in identifying groups at risk without further stigmatizing groups already at risk? To what extent are humans rational beings who act in their best interest provided they are given the right information?

This chapter on prevention begins with a statement that will come as no surprise to health or justice experts: when it comes to prevention, there is lots of talk, but the resources allocated are small and the initiatives weak. The second section asks the question: what prevention? We look at current knowledge of the factors underlying prevention initiatives and the effectiveness of some preventive measures, with special emphasis on one of the most important weapons in the war on drugs, the DARE program. The third section looks at the harm reduction approach to prevention. As in the other chapters, our conclusions are in the form of observations that may serve to guide future actions.

The Committee found that:

- Prevention is not designed to control but rather to empower individuals to make informed decisions and acquire tools to avoid at-risk behaviour;
- A national drug strategy should include a strong prevention component;
- Prevention strategies must be able to take into account contemporary knowledge about drugs;
- Prevention messages must be credible, verifiable and neutral;
- Prevention strategies must be comprehensive, cover many different factors and involve the community;
- Prevention strategies in schools should not be led by police services or delivered by police officers;
- The RCMP should reconsider its choice of the DARE program that many evaluation studies have shown to be ineffective;
- Prevention strategies must include comprehensive evaluation of a number of key elements;

- A national drug strategy should include mechanisms for widely disseminating the results of research and evaluations;
- Evaluations must avoid reductionism, involve stakeholders in prevention, be part of the program, and include longitudinal impact assessment;
- Harm reduction strategies related to cannabis should be developed in coordination with educators and the social services sector; and
- Harm reduction strategies related to cannabis should include information on the risks associated with heavy chronic use, tools for detecting at-risk and heavy users and measures to discourage people from driving under the influence of marijuana.

CHAPTER 17 - TREATMENT PRACTICES

With the exception of the treatment given to offenders imprisoned in federal institutions and Aboriginals, the care available to individuals who are substance-dependent is essentially the responsibility of the provinces and territories. This chapter is therefore brief since we received only a few submissions and heard few witnesses on this question.

In Chapter 7 we determined that physical dependency on cannabis was rare and insignificant. Some symptoms of addiction and tolerance can be identified in habitual users but most of them have no problem in quitting and do not generally require a period of withdrawal. As far as forms of psychological dependency are concerned, the studies are still incomplete but the international data tend to suggest that between 5% and 10% of regular users (using at least in the past month) are at risk of becoming dependent on cannabis. We estimated that approximately 3% or 600,000 adult Canadians have consumed cannabis in the past month and that approximately 0.5% or 100,000 use it on a daily basis. This indicates that somewhere between 30,000 and 40,000 people might be at-risk and 5,000 to 10,000 might make excessive use. For those aged 16 and 17, the numbers were between 50,000 and 70,000 at-risk and 8,000 to 17,000 potentially excessive users. The data also indicated that the peak period for intensive use is between the ages of 17 and 25 years. These broad parameters indicate where to look to prevent dependency and offer treatment services for those in need.

What form does cannabis dependency take? Most authors agree that psychological dependency on cannabis is relatively minor. In fact, it cannot be compared in any way with tobacco or alcohol dependency and is even less common than dependency on certain psychotropic medications.

We have observed that:

- The expression ‘drug addiction’ should no longer be used and we should talk instead of substance abuse and dependency;
- Between 5% and 10% of regular cannabis users are at risk of developing a dependency;
- Physical dependency on cannabis is virtually non-existent;

- Psychological dependency is moderate and is certainly lower than for nicotine or alcohol;
- Most regular users of cannabis are able to diverge from a trajectory of dependency without requiring treatment;
- There are many forms of treatment but nothing is known about the effectiveness of the different forms of treatment for cannabis dependency specifically;
- As a rule, treatment is more effective and less costly than incarceration;
- Studies of the treatment programs should be conducted, including treatments programs for people with cannabis dependency; and
- Studies should be conducted on the interaction of the cannabinoid and the opioid systems.

CHAPTER 18 - OBSERVATIONS ON PRACTICES

Previous chapters have described public action by dividing it into the major sectors of involvement. Before closing the third part of this report, we make some general observations that cut across the individual areas we have examined. The first concerns difficulties in harmonizing the various levels and sectors of involvement; the second, the difficulty in co-ordinating their various approaches; and the third, the costs of drugs and public policy.

A study published by CCSA in 1996 but based on 1992 data had identified the following costs of substance abuse:

- The costs associated with all illegal drugs were $1.4 billion, compared with $7.5 billion in the case of alcohol and $9.6 billion in the case of tobacco.
- Expressed as a percentage of the gross domestic product, the total costs for all substances was 2.67%. Of this, 0.2% was for illegal drugs, 1.09% for alcohol and 1.39% for tobacco.
- The principal costs of illegal drugs are externalities, that is, loss of productivity - $823 million, health care - $88 million, and losses in the workplace - $5.5 million, for a total of about 67% of all costs related to illegal drugs.
- The cost of public policies, or opportunity costs, represent about 33%.
- The cost of enforcing the law represents about 29.2% of all costs, or about 88% of all policy costs. The balance goes to prevention, research and administration.

Previous studies conducted in British Columbia in 1991, in Ontario in 1988 and in Quebec in 1988, using different methodologies, established costs of $388 million, $1.2 billion and $2 billion respectively, for a total cost of $3.5 billion in these three provinces alone. These figures demonstrate the extent to which such estimates can vary, according to the methodology selected and the availability of data.

Nevertheless, with the CCSA study taken as the standard, two comments must be made. First, loss of productivity – the major cost – is measured in mortality - $547 million and morbidity - $275 million. Except in the case of traffic fatalities, cannabis is not a cause of death and involves none of this type of social cost. Morbidity corresponds to losses attributed to problems caused by drug use as measured by the difference between the average annual income of users and of the population in general. Here, two further observations about cannabis should be noted. A large proportion of cannabis users are young people who are not yet part of the workforce and cannabis use involves none of the addiction and attendant problems that follow from heroin or cocaine use. Therefore, the costs that can be attributed to cannabis in this regard are likely minimal. If one accepts the methodology of the authors, **cannabis in itself entails few externalities**, which are the main measures of the social cost of illegal drugs.

However, it should also be noted that the study did not calculate the costs of substance-related crime. Alcohol is well known for its frequent association with crimes of violence (at least 30% of all cases), as well as with impaired driving, which results in major social and economic losses. Crime related to illegal drugs is of several types: organized crime, crimes against property committed in order to pay for drugs, true mainly in the case of heroin and cocaine, and crimes of violence committed under the influence of drugs. With the exception of organized crime and driving under the influence, cannabis involves few of the factors that generate criminal behaviour.

Secondly, according to the CCSA's study, the main cost of illegal drugs, after loss of productivity, is the cost of law enforcement, which the study estimates at approximately $400 million. In Chapters 14 and 15, we note that police and court costs are certainly much higher than this figure, and probably total between $1 and $1.5 billion. The proportion of these costs attributable to cannabis is impossible to determine for certain. But, insofar as 77% of all drug-related offences involve cannabis, and of these 50% simple possession, and given that about 60% of incidents result in a charge, of which some 10% to 15% of cases the accused receives a prison sentence, it is clear that a considerable proportion of the drug-related activity addressed by the penal justice system is concerned with cannabis. While admitting this to be a very rough estimate, we suggest that about 30% of the activity of the justice system is tied up with cannabis. On the basis of our estimates and the lowest cost of law enforcement, or $1 billion, it costs about $300 million annually to enforce the cannabis laws.

In effect, the main social costs of cannabis are a result of public policy choices, primarily its continued criminalization, while the consequences of its use represent a small fraction of the social costs attributable to the use of illegal drugs.

Overall, we observed the following:

- The lack of any real national platform for discussion and debate on illegal drugs prevents the development of clear objectives and measurement indicators;
- The absence of a national platform makes exchange of information and best practices impossible;
- Practices and approaches vary considerably between and within provinces and territories;
- The conflicting approaches of the various players in the field are a source of confusion;
- The resources and powers of enforcement are greatly out of balance compared with those of the health and education fields and the civil society;
- The costs of all illegal drugs had risen to close to $1.4 billion in 1992;
- Of the total costs of illegal drugs in 1992, externalities (social costs) represented 67% and public policy costs 33%;
- The social costs of illegal drugs and the public policy costs are underestimated ;
- The cost of enforcing the drug laws is more likely to be closer to $1 billion to $1.5 billion per annum;
- The principal public policy cost relative to cannabis is that of law enforcement and the justice system; which may be estimated to represent a total of $300 to $500 million per annum;
- The costs of externalities attributable to cannabis are probably minimal - no deaths, few hospitalizations, and little loss of productivity;
- The costs of public policy on cannabis are disproportionately high given the drug's social and health consequences; and
- The Canadian Centre on Substance Abuse is seriously under-funded; its annual budget amounts to barely 0.1% of the social costs of illegal drugs alone (alcohol not included). Its budget should be increased to at least 1%; that is, approximately $15 million per annum.

PART IV-PUBLIC POLICY OPTIONS

CHAPTER 19 - THE INTERNATIONAL LEGAL ENVIRONMENT

This chapter could begin and end with the same words: The international drug control conventions are, at least with respect to cannabis, an utterly irrational restraint that has nothing to do with scientific or public health considerations.

Three points bear making concerning the substance of the current conventions.

The first has to do with the absence of definitions. The terms drugs, narcotics and psychotropics are not defined in any way except as lists of products included in schedules. It follows that any natural or synthetic substance on the list of narcotics is, for the purposes of international law, a narcotic, and that a psychotropic is defined in

international law by its inclusion in the list of psychotropics. The only thing that the 1961 Convention tells us about the substances to which it applies is that they can be abused. The 1971 Psychotropics Convention, which reversed the roles in that the synthetic drug producing countries wanted narrower criteria, indicates that the substances concerned may cause dependence or central nervous system stimulation or depression and may give rise to such abuse as to "constitute a public health problem or a social problem that warrants international control."

The second point, following from the first, relates to the arbitrary nature of the classifications. While cannabis is included, along with heroin and cocaine, in Schedules I and IV of the 1961 Convention, which carry the most stringent controls, it is not even mentioned by name in the 1971 Convention, though THC is listed as a Schedule I psychotropic along with mescaline, LSD and so on. The only apparent criterion is medical and scientific use, which explains why barbiturates are in Schedule III of the 1971 Convention and therefore subject to less stringent controls than natural hallucinogens. These classifications are not just arbitrary, but inconsistent with the substances' pharmacological classifications and their danger to society.

Third, if there was so much concern about public health based on how dangerous "drugs" are, one has to wonder why tobacco and alcohol are not on the list of controlled substances.

We conclude from these observations that the international regime for the control of psychoactive substances, beyond any moral or even racist roots it may initially have had, **is first and foremost a system that reflects the geopolitics of North-South relations in the 20th century**. Indeed, the strictest controls were placed on organic substances – the coca bush, the poppy and the cannabis plant – which are often part of the ancestral traditions of the countries where these plants originate, whereas the North's cultural products, tobacco and alcohol, were ignored and the synthetic substances produced by the North's pharmaceutical industry were subject to regulation rather than prohibition. It is in this context that the demand made by Mexico on behalf of a group of Latin American countries during the negotiations leading up to the 1988 Convention, that their use be banned, must be understood. It was a demand that restored the balance to a degree, as the countries of the South had been forced to bear the full brunt of the controls and their effects on **their own people** since the inception of drug prohibition. The result may be unfortunate, since it reinforces a prohibitionist regime that history has been shown to be a failure, but it may have been the only way, given the mood of the major Western powers, to demonstrate the irrationality of the entire system in the longer term. In any case, it is a short step from there to question the legitimacy of instruments that help to maintain the North-South disparity yet fail miserably to reduce drug supply and demand.

We make the following observations:

- The series of international agreements concluded since 1912 have failed to achieve their ostensible aim of reducing the supply of drugs;
- The international conventions constitute a two-tier system that regulates the synthetic substances produced by the North and prohibits the organic substances produced by the South, while ignoring the real danger the substances represent for public health;
- When cannabis was included in the international conventions in 1925, there was no knowledge of its effects;
- The international classifications of drugs are arbitrary and do not reflect the level of danger they represent to health or to society;
- Canada should inform the international community of the conclusions of our report and officially request the declassification of cannabis and its derivatives.

CHAPTER 20 - PUBLIC POLICIES IN OTHER COUNTRIES

The vast majority of Canadians have heard about the "war on drugs" which the USA is conducting and about its prohibitionist approach, but many would be surprised to see the major variations between states, indeed between cities, within that country. Even fewer know that Sweden enforces a prohibitionist policy at least as strict as that of the US, but through other means. Many of us have, in one way or another, heard about the "liberal" approach introduced in the Netherlands in 1976. Fewer people know of the Spanish, Italian, Luxembourg or Swiss approaches, which are even more liberal in certain respects. More recently, Canadians learned of the decision by the UK's Minister of the Interior to reclassify cannabis as a Class C drugs, but it is not clear that we know precisely what that means. In view of the preconceptions that many may have in relation to France with regard to wine, many may be surprised to learn that its policy on cannabis appears more "conservative" than that of neighbouring Belgium, for example. As may be seen, after the overall framework of the puzzle has been established by the international community, the ways the pieces are put together vary widely among states, and at times among the regions of a single state.

That is why, in order to learn about the experience and approaches of other countries, the Committee commissioned a number of research reports on the situations in other countries and heard representatives of some of those countries in person. We of course had to make some choices, such as limiting ourselves to the western countries of the northern hemisphere. This is a weak point in our Report, we agree, but our resources were limited. In addition, as we wanted to compare public policies with data on use trends and judicial practices, we were forced to choose countries with an information base. In our hearings with representatives of those countries, we were mainly limited by time and cost.

In this chapter, we describe the situations in five European countries — France, the Netherlands, the United Kingdom, Sweden and Switzerland — and in Australia and the United States.

CHAPTER 21 - PUBLIC POLICY OPTIONS

Public policy is not just a matter of enabling legislation, in this case criminal legislation. Nonetheless, when it comes to illegal drugs, criminal legislation occupies a symbolic and determinative place. It is as if this legislation is the backbone of our public policy. Public discussions of cannabis do not deal so much with such matters as public health, user health, prevention of at-risk or excessive use, but with such questions as the pros and cons of decriminalization, establishing a civil offence or maintaining a criminal offence, or possible legalization and the extent thereof.

In respect of illegal drugs, where the key issues are, first and foremost, matters of public health and culture (including education and research), and where criminal law should be used only as a last resort, public policy must be based primarily on clear principles and objectives. For this to come about, public policy must be equipped with a set of tools designed to deal with the various issues that drugs represent to societies. Legislation is only one such tool. The social and economic costs of illegal drugs affect many aspects of society through lower productivity and business loss, hours of hospitalization and medical treatment of all kinds, police time and prison time, and broken or lost lives. Even if no one can pinpoint the exact figures, a portion of these costs arise, not from the substances themselves, but from the fact that they are criminalized. In fact, more than for any other illegal drug, its criminalization is the principal source of social and economic costs. However, in spite of the fact that the principal social costs of drugs affect business, health and family, the emphasis on the legal debate tips the scales of public action in favour of law enforcement agencies. No one can deny that their work is necessary to ensure public order and peace and fight organized crime. At the same time, over 90% of resources are spent on enforcing the law, the most visible actions with respect to drugs in the public sphere are police operations and court decisions and, at least with respect to cannabis, the law lags behind individual attitudes and opinions, thus creating a huge gap between needs and practice.

Most national strategies display a similar imbalance. The national strategies that appear to have the greatest chance of success, however, are those that strive to correct the imbalance. These strategies have introduced knowledge and observation tools, identified indicators of success with respect to their objectives, and established a veritable nerve centre for implementing and monitoring public policy. The law, criminal law especially, is put in its proper place as one method among many of reaching the defined objectives, not an aim in itself.

This chapter is divided into three sections. The first examines the effectiveness of legal measures for fighting drugs, and shows that legal systems have little effect on consumption or supply. The second section describes the various components of a public policy. The third considers the direction of criminal policy, and defines the main terms used: decriminalization, depenalization, diversion, legalization, and regulation.

In our view, it is clear that if the aim of public policy is to diminish consumption and supply of drugs, specifically cannabis, all signs indicate

complete failure. One might think the situation would be worse if not for current anti-drug action. This may be so. Conversely, one might also think that the negative impact of anti-drug programs that are currently centre stage are greater than the positive effect, specifically non-compliance with laws that are inconsistent with majority attitudes and behaviour. One of the reasons for this failure is the excessive emphasis placed on criminal law in a context where prohibition of use and a drug-free society appear to remain the omnipresent and determining direction of current public policies.

We think that a public policy **on psychoactive substances must be both integrated and adaptable, target at-risk uses and behaviours and abuses based on a public health approach that neither trivializes nor marginalizes users**. Implementation of such a policy must be multifaceted.

Some say that decriminalization is a step in the right direction, one that gives society time to become accustomed to cannabis, to convince opponents that chaos will not result, to adopt effective preventive measures. We believe however that **this approach is in fact the worst case scenario, depriving the State of a necessary regulatory tool for dealing with the entire production, distribution, and consumption network, and delivering hypocritical messages at the same time.**

In our opinion, the data we have collected on cannabis and its derivatives provide sufficient grounds for our general conclusion that the **regulation of the production, distribution and consumption of cannabis, inasmuch as it is part of an integrated and adaptable public policy, is best able to respond to the principles of autonomy, governance that fosters human responsibility and limitation of penal law to situations where there is demonstrable harm to others. A regulatory system for cannabis should permit, specifically:**

- ***more effective targeting of illegal traffic and a reduction in the role played by organized crime;***
- ***prevention programs better adapted to the real world and better able to prevent and detect at-risk behaviour;***
- ***enhanced monitoring of products, quality and properties;***
- ***better user information and education; and***
- ***respect for individual and collective freedoms, and legislation more in tune with the behaviour of Canadians.***

In our opinion, Canadian society is ready for a responsible policy of cannabis regulation that complies with these basic principles.

CONCLUSIONS AND RECOMMENDATIONS

The Senate Special Committee on Illegal Drugs' mandate was to examine Canada's public policy approach in relation to cannabis and assess its effectiveness and impact in light of the knowledge of the social and health-related effects of cannabis and the international context. Over the past two years, the Committee has heard from Canadian and foreign experts and reviewed an enormous amount of scientific research. The Committee has endeavoured to take the pulse of Canadian public opinion and attitudes and to consider the guiding principles that are likely to shape public policy on illegal drugs, particularly cannabis. Our report has attempted to provide an update on the state of knowledge and the key issues, and sets out a number of conclusions in each chapter.

This final section sets out the main conclusions drawn from all this information and presents the resulting recommendations derived from the thesis we have developed namely: ***in a free and democratic society, which recognizes fundamentally but not exclusively the rule of law as the source of normative rules and in which government must promote autonomy as far as possible and therefore make only sparing use of the instruments of constraint, public policy on psychoactive substances must be structured around guiding principles respecting the life, health, security and rights and freedoms of individuals, who, naturally and legitimately, seek their own well-being and development and can recognize the presence, difference and equality of others.***

LE DAIN – THIRTY YEARS AGO ALREADY

Thirty years ago, the Le Dain Commission released its report on cannabis. This Commission had far greater resources than we did. However, we had the benefit of Le Dain's work, a much more highly developed knowledge base since then and of thirty years' historical perspective.

The Commission concluded that the criminalization of cannabis had no scientific basis. Thirty years later, we confirm this conclusion and add that continued criminalization of cannabis remains unjustified based on scientific data on the danger it poses.

The Commission heard and considered the same arguments on the dangers of using cannabis: apathy, loss of interest and concentration, learning difficulties. A majority of the Commissioners concluded that these concerns, while unsubstantiated, warranted a restrictive policy. Thirty years later, we assert that the studies done in the meantime have not confirmed the existence of the so-called amotivational syndrome

and add that most studies rule out this syndrome as a consequence of the use of cannabis.

The Commission concluded that not enough was known about the long-term and excessive use of cannabis. We assert that these types of use exist and may present some health risks; excessive use, however, is limited to a minority of users. Public policy, we would add, must provide ways to prevent and screen for at-risk behaviour, something our policies have yet to do.

The Commission concluded that the effects of long-term use of cannabis on brain function, while largely exaggerated, could affect adolescent development. We concur, but point out that the long-term effects of cannabis use appear reversible in most cases. We note also that adolescents who are excessive users or become long-term users are a tiny minority of all users of cannabis. Once again, we would add that a public policy must prevent use at an early age and at-risk behaviour.

The Commission was concerned that the use of cannabis would lead to the use of other drugs. Thirty years' experience in the Netherlands disproves this clearly, as do the liberal policies of Spain, Italy and Portugal. And here in Canada, despite the growing increase in cannabis users, we have not had a proportionate increase in users of hard drugs.

The Commission was also concerned that legalization would mean increased use, among the young in particular. We have not legalized cannabis, and we have one of the highest rates in the world. Countries adopting a more liberal policy have, for the most part, rates of usage lower than ours, which stabilized after a short period of growth.

Thirty years later, we note that:

- Billions of dollars have been sunk into enforcement without any greater effect. There are more consumers, more regular users and more regular adolescent users;
- Billions of dollars have been poured into enforcement in an effort to reduce supply, without any greater effect. Cannabis is more available than ever, it is cultivated on a large scale, even exported, swelling coffers and making organized crime more powerful; and
- There have been tens of thousands of arrests and convictions for the possession of cannabis and thousands of people have been incarcerated. However, use trends remain totally unaffected and the gap the Commission noted between the law and public compliance continues to widen.

It is time to recognize what is patently obvious: our policies have been ineffective, because they are poor policies.

INEFFECTIVENESS OF THE CURRENT APPROACH

No clearly defined federal or national strategy exists. Some provinces have developed strategies while others have not. There has been a lot of talk but little significant action. In the absence of clear indicators accepted by all stakeholders to assess Canadian public policy, it is difficult to determine whether action that has been taken is effective.

Given that policy is geared to reducing demand (i.e. drug-use rates) and supply (by reducing the availability of drugs and pushing up drug prices), both these indicators may be used. A look at trends in cannabis use, both among adults and young people, **forces us to admit that current policies are ineffective**. In Chapter 6, we saw that trends in drug-use are on the increase. If our estimates do indeed reflect reality, no fewer that 2 million Canadians aged between 18 and 65 have used cannabis at least once over the past 12 months, while at least 750,000 young people between the ages of 14 and 17 use cannabis at least once per month, one third of them on a daily basis. This proportion appears, at least in the four most highly-populated provinces, to be increasing. Statistics suggest that both use and at-risk use is increasing.

Of course, we must clearly establish whether the ultimate objective is a drug-free society, at least one free of cannabis, or whether the goal is to reduce at-risk behaviour and abuse. This is an area of great confusion, since Canadian public policy continues to use vague terminology and has failed to establish whether it focuses on substance abuse as the English language terminology used in several documents seems to suggest or on drug-addiction as indicated by the French language terminology.

It is all very well to criticize the "trivialization" of cannabis in Canada, to "explain" increases in use, but it must also be established why, if this is indeed the case, this trivialization has occurred. It is also important to identify the root cause of this trivialization against a backdrop of mainly anti-drug statements. The courts and their lenient attitude might be blamed for this. Perhaps the judiciary is at the forefront of those responsible for cannabis policies and the enforcement of the law. It must also be determined whether sentences are really as lenient as some maintain. A major issue to be addressed is whether harsher sentences would indeed be an effective deterrent given that the possibility of being caught by the police is known to be a much greater deterrent. Every year, over 20,000 Canadians are arrested for cannabis possession. This figure might be as high as 50,000 depending on how the statistics are interpreted. No matter what the numbers, they are too high for this type of conduct. However, even those numbers are laughable number when compared to the three million people who have used cannabis over the past 12 months. We should not think that the number of arrests could be significantly increased even if billions more dollars were allocated to police enforcement. Indeed, such a move should not even be considered.

A look at the availability and price of drugs, **forces us to admit that supply-reduction policies are ineffective**. Throughout Canada, above all in British Columbia

and Quebec, the cannabis industry is growing, flooding local markets, irritating the United States and lining the pockets of criminal society. Drug prices have not fallen but quality has improved, especially in terms of THC content – even if we are sceptical of the reported scale of this improvement. Yet, police organizations already have greater powers and latitude – especially since the September 11, 2001 tragedy – in relation to drugs than in any other criminal matter. In addition, enforcement now accounts for over 90 % of all spending related to illegal drugs. To what extent do we want to go further down this road?

Clearly, current approaches are ineffective and inefficient. Ultimately, their effect amounts to throwing taxpayers' money down the drain in a crusade that is not warranted by the danger posed by the substance. It has been maintained that drugs, including cannabis, are not dangerous because they are illegal but rather are illegal because they are dangerous. This is perhaps true of other types of drugs, but not of cannabis. We should state this clearly once and for all, for public good: it is time to stop this crusade.

PUBLIC POLICY BASED ON GUIDING PRINCIPLES

However much we might wish good health and happiness for everyone, we all know how fragile they are. Above all, we realize that health and happiness cannot be forced on a person, especially not by criminal law based on a specific concept of what is morally 'right'. No matter how attractive calls for a drug-free society might be, and even if some people might want others to stop smoking, drinking alcohol, or smoking joints, we all realize that these activities are part of our social reality and the history of humankind.

Consequently, what role should the State play? It should neither abdicate responsibility and allow drug markets to run rife, nor should it impose a particular way of life on people. We have opted, instead, for a concept whereby public policy **promotes and supports freedom for individuals and society as a whole**. For some, this would undoubtedly mean avoiding drug use. However, for others, the road to freedom might be via drug use. For society as a whole, in practice, this concept means a State that does not dictate what should be consumed and under what form. Support for freedom necessarily means flexibility and adaptability. It is for this reason that public policy on cannabis has to be clear while at the same time tolerant, to serve as a guide while at the same time avoiding imposing a single standard. This concept of the role of the State is based on the **principle of autonomy and individual and societal responsibility.** Indeed, it is much more difficult to allow people to make their own decisions because there is less of an illusion of control. It is just that: an illusion. We are all aware of that. It is perhaps sometimes comforting, but is likely to lead to abuse and unnecessary suffering. An ethic of responsibility teaches social expectations, expectations not to use drugs in public or sell them to children and responsible

behaviour, recognizing at-risk behaviour and being able to use moderately, and supports people facing hardship by providing a range of treatment.

From this concept of government action ensues a limited role for criminal law. As far as cannabis is concerned, **only behaviour causing demonstrable harm to others should be prohibited**: illegal trafficking, selling to minors and impaired driving.

Public policy shall also draw on available knowledge and scientific research but without expecting science to provide the answers to political issues. Indeed, scientific knowledge does have a major role to play **in supporting decision-making,** at both the individual and government levels. But science should play no greater role. It is for this reason that the Committee considers that a drug and dependency monitoring agency and a research program should be set up to help future decision-makers.

A CLEAR AND COHERENT FEDERAL STRATEGY

Although the Committee has focused on cannabis, we have nevertheless observed inherent shortcomings in the federal drug strategy. Quite obviously, there is no real strategy or focused action. Behind the assumed leadership provided by Health Canada there emerges a lack of necessary tools for action, a patchwork of ad hoc approaches varying from one substance to another and piecemeal action by various departments. Of course, co-ordinating bodies do exist, but lack real tools and clear objectives, each focusing its action according to its own particular priorities. This state of affairs has resulted in a whole series of funded programs being developed without any tangible cohesion.

Many stakeholders have expressed their frustration to the Committee at the apparently vanishing pieces of the puzzle and at the whole gamut of incoherent decisions, that cause major friction on the front lines. Various foreign observers also expressed their surprise that a country as rich as Canada, which is not immune to psychoactive substance-related problems, did not have a “champion”, a spokesperson or a figure of authority able to fully grasp the real issues and obtain genuine cooperation from all of the stakeholders.

It is for this reason that we are recommending the creation of the position of National Advisor on Psychoactive Substances and Dependency to be attached to the Privy Council. We do not envisage this as a superstructure responsible for managing budgets and action related to psychoactive substances. We favour an approach similar to that of the *Mission interministérielle à la drogue et à la toxicomanie* in France over one modelled on that of the United States’ Office of National Drug Control Policy. The Advisor would have a small dedicated staff, the majority of whom would be on assignment from various federal departments and bodies involved in drug issues.

The Advisor would be responsible: for advising the Cabinet and the Prime Minister on national and international psychoactive substance-related issues; for ensuring coordination between federal departments and agencies; for overseeing the

development of federal government psychoactive substance-related objectives and ensuring these objectives are satisfied; and to serve as a Canadian government spokesperson on issues related to psychoactive substances at an international level.

Recommendation 1
The Committee recommends that the position of National Advisor on Psychoactive Substances and Dependency be created within the Privy Council Office; that the Advisor be supported by a small secretariat and that the necessary staff be assigned by federal departments and agencies involved with psychoactive substances on request.

NATIONAL STRATEGY SUSTAINED BY ADEQUATE RESSOURCES AND TOOLS

A federal policy and strategy do not in themselves make a national strategy. Provinces, territories, municipalities, community organizations and even the private sector all have a role to play in accordance with their jurisdiction and priorities. This is necessary and this diversity is worth encouraging. However, some harmonization and meaningful discussion on practices and pitfalls, on progress and setbacks, and on knowledge are to be encouraged. Apart from those provided by the resource-starved piecemeal actions of the Canadian Centre on Substance Abuse, there are all too few opportunities and schemes to promote exchanges of this type. **The current and future scale of drug and dependency-related issues warrants that the Canadian government earmark the resources and establish the tools with which to develop fair, equitable and considered policies**.

Like the majority of Canadian and foreign observers of the drug situation, we were struck by the relative lack of tools and measures for determining and following up on the objectives of public psychoactive substance policy. One might not agree with the numbers-focused goals set out by the Office of National Drug Control Policy for the reduction of drug use or for the number of drug treatment programs set up and evaluated. However, we have to admit that at least these figures serve as guidelines for all stakeholders and as benchmarks against which to measure success.

Similarly, one might not feel totally comfortable with the complex Australian goal-definition process, whereby the whole range of partners from the various levels of government, organizations and associations meet at a conference every five years to review goals. However, at least those goals agreed upon by the various stakeholders constitute a clear reference framework and enable better harmonization of action.

The European monitoring system with its focal points in each country of the European Union under the European Monitoring Centre for Drugs and Drug Addiction umbrella might seem cumbersome; and the American system of conducting various annual epidemiological studies might appear expensive. We might even

acknowledge that there are problems with epidemiological studies, which are far from providing a perfect picture of the psychoactive substance use phenomena. However, at least these tools, referred to and used throughout the western world, permit the development of a solid information base with which to analyse historical trends, identify new drug-use phenomena and react rapidly. In addition, it allows for an assessment of the relevance and effectiveness of action taken. No system of this type exists in Canada, which is the only industrialized western country not to have such a knowledge structure.

It is for these reasons that the Committee recommends that the Government of Canada support various initiatives to develop a genuine national strategy. Firstly, the Government should call a national conference of the whole range of partners with a view to setting out goals and priorities for action over a five-year period. This conference should also identify indicators to be used in measuring progress at the end of the five-year period. Secondly, the Canadian Centre on Substance Abuse needs to be renewed. Not only does this body lack resources but it is also subject to the vagaries of political will of one Minister, the Minister of Health. The Centre should have a budget in proportion with the scale of the psychoactive substance problem and should have the independence required to address this issue. Lastly, a Canadian Monitoring Agency on Drugs and Dependency should be created within the Centre.

Recommendation 2

The Committee recommends that the Government of Canada mandate the National Advisor on Psychoactive Substances and Dependency to call a high-level conference of key stakeholders from the provinces, territories, municipalities and associations in 2003, to set goals and priorities for action on psychoactive substances over a five-year period.

Recommendation 3

The Committee recommends that the Government of Canada amend the enabling legislation of the Canadian Centre on Substance Abuse to change the Centre's name to the *Canadian Centre on Psychoactive Substances and Dependency*; make the Centre accountable to Parliament; provide the Centre with an annual basic operating budget of $15 million to be increased annually; require the Centre to table an annual report on actions taken, key issues, research and trends in Parliament and in the provincial and territorial legislatures; mandate the Centre to ensure national coordination of research on psychoactive substances and dependency and to conduct studies into

specific issues; and mandate the Centre to undertake an assessment of the national strategy on psychoactive substance and dependency every five years.

Recommendation 4
The Committee recommends that, in the legislation creating the Canadian Centre on Psychoactive Substances and Dependency, the Government of Canada specifically include provision for the setting up of a Monitoring Agency on Psychoactive Substances and Dependency within the Centre; provide that the Monitoring Agency be mandated to conduct studies every two years, in cooperation with relevant bodies, on drug-use trends and dependency problems in the adult population; work with the provinces and territories towards increased harmonization of studies of the student population and to ensure they are carried out every two years; conduct ad hoc studies on specific issues; and table a bi-annual report on drug-use trends and emerging problems.

A PUBLIC HEALTH POLICY

When cannabis was listed as a prohibited substance in 1923, no public debate or discussion was held on the known effects of the drug. In fact, opinions expressed were disproportionate to the dangers of the substance. Half a century later, the Le Dain Royal Commission of Inquiry on the Non-Medical Use of Drugs held a more rational debate on cannabis and took stock of what was known about the drug. Commissioners were divided not so much over the nature and effects of the drug but rather over the role to be played by the State and criminal law in addressing public health-related goals. Thirty years after the Le Dain Commission report, we are able to categorically state that, **used in moderation, cannabis in itself poses very little danger to users and to society as a whole, but specific types of use represent risks for users**.

In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed to discrimination by the police and the criminal justice system; society sees the power and wealth of organized crime enhanced as criminals benefit from prohibition; and governments see their ability to prevent at-risk use diminished.

We would add that, **even if cannabis were to have serious harmful effects, one would have to question the relevance of using the criminal law to limit these effects**. We have demonstrated that criminal law is not an appropriate governance tool for matters relating to personal choice and that prohibition is known to result in harm

which often outweighs the desired positive effects. However, current scientific knowledge on cannabis, its effects and consequences are such that this issue is not relevant to our discussion.

Indeed available data indicate that the scale of the cannabis use phenomenon can no longer be ignored. Chapter 6 indicated that no fewer than 30% of Canadians (12 to 64 years old) have experimented with cannabis at least once in their lifetime. In all probability, this is an underestimation. We have seen that approximately 50% of high school students have used cannabis within the past year. Nevertheless, a high percentage of them stop using, and the vast majority of those who experiment do not go on to become regular users. Even among regular users, only a small proportion develop problems related to excessive use, which may include some level of psychological dependency. Consumption patterns among cannabis users do not inevitably follow an upward curve but rather a series of peaks and valleys. Regular users also tend to have a high rate of consumption in their early twenties, which then either drops off or stabilizes, and in the vast majority of cases, most often ceasing altogether in their thirties.

All of this does not in any way mean, however, that cannabis use should be encouraged or left unregulated. Clearly, it is a psychoactive substance with some effects on cognitive and motor functions. When smoked, cannabis can have harmful effects on the respiratory airways and is potentially cancerous. Some vulnerable people should be prevented, as much as possible, from using cannabis. This is the case for young people under 16 years of age and those people with particular conditions that might make them vulnerable, for example those with psychotic predispositions. As with alcohol, adult users should be encouraged to use cannabis in moderation. Given that, as for any substance, at-risk use does exist, preventive measures and detection tools should be established and treatment initiatives must be developed for those who use the drug excessively. Lastly, it goes without saying that education initiatives and severe criminal penalties must be used to deter people from operating vehicles under the influence of cannabis.

As for any other substance, there is at-risk use and excessive use. There is no universally accepted criterion for determining the line between regular use, at-risk use and excessive use. The context in which use occurs, the age at which users were introduced to cannabis, substance quality and quantity are all factors that play a role in the passage from one type of use to another. Chapters 6 and 7 identified various criteria, which we have collated in table form below.

Proposed Criteria for Differentiating Use Types

	Environment	Quantity	Frequency	Period of use and intensity
Experimental / Occasional	Curiosity	Variable	A few times over lifetime	None
Regular	Recreational, social Mainly in evening Mainly in a group	A few joints Less than one gram per month	A few times per month	Spread over several years but rarely intensive
At-risk	Recreational and occupational (to go to school, to go to work, for sport…) Alone, in the morning Under 16 years of age	Between 0.1 and 1 gram per day	A few times per week, evenings, especially weekends	Spread over several years with high intensity periods
Excessive	Occupational and personal problems No self regulation of use	Over one gram per day	More than once per day	Spread over several years with several months at a time of high intensity use

Even if **cannabis itself poses very little danger to the user and to society as a whole, some types of use involve risks**. It is time for our public policy to recognize this and to **focus on preventing at-risk use and on providing treatment for excessive cannabis users**.

Recommendation 5
The Committee recommends that the Government of Canada adopt an integrated *policy on the risks and harmful effects of psychoactive substances* covering the whole range of substances (medication, alcohol, tobacco and illegal drugs). With respect to cannabis, this policy should focus on educating users, detecting and preventing at-risk use and treating excessive use.

A REGULATORY APPROACH TO CANNABIS

The **prohibition of cannabis does not bring about the desired reduction in cannabis consumption or problematic use**. However, this approach does have a whole series of harmful consequences. Users are marginalized, and over 20,000 Canadians are arrested each year for cannabis possession. Young people in

schools no longer enjoy the same constitutional and civil protection of their rights as others. Organized crime benefits from prohibition and the criminalization of cannabis enhances their power and wealth. Society will never be able to stamp out drug use – particularly cannabis use.

Some might believe that an alternative policy signifies abandoning ship and giving up on promoting well-being for Canadians. Others might maintain that a regulatory approach would fly in the face of the fundamental values of our society. We believe, however, that the continued prohibition of cannabis jeopardizes the health and well-being of Canadians much more than does the substance itself or the regulated marketing of the substance. In addition, we believe that the continued criminalization of cannabis undermines the fundamental values set out in the *Canadian Charter of Rights and Freedoms* and confirmed in the history of a country based on diversity and tolerance.

We do not want to see cannabis use increase, especially among young people. Of note, the data from other countries that we compared in Chapters 6 and 20 indicate that countries such as the Netherlands, Australia and Switzerland, which have put in place a more liberal approach, have not seen their long-term levels of cannabis use rise. The same data also clearly indicate that countries with a very restrictive approach, such as Sweden and the United States, are poles apart in terms of cannabis use levels and that countries with similar liberal approaches, such as the Netherlands and Portugal, are also at opposite ends of the spectrum, falling somewhere between Sweden and the United States. We have concluded that public policy itself has little effect on cannabis use trends and that other more complex and poorly understood factors play a greater role in explaining the variations.

An exemption regime making cannabis available to those over the age of 16 could probably lead to an increase in cannabis use for a certain period. Use rates would then level off as interest wanes and as effective prevention programs are set up. A roller coaster pattern of highs and lows would then follow, as has been the case in most other countries.

This approach is neither one of total abdication nor an indication of abandonment but rather a vision of the role of the State and criminal law as **developing and promoting but not controlling human action** and as **stipulating only necessary prohibitions** relating to the fundamental principle of respect for life, other persons and a harmonious community, and as **supporting and assisting others, not judging and condemning difference**.

We might wish for a drug-free world, fewer smokers or alcoholics or less prescription drug dependency, but we all know that we shall never be able to eliminate these problems. More importantly, we should not opt to criminalize them. The Committee believes that the same healthy and respectful approach and attitude should be applied to cannabis.

It is for this reason that the Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme, under which the production and sale of cannabis would be licensed. Licensing

and the production and sale of cannabis would be subject to specific conditions, which the Committee has endeavoured to specify. For clarity's sake, these conditions have been compiled at the end of this section. It should be noted at the outset that the Committee suggests cigarette manufacturers should be prohibited from producing and selling cannabis.

Recommendation 6
The Committee recommends that the Government of Canada amend the *Controlled Drugs and Substances Act* to create a criminal exemption scheme. This legislation should stipulate the conditions for obtaining licences as well as for producing and selling cannabis; criminal penalties for illegal trafficking and export; and the preservation of criminal penalties for all activities falling outside the scope of the exemption scheme.

Recommendation 7
The Committee recommends that the Government of Canada declare an amnesty for any person convicted of possession of cannabis under current or past legislation.

A COMPASSION-BASED APPROACH FOR THERAPEUTIC USE

In Chapter 9, we noted that cannabis has not been approved as a medicinal drug in the pharmacological sense of the word. In addition to the inherent difficulties in conducting studies on the therapeutic applications of cannabis, there are issues arising from the current legal environment and the undoubtedly high cost to governments of conducting such clinical studies.

Nevertheless, we do not doubt that for some medical conditions and for certain people cannabis is indeed an effective and useful therapy. Is it more effective than other types of medication? Perhaps not. Can physicians currently prescribe cannabis at a known dosage? Undoubtedly not. Should persons suffering from certain physical conditions diagnosed by qualified practitioners be permitted to use cannabis if they wish to do so? Of this, we are convinced.

The regulations made in 2001 by Health Canada, even though they are a step in the right direction, are fundamentally unsatisfactory. They do not facilitate access to therapeutic cannabis. They do not consider the experience and expertise available in compassion clubs. These regulations only govern marijuana and do not include cannabis derivatives such as hashish and cannabis oils.

It is for these reasons that the Committee recommends that Health Canada amend the *Marihuana Medical Access Regulations* in order to allow compassionate access to cannabis and its derivatives. As in the previous chapter, proposed rules have been compiled at the end of this chapter.

Recommendation 8
The Committee recommends that the *Marijuana Medical Access Regulations* be amended to provide new rules regarding eligibility, production and distribution with respect to cannabis for therapeutic purposes. In addition, research on cannabis for therapeutic purposes is essential.

PROVISIONS FOR OPERATING A VEHICLE UNDER THE INFLUENCE OF CANNABIS

In Chapter 8, we discussed the fact that research has not clearly established the effects of cannabis when taken alone on a person's ability to operate a vehicle. Nevertheless, there is enough evidence to suggest that operating a vehicle while under the influence of cannabis alters motor functions and affects a person's ability to remain in his or her lane. We have also established that the combined effects of cannabis and alcohol impair faculties even more than does alcohol taken alone. Epidemiological studies have shown that a certain number of cannabis users do drive under the influence of the substance and that a large proportion of these people, mainly the young, appear to believe that cannabis does not impair their ability to drive.

This chapter also indicated that no reliable and non-intrusive roadside detection tools exist. Saliva-based equipment is a promising development but for the time being, provide random results. We have also established that a visual recognition system, which has mainly been developed and assessed in the United States, is a reliable way of detecting drug-induced impaired driving faculties.

Recommendation 9
The Committee recommends that the Criminal Code be amended to lower permitted alcohol levels to 40 milligrams of alcohol per 100 millilitres of blood, in the presence of other drugs, especially, but not exclusively cannabis; and to admit evidence from expert police officers trained in detecting persons operating vehicles under the influence of drugs.

RESEARCH

Research on psychoactive substances, and particularly on cannabis, has undergone a boom over the past 20 years. The Committee was able to fully grasp the actual extent of this increase since we faced the challenge of summarizing it. Not all research is of the same quality and the current political and legal climate governing cannabis hampers thorough and objective studies. Nevertheless, a solid fact base was available to the Committee, on which to establish its conclusions and recommendations.

However, more research needs to be done in a certain number of specific areas. In Chapter 6, we established that a lack of practical research on cannabis users has resulted in only a limited amount of information on contexts of use being available. It is also currently difficult to establish criteria on the various types of cannabis use in order to guide those responsible for prevention. The Committee suggests that cannabis use of over one gram per day constitutes excessive use and that between 0.1 and one gram per day equates to at-risk use. We also suggest that any use below 16 years of age is at-risk use. This is of course enlightened speculation, but speculation nevertheless, which remains to be explored.

In Chapters 16 and 17, we referred to the fact that we know very little about the most effective prevention practices and treatment. Here also, the current context hindered. As far as prevention is concerned, the more or less implicit "*just say no*" message and the focus on cannabis use prevention are strategies that have been dictated by the prohibition-based environment. In terms of treatment for problem users, abstinence-based models have long been the dominant approach and continue to sit very poorly with harm-reduction-based models. Thorough assessment studies are required.

The Canadian Centre on Psychoactive Substances and Dependency must play a key role in co-ordinating and publishing the results of studies. The Centre does not have to conduct research itself. This can and indeed must sometimes be carried out by academics. The Health Research Institutes are also natural players. However, it is important to clearly identify a single central body to collect research information. This will enable the information to be distributed as widely possible and, we hope, used.

Recommendation 10

The Committee recommends that the Government of Canada create a national fund for research on psychoactive substances and dependency to fund research on key issues, more particularly on various types of use, on the therapeutic applications of cannabis, on tools for detecting persons operating vehicles under the influence of drugs and on effective prevention and treatment programs; that the Government of Canada mandate the Canadian Centre on

Psychoactive Substances and Dependency to co-ordinate national research and serve as a resource centre.

CANADA'S INTERNATIONAL POSITION

The Committee is well aware that were Canada to choose the rational approach to regulating cannabis we have recommended, it would be in contravention of the provisions of the various international conventions and treaties governing drugs. We are also fully aware of the diplomatic implications of this approach, in particular in relation to the United States.

We are keen to avoid replicating, at the Canada - US border, the problems that marked relations between the Netherlands, France, Belgium and Germany over the issue of drug tourism between 1985 and 1995. This is one of the reasons that justifies restricting the distribution of cannabis for recreational purposes to Canadian residents.

We are aware of the fact that a proportion of the cannabis produced in Canada is exported, mainly to the United States. We are also aware that a considerable proportion of heroin and cocaine comes into Canada via the United States. We are particularly cognisant of the fact that Canadian cannabis does not explain the increase in cannabis use in the United States. It is up to each country to get its own house in order before criticizing its neighbour.

Internationally, Canada will either have to temporarily withdraw from the conventions and treaties or accept that it will be in temporary contravention until the international community accedes to its request to amend them. The Committee opts for the second approach, which seems to us to be more consistent with the tradition and spirit of Canadian foreign policy. In addition, we have seen that international treaties foster the imbalanced relationship between the northern and southern hemispheres by prohibiting access to plants, including cannabis, produced in the southern hemisphere, while at the same time developing a regulatory system for medication manufactured by the pharmaceutical industry in the northern hemisphere. Canada could use this imbalanced situation to urge the international community to review existing treaties and conventions on psychoactive substances.

Canada can and indeed should provide leadership on drug policy. Developing a national information and action infrastructure would undoubtedly be key to this. **Canada must also play a leading role in the Americas**. We believe that Canada enjoys a favourable international reputation and that it can promote the development of fairer and more rational drug, in particular cannabis policies. We also contend that Canada should strive for the creation of a European observatory style Drug and Dependency Monitoring Agency for the Americas within the Organization of American States.

Recommendation 11

The Committee recommends that the Government of Canada instruct the Minister of Foreign Affairs and International Trade to inform the appropriate United Nations authorities that Canada is requesting an amendment to the conventions and treaties governing illegal drugs; and that the development of a Drugs and Dependency Monitoring Agency for the Americas be supported by the Government of Canada.

PROPOSALS FOR IMPLEMENTING THE REGULATION OF CANNABIS FOR THERAPEUTIC AND RECREATIONAL PURPOSES

Amendments to the
Marijuana Medical Access Regulations
(Production and sale of cannabis for therapeutic purposes)

A. Eligible person

A person affected by one of the following: wasting syndrome; chemotherapy treatment; fibromyalgia; epilepsy; multiple sclerosis; accident-induced chronic pain; and some physical condition including migraines and chronic headaches, whose physical state has been certified by a physician or an individual duly authorized by the competent medical association of the province or territory in question, may choose to buy cannabis and its derivatives for therapeutic purposes. The person shall be registered with an accredited distribution centre or with Health Canada.

B. Licence to distribute

A Canadian resident may obtain a licence to distribute cannabis and its derivatives for therapeutic purposes. The resident must undertake to only sell cannabis and its derivatives to eligible persons; to only sell cannabis and its derivatives purchased from producers duly licensed for this purpose; to keep detailed records on the medical conditions and their development, consumption and the noted effects on patients; to take all measures needed to ensure the safety of the cannabis products and to submit to departmental inspections.

C. Licence to produce

A Canadian resident may obtain a licence to produce cannabis and its derivatives for therapeutic purposes. The resident must undertake: to not hold a licence to produce cannabis for non therapeutic purposes; to take the measures necessary to ensure the consistency, regularity and quality of crops; to take the measures necessary to ensure the security of production sites; to know and document the properties and concentrations of each harvest with respect to Delta 9 THC; to sell only to accredited distribution centres and to submit to departmental inspections.

D. Other proposals

- Ensure that expenses relating to the use of cannabis for therapeutic purposes will be eligible for a medical expenses tax credit;
- Establish a program of research into the therapeutic applications of cannabis, by providing sufficient funding; by mandating the Canadian Centre on Psychoactive Substances and Dependency to co-ordinate the research program; and by providing for the systematic study of clinical cases based on the documentation available in organizations currently distributing cannabis for therapeutic purposes and in future distribution centres; and
- Ensure that the advisory committee on the therapeutic use of cannabis represents all players, including distribution centres and users.

Amendment to the *Controlled Drugs and Substances Act* (CDSA) (Production and sale of cannabis for non therapeutic purposes)

A. General aims of the bill

- To reduce the injurious effects of the criminalization of the use and possession of cannabis and its derivatives;
- To permit persons over the age of 16 to procure cannabis and its derivatives at duly licensed distribution centres; and
- To recognize that cannabis and its derivatives are psychoactive substances that may present risks to physical and mental health and, to this end, to regulate the use and trade of these substances in order to prevent at-risk use and excessive use.

B. Licence to distribute

Amend the Act to create a scheme providing for exemption to the criminal offences provided in the CDSA with respect to the distribution of cannabis. A Canadian resident may obtain a licence to distribute cannabis. The resident must undertake **not to distribute to persons under the age of 16; must never have been sentenced for a criminal offence, with the exception of offences related to the possession of cannabis, for which an amnesty will be declared**; and must agree to procure cannabis only from duly licensed producers. In addition, in accordance with potential restrictions under the *Canadian Charter of Rights and Freedoms*, licensed distributors shall not display products explicitly and shall not advertise in any manner.

C. Licence to produce

Amend the Act to create an exemption to the criminal offences provided in the CDSA with respect to the production of cannabis. A Canadian resident may obtain a licence to produce cannabis. The resident must undertake to only sell to duly licensed distributors; to sell only marijuana and hashish with a THC content of 13% or less; to limit production to the quantity specified in the licence; to take the measures needed to ensure the security of production sites; to keep detailed records of quantities produced, crops, levels of THC concentration and production conditions; and to submit to departmental inspections. No person charged with and sentenced for criminal offences, with the exception of the possession of cannabis, for which an amnesty will be declared, shall be granted a licence. No person or legal entity, directly or indirectly associated with the production, manufacture, promotion, marketing or other activity connected with tobacco products and derivatives shall be granted a licence. In accordance with potential restrictions under the *Canadian Charter of Rights and Freedoms*, cannabis products and their derivatives shall not be advertised in any manner.

D. Production for personal use

Amend the Act to create an exemption to the criminal offences provided in the CDSA in order to permit the personal production of cannabis so long as it is not sold for consideration or exchange in kind or other and not advertised or promoted in any other way. In addition, quantities shall be limited to ensure production is truly for personal consumption.

E. Consumption in public

Consumption in public places frequented by young people under 16 years of age shall be prohibited.

F. International trade

All forms of international trade, except those explicitly permitted under the Act shall be subject to the penalties provided in the CDSA for illegal trafficking.

G. Other proposals

- Ensure the establishment of a National Cannabis Board with duly mandated representatives of the federal government and the governments of the provinces and territories. The Board would keep a national register on the production and sale of cannabis and its derivatives, set the amount and distribution of taxes taken on the sale of cannabis products and ensure the taxes collected on the production and sale of cannabis and derivatives are

directed solely to prevention of at-risk use, treatment of excessive users, research and observation of trends and the fight against illegal trafficking.

- The provinces and territories would continue to develop prevention measures that should be directed at at-risk use, as a priority. The Canadian Centre on Psychoactive Substances and Dependency should be mandated to collect best treatment practices and ensure an exchange of information on effective practices and their evaluation.
- The provinces and territories would continue to develop support and treatment measures that should be directed at excessive use, as a priority. The Canadian Centre on Psychoactive Substances and Dependency should be mandated to collect best prevention practices and ensure an exchange of information on effective practices and their evaluation.
- Resources available to police and customs to fight smuggling, export in all its forms and cross-border trafficking should be increased.

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