

**Drugs and Drug Policy in Canada:  
A Brief Review & Commentary**

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*The prosecution of thousands of otherwise law-abiding citizens every year is both hypocritical and an affront to individual, civil and human rights.*

(Raymond Kendall, Secretary General of Interpol).<sup>1</sup>

**1. Introduction**

**An Overview of the Issues<sup>2</sup>**

In a year which marks the tenth anniversary of the *Vienna Convention* on drug trafficking and the fiftieth anniversary of the *Universal Declaration of Human Rights*, it is appropriate to reflect on the state of the global war on drugs and on Canada's part in that war. Every decade the United Nations reaches new international agreements, focused largely on criminalization and punishment, that restrict the ability of member nations to devise effective solutions to local drug problems. In the name of compliance with these agreements, governments enact more punitive and costly drug control measures and politicians endorse harsher new drug war strategies which add to the long list of human rights violations. Yet in spite of -- or perhaps because of -- these efforts, UN agencies estimate the annual revenue generated by the illegal drug industry at \$US400 billion, or the equivalent of roughly eight per cent of total international trade. This industry has fueled organized crime, corrupted governments and police at all levels, increased violence, distorted economic markets and twisted societal values. These drug-related problems are the consequences not of drug use *per se*, but of decades of ineffective drug policies and inappropriate drug laws.

In many parts of the world, including Canada, the politics of prohibition form a huge barrier to public health efforts to stem the spread of HIV, hepatitis and other pathogens. In the name of the War against Drugs, human rights are violated, environments damaged and prisons filled with drug "offenders", many with no other crime than simple possession of drugs for personal use. Scarce resources better spent on health, education and economic development are used on ever more expensive supply-reduction efforts. Sensible proposals to reduce drug-related crime, disease and death are abandoned in favor of proposals for "drug-free" societies, inhuman and unattainable though they may be. The War against Drugs has become a War against Drug Users and against those farmers, often the world's poorest, who grow drugs or their precursors. This war is more akin to a Crusade, in which there can be no victory but only some distorted sense of moral superiority.

Yet Canada actively participates in and supports this global violation of rights and resources, hiding behind the excuse that it is bound to do so by UN drug conventions; examination of these treaties does not provide support for this stance. Indeed, our obligations to overarching national and international human rights legislation would suggest that we need to pay far more attention to the neglected rights of citizens -- even those who choose the "wrong" type of drug. Rather than demonstrating the tolerance that is supposed to be the defining feature of democratic societies, Canada has turned hundreds of thousands its citizens into criminals and put many of

them into prison for possession of illegal drugs. Incarcerating people unnecessarily, and all of the other costs of the criminal justice system, is a financial burden that the economy cannot afford, quite apart from the numerous other problems attendant on such an overreliance on (or addiction to) criminalisation as a “solution” to the drug “problem”. While the real drug “problems” in Canada are related to alcohol and tobacco consumption in the general population and to underlying poverty and social dislocation in high-risk populations, these issues attract limited attention and resources. Instead, resources are focused disproportionately on enforcing laws pertaining to illicit drugs. Ironically, these very laws give rise to more problems than do the drugs themselves.

Our prohibitionist drug laws have encouraged marketers to sell and users to use more potent forms of drugs or more dangerous methods of ingestion in order to better hide the drug or to get a bigger “hit” for less money. Users have no guarantee of the quality of black-market drugs and as a result, some die (300 in Vancouver in the last year alone) and others are seriously injured because of adulterated drugs or drugs of unknown potency. Instead of looking for policies that might minimize the harm of all psychoactive substances, including alcohol and tobacco, Canada has created a black market for some drugs. Money that could be far better spent in dealing with real drug problems and their causes instead goes to those who support the prohibition system and all that is attendant upon it. The active support for prohibition of countries like Canada and the United States is destabilizing to developing countries as well as to the new states emerging in Central and Eastern Europe.

Drug warrior attitudes towards “evil” drugs have encouraged a dangerous inattention to one of the most tragic by-products of drug prohibition: the pandemic of HIV infection caused by injection drug use. More than 45 per cent of new HIV infections in Canada and the United States are related to the injection of drugs. This percentage is increasing at an alarming rate in Canada, as elsewhere; Vancouver has the highest incidence rate of HIV in injection users in the Western world. Globally, injection drug use is one of the major sources of new HIV infection. Prohibitionist attitudes have prevented the expansion of vital programs such as needle exchange and have increased the sharing of dirty needles, causing the spread of HIV and other deadly pathogens not only among users but among the general population as well. These attitudes prevent the opening of safe injecting sites, where users can receive medical attention if needed, which can increase overdose deaths by eighty percent. There have been more than 300 overdose deaths in Vancouver this year, more than 2000 since 1991; the majority of these kinds of deaths could be prevented, as has been done in cities such as Frankfurt where comprehensive harm reduction programs have been introduced.

In a bizarre hypocrisy that allows us on the one hand to speak of all drug dependence as an illness but to deal with arbitrarily-selected drug use as a crime, the justice system has become part of the drug war industry. We sentence drug users to prison, then we do not give them the means to prevent HIV infection from the high levels of injection drug use in prisons. Not until recently did we make condoms available to prisoners, in part out of concern that condoms would be used to hide drugs. Still, despite finally acknowledging that drug use in prisons is widespread, authorities have refused to provide prisoners with needle exchanges that would help prevent the further transmission of AIDS and hepatitis in prisons. HIV rates in Canadian prisons are ten

times those in the general population; in some facilities, 8% of inmates are estimated to be infected with HIV and 50% with hepatitis C, a disease spread by injection and a marker for HIV.

And so the central irony remains: We speak of drug dependence as an illness and yet we continue to treat those who choose the wrong sort of drug as criminals, as evil. The ancient Greek word for scapegoat, “pharmacopei”, meant outcast; how fitting that pharmacological McCarthyism should define the scapegoats of our times.

As an increasing number of countries around the world desert from the war on drugs and move to more peaceful measures, Canada persists in supporting criminalization of drug possession and has only last year put into force a new, thoroughly prohibitionist, drug law. Why? The rest of this paper attempts to address that question in some detail. In short, one reason persistently put forth is that Canada is obliged to do as it does because it is a signatory to the international drug conventions. But, as we shall see, this does not seem to be reason enough; not only do these treaties not require the level of penalties exacted by Canadian law, but also they themselves are in conflict with Canada’s own legal protections of civil liberties as well as of the international legal protections of human rights.

### **Some Definitions**

**Prohibition:** this system makes it a criminal offence to produce, import distribute or possess controlled substances for non-medical purposes. Total prohibition, in which all offences are strictly penalized, is sometimes referred to as “zero tolerance”. Total prohibition with an expediency principle is practiced in the Netherlands with respect to cannabis.

**Partial prohibition:** adults would be permitted to possess a defined amount of certain drugs and to cultivate up to a specified number of plants. An important question raised by such a system is the extent to which it would affect the black market.

**Decriminalization (prohibition with civil penalties):** usually used in the context of possession, this refers to the absence of criminal charges for small quantities of certain drugs. Often referred to as “de facto” decriminalization, because under the present International Treaties possession usually remains a “crime” on the books but there is no enforcement around this. In such a system, fines may be imposed.

**Medicalization:** specific exemptions can be given to criminal offences for the medical management of drug dependence, such as in the use of methadone for opioid dependence. In Canada, federal regulations would allow for the use of any drug in the management of dependence, provided the method used is scientifically sound and medically acceptable.

**Depenalization:** refers to the absence of all penalties for the possession of certain drugs.

**Legalization:** this refers to a system in which no aspect of the production-possession cycle is an offence for any substance. One model for this is often called regulation, as in the alcohol model of a control board. Another, less popular model, is that of free enterprise.

### **A Brief History**

The legal framework of the current system of drug control in Canada was laid down in the early part of the 20th century. By 1908, all medicines, as well as tobacco and alcohol, were on the way to regulation. In the same year, the Opium Act created the first drug prohibition. Other opiates and cocaine were covered in the Opium and Drug Act of 1911 and cannabis was added

in 1923. Anti-alcohol groups gained support during the first two decades of the century, and all provinces enacted some form of alcohol prohibition during the First World War. By 1929, all provinces except Prince Edward Island had rescinded alcohol prohibition and imposed regulation of the alcohol trade. The Opium and Narcotic Drug Act of 1929 was Canada's main instrument of drug policy for the next 40 years. International drug prohibition and regulation through the Single Convention on Narcotic Drugs (1961) and the Convention on Psychotropic Substances (1971), to which Canada was a signatory, have further reinforced the artificial division between legal and illegal -- licit and illicit -- drugs.

An increase in illicit drug use in the 1960's and the 1970's was met by greatly increased criminalization and the associated individual and social costs. Despite these costs, the prohibition of illicit drug possession with penalties of up to 7 years imprisonment appeared to have had relatively little deterrent effect on levels of cannabis use in Canada. Rates of use climbed sharply through the 1960's and early 1970's, despite a large allocation of enforcement resources.<sup>3</sup> The strain on the courts, and the rising numbers of otherwise law-abiding youth being sentenced for drug offences (particularly cannabis possession) created pressures for the liberalization of Canada's drug laws. The Commission of Inquiry in the Non-Medical Use of Drugs (generally referred to as the Le Dain Commission) was formed in 1969 to address this growing concern about drug use and appropriate responses. The Le Dain Commission described and analyzed the social costs and individual consequences of the criminalization policy. Social costs include the costs of law enforcement, court costs and expenditures for incarceration. Individual consequences include the penalties (such as a fine or prison term), the impact on the offender's employment, and the consequences of a criminal record.

Illicit drug policy has meant a criminal record for hundreds of thousands of Canadians who have been convicted of illicit drug possession under the old *Narcotic Control Act* and the new *Controlled Drugs and Substances Act*. The term "criminal record" is not statutorily defined, but generally refers to any official account of the process of conviction. A trail of information automatically begins when a suspect is arrested. The arresting officer, the local police station, the RCMP police information system in Ottawa, the prosecutor, the drug analysts and the courts involved all generate extensive records of any arrest and charge. This information may also be recorded in a legal aid office, detention centre and various criminal intelligence agencies. Once the accused appears in court, the charge becomes a matter of public record and may be reported in the media. There are reciprocal information sharing arrangements with foreign police agencies. Even if a charge is dropped or the accused is acquitted, he or she has no legal right to review police data or demand that the files be destroyed. The existence of a criminal record can result in the police laying a charge rather than issuing a warning in a subsequent incident; influence subsequent bail decisions; influence a prosecutor to proceed by way of indictment rather than summarily in a subsequent case; or be raised to impeach someone's credibility in court. It can also influence a sentencing decision or granting of parole. Entry into Canada or other countries may be denied, or a landed immigrant may fail to obtain citizenship due to a criminal record. Many jobs in the federal and provincial governments can be denied to persons with a criminal record, as well as certain professions regulated under provincial statutes.

The Le Dain Commission also identified the need for sweeping police powers as a social cost of drug policy. Under special provisions of old and new drug law, a law enforcement officer in Canada has broader powers of search and seizure in even minor drug cases, than he has in a murder, rape or other serious criminal case.<sup>4</sup> There are also enforcement methods associated with drug investigations which constitute a loss of established rights and freedoms. The use of wiretaps, paid informants, undercover agents, police dogs, arrests without warning, surprise raids, strip-searches and the granting of immunity of suspects in return for information are legal.

Such methods have been widely criticized for impugning the integrity of the police and the criminal justice system, particularly among youth.<sup>5</sup> These powers have been expanded under the new drug law to include what is called a “reverse sting”, where a police officer can legally sell drugs to a buyer in order to have grounds for arrest.

Following much consultation and study, the Le Dain Commission inquiry concluded that drug prohibition results in high costs but relatively little benefit. The majority of the commissioners recommended a gradual withdrawal from criminal sanctions against users, along with the development of less coercive and costly alternatives to replace the punitive application of criminal law. The Le Dain Commission served the role of most Royal Commissions: it delayed action on a controversial issue long enough for the public demand for action to subside. Interest in reform of drug policy gradually declined.<sup>6</sup> There was one significant change in law in 1969, an amendment of the *Narcotic Control Act* that allowed prosecutors to proceed summarily in possession cases. Amendments to the *Criminal Code* in the early 1970s also allowed for absolute and conditional discharges as sentencing options in drug possession cases. Attempts to reduce the consequences of criminalization met with limited success. A bill which would have decriminalized possession of cannabis (Bill S-19) was introduced but was defeated in 1975. In the space of a decade (1970s) cannabis possession convictions grew from less than 1,000 per year to more than 40,000.

Following the Le Dain Report, a reorganization of government agencies responsible for drugs took place. It was apparent that the previous government response was not adequate, being to do more with questions of jurisdiction than health. The Non-Medical Use of Drugs Directorate (NMUDD) of National Health and Welfare Canada was formed and an integrated national approach was said to be necessary. After the initial concern over illicit drug use had subsided, NMUDD was re-organized as the Health Promotion Directorate. This reorganization was based on the notion that there is a common base for many behaviours which have negative effects on health. The shift to a health promotion paradigm, however, had the unintended effect of creating even more problems of coordination between levels of government than before. In addition, law enforcement personnel had difficulty working with a government agency that was also concerned with other health issues, including fitness, diet and cardiovascular health.<sup>7</sup>

By the mid-1980's there was growing acknowledgment of the serious limitations of law enforcement and education in reducing the demand for drugs. In 1987 the Canadian federal government announced "Action on Drug Abuse", Canada's Drug Strategy. Canada's Drug Strategy (CDS) gave a means to address substance use with both supply and demand reduction strategies. The new drug strategy brought \$210 million in new funding in roughly equal amounts to enforcement, treatment and prevention programming. This move was clearly influenced by the latest American "War on Drugs", but it was also an acknowledgment of Canada's problems with both licit and illicit drugs. Canada's Drug Strategy was funded for an initial five year term ending in April 1992 and was then renewed to 1997. It then “sunsetted”, with drug issues being brought under the general umbrella of “population health”. Considered to no longer be a serious problem by the bureaucrats in charge, the health budget for drugs was cut to 40% of its former amount. The RCMP drug-related budget was cut to 60% that of the previous period. The Policy and Research Unit of the Canadian Centre on Substance Abuse, which had begun to research and document alternatives to drug prohibition, was closed in 1996 as part of the demise of the Drug Strategy. The term “Drug Strategy” was reapplied to the remaining efforts in 1998 at the urging of the RCMP, but it is a strategy without the weight, collaborators, or funding of the forerunners.

Despite some attempts for balance during the time of the Drug Strategy, the dominant policy regarding illicit drugs has remained one of criminal prohibition. With the introduction of a new drug law in the 1990s, there was an opportunity to address some of the problems of past law and to benefit from what had been learned from the experience of other countries. The new law, the *Controlled Drugs and Substances Act*, however, is soundly prohibitionist and rather than retreating from the drug war rhetoric of the past it expands the net of prohibition further still. The problems related to criminalizing drug users, the social and economic costs of this approach, and its failure to reduce drug availability, have still not been addressed. As a result, the costs, both financial and human, of licit drug use remain unnecessarily high while the costs of criminalizing illicit drug use continue to rise, steadily, predictably and avoidably.

## 2. Drug Use in Canada

### Summary

Alcohol and tobacco are the most widely used psychoactive drugs in Canada, and cause by far the greatest number of harms and costs to the population. The most widely used illicit drug is marijuana which causes relatively few harms for its level of use. By far the most direct harms from licit and illicit drugs occur in high-risk populations such as injectors, street youth, the inner-city poor, and Natives (obviously many of these groups overlap). **The indirect harms and costs of illicit drugs by far outweigh direct harms and are completely disproportionate to their level of use; these indirect harms and costs are the result of drug policy and legislation, not the drugs per se.**

### Nature and patterns of drug use

#### Alcohol

Results of the Canadian Alcohol and Other Drug Survey (1994)<sup>8</sup> indicate that 72% of women and men aged 15 years and older--about 16.5 million Canadians--report drinking alcohol in the past 12 months. Approximately one quarter of current drinkers drink less than once per month and 5% drink on a daily basis; the rest fall somewhere in between. Young adults, males and those with higher incomes drink more than other Canadians.

#### Tobacco

Twenty-seven percent of Canadians aged 15 and over reported current smoking in the 1994 survey. The majority of smokers (58.6%) smoke between 11 and 25 cigarettes daily and 7.3% smoke more than 25 cigarettes daily. Younger age groups report the highest levels of current smoking (18 to 19, 29%, 20 to 24, 37%). By the age of 19, 71% of Inuit youth, 63% of Dene and Metis youth and 43% of non-native youth in the Canadian Arctic are cigarette smokers.

Prevalence rates for use of chewing tobacco and snuff are high in Dene and Metis groups, with children as young as five reporting regular use.

### Other Licit and Illicit Drugs

While there is no doubt that it would be useful to do so, it is not possible to deal with legal and illegal drugs in a totally separate manner. The nature of drug reporting systems and the harms to individuals and society make such a separation unrealistic. For example, physicians merge the diagnostic classifications for licit and illicit drugs problems. In addition, the diversion of licit drugs into illicit markets plays a key role in drug-related harms. The use of most licit and illicit drugs is quite unlike that of alcohol, where use and harms are well documented. Sales of prescription drugs are not monitored on a national basis and information about illicit drugs is limited to reports

of drug seizures, enforcement activities and surveys. This data base is limited both in terms of scope and quality

### **Licit Drugs**

Information about prescription drugs is available from industry-based services that supply market information and analysis to Canada's health and pharmaceutical industries. Surveys are another source of information but these are limited in that they do not distinguish between safe use and problematic use. The information about licit drugs contained in this paper is from five sources: the 1994 Canadian Alcohol and Drugs Survey; market survey research; the Bureau of Drug Surveillance diversion statistics; hospital data from the Canadian Centre for Health Information; causes of death, from Statistics Canada.

### **Pharmaceuticals**

Nearly five million Canadians (21%) use one or more of the following medications: tranquilizers, sleeping pills, diet pills/stimulants, anti-depressants, prescription pain relievers (codeine/demerol/morphine). More women than men use these medications (24% versus 18%). There is a wide range in levels of use of the different medications across the provinces.

**Prescription Pain Relievers:** Slightly more than 3 million Canadians (13 %) use prescription pain pills (opiate narcotics such as codeine, morphine and Demerol); more women (14 %) than men (12%) use these pills. Use is highest in people 18-19 (15.5%) and lowest between ages 55-64 (11%). Use is highest among those with the lowest income. Regionally, the highest use was in BC (21%) and lowest in Quebec (7%).

**Sleeping Pills:** Approximately 4.5% of Canadians reported using sleeping pills in the 1994 survey. Use increases with age, with 7.5% of persons 55 and older and 11.5% of those 75 and over using them. More women (5.5%) than men (3.5%) use sleeping pills. Regionally, sleeping pills are used most often in PEI (6%) and least in Newfoundland (2.5%).

**Tranquilizers:** Almost 1 million Canadians (4.5%) use tranquilizers. More women (5.5%) than men (3.5%) report use of tranquilizers and use tends to increase with age and to decrease with income. Regionally, tranquilizers are used most in Quebec (7%) and least in Alberta (3.0%).

**Anti-depressants:** About 3% of Canadians use anti-depressants, with women being twice as likely as men to report their use (4% versus 2%). They are used more often by people aged 45-64 years of age (4%). Regionally, antidepressants are used most in Nova Scotia (4%) and least in Ontario (2%).

**Diet Pills/Stimulants:** Approximately 1% of Canadians use diet pills or stimulants. Use is highest among those aged 20 to 24 years (2%) and in those living in New Brunswick and Alberta (1.5%).

### **Steroids and Solvents**

Less than 0.5% of Canadians report ever having used steroids. Solvents, glues and inhalants are used by youth and street people who are not reached by the kinds of surveys carried out nationally; less than 1% of Canadians contacted in the 1994 survey reported ever having used solvents.

### **Illicit Drugs<sup>9</sup>**

**Many Canadians report that they have used illicit drugs. At some point in their lives, 24% of Canadians have used one or more of the following illegal drugs: cannabis, cocaine, LSD, speed/amphetamines, heroin.** More males than females report having used these drugs (30% versus 18%).

Cannabis (marijuana/hashish): Cannabis is the most widely used illegal drug in Canada. **Just over 23% of Canadians report having used cannabis at some point in their life.** Current use is around 7.5% as compared to 6.5% in 1989. Twice as many males (10%) as females (5%) report use in the past 12 months.

Cocaine: The percentage of Canadians reporting that they have ever used cocaine or crack-cocaine is just under 4%, which is only slightly different from the 1989 survey (3.5%). The number of current users (in the past 12 months) has dropped to 0.7% of the population (from 1.4% in 1989).

LSD, Amphetamines (Speed) and Heroin: The percentage of Canadians reporting use of one or more of these drugs in the past 12 months is just over 1%, an increase from 0.4% in 1989. More males (1.5%) than females (0.7%) use these drugs. The proportion of Canadians who have used these drugs at least once in their lives has risen to 6% in 1994, from 4% in 1989.

Overall, illicit drug use increased substantially across the country from 1993 to 1994. Use of cannabis increased from 4.2% to 7.4%, cocaine increased from 0.3 % to 0.7% and use of LSD, speed or heroin increased from 0.3% in 1993 to just over 1% in 1994. There are no recent national data to allow us to see whether this trend has continued.

### **Injection Drug Use**

Of those responding to the 1994 survey who reported using cocaine, LSD, speed, heroin and/or steroids, 7.7% (132,000) reported injecting drugs at some time. Of these, 41% reported sharing needles at some time in their lives. These numbers are clearly underestimates. As mentioned above, the majority of users of illicit drugs are not captured in this kind of survey; this is especially true of injection drug users. Further, the frequently illegal nature of the activity makes it more likely that a person who is surveyed will give an inaccurate response for fear of reprisal.

### **Populations At Risk**

The people regarded as being most at risk for experiencing harms from legal and/or illegal substances are impaired drivers, street youth and school drop-outs, injection drug users, women, seniors, the poor, Metis, Inuit and off-reserve aboriginal people. These populations-at-risk range widely in terms of the amount of research done on them to date and the ease with research can be done.

### **Indigenous Canadians<sup>10</sup>**

Medical Services Branch (MSB) reports that the leading causes of death for Indian and Inuit are injury and poisoning (including suicides) and circulatory system diseases, with the exception of the Atlantic and Ontario regions, where this order is reversed. **Indigenous patterns of violent death show a clear and consistently elevated risk which is in some cases 3-4 times greater than national norms. Accidental death rates are sometimes twice the suicide rate.** In Alberta, Indigenous risk was found to be 4-5 times the general rate. A similar pattern has been found in Saskatchewan and BC. Men are much more likely to die violently than are women. This is not because Indigenous females are less likely to use alcohol and other drugs but only that the consequences are less likely to be fatal. **The majority (72%) of Aboriginal Canadians smoke tobacco;** half of those who smoke do so on a daily basis.

In British Columbia, alcohol and drug problems are the biggest health and social issues facing aboriginal people living off-reserve and in Vancouver. Survey data suggest that 65% of these people experience alcohol and drug problems. The data cannot explain whether alcohol and other drug misuse is a cause or a result of the other problems. Researchers note that alcohol and other drug misuse affects 90% of the native people in BC. The existing service network does not meet the needs of people with substance use problems or those with mental disorders. The majority of children identified as having problems related to their mothers use of alcohol during pregnancy were native.

Research in Alberta suggests that aboriginal people experience significantly more problems with alcohol than non-natives do. One 1991 report suggests that about 80% of aboriginal people in Alberta have problems with alcohol and other drugs. Native people are also greatly overrepresented in the corrections system with respect to Liquor Control Act (LCA) convictions: in 1990, 21% of all sentences for natives were for LCA violations, compared to 6% for non-natives. One study, by Alberta's Chief Medical Examiner for the Royal Commission on Aboriginal Peoples, compared rates of unnatural death for natives and non-natives in Alberta from 1986 to 1990. Among key findings were:

- Two-thirds of natives who met unnatural deaths were drinking prior to death, compared to fewer than half (45%) of non-natives.
- Deaths involving evidence of alcohol or drug misuse as the primary cause were five times greater for natives than non-natives.
- The native suicide rate was two-and-a-half times greater than that for non-natives; the accidental death rate was three times greater; and the homicide death rate more than eight times that of non-natives.

Fetal Alcohol Syndrome: There is a great deal of controversy around the estimation of FAS incidence and prevalence in Indigenous communities; there are many methodological problems with studies. By most accounts, FAS incidence is higher than average among Indigenous Canadians. Conservative estimates of FAS/FAE (Fetal Alcohol Effect) incidence in general population samples are 1-3 per 1000 population. One study found an FAS/FAE rate of 25 per 1000 (i.e., 8-25 times the norm) children among Indigenous northwestern BC populations and a rate of 46 per 1000 (i.e., 15-46 times the norm) among Yukon Indigenous groups. A national survey of Indian and Inuit women revealed that 78% of Inuit women smoke before pregnancy, 76% during pregnancy and 75% in the first month postpartum.

Children: Rates of substance use are very high in Indigenous children under 12 years of age. These children are most likely to use tobacco, cannabis and solvents, but they are also much more likely than non-indigenous children to use other psychoactive substances as well. **An 1985 study of Saskatchewan Indian children found a suicide rate 27.5 times that of Canadian children generally and 33.6 times that of other Saskatchewan children.** Service centres report that children consume alcohol and sniff solvents during school hours, after school, on the streets, and in their homes, sometimes with their families.

**Youth: Native youth are at two to six times greater risk for every alcohol-related problem than their counterparts in the rest of the population. One in five native youth**

**have used solvents (about ten times that of the national norm).** One third of all users are under 15 and more than half began to use solvents before they were 11 years old. In a 1993 national consultation involving Indigenous youth and service providers, the typical chronic solvent user was described as: aged 9 at use onset (or as young as 5); from families with histories of alcohol and other drug misuse; from an isolated community; a drop-out; from backgrounds involving unemployment, illiteracy, poor housing and a history of physical/emotional/sexual abuse.

### **Street Youth**

Street youth are youth (12-25 years) who are absent from home without their parents permission for 24 hours or more. It is estimated that as many as 150,000 street youths move through Canadian cities every year.<sup>11</sup> Studies suggest that adolescents go to the street to escape physical, emotional and sexual abuse or neglect in the home. The lifestyles of street youth involve many high risk behaviours including high levels of licit and illicit drug use and needle sharing. **A 1989 study showed that two-thirds of all street youth used alcohol and/or other drugs of a weekly or daily basis.**<sup>12</sup> The most popular drugs are alcohol, cannabis, LSD and cocaine. In the 1989 survey, about 88% reported drinking alcohol, 9% of them on a daily basis. The same survey found that 71% reported cannabis use in the past year, 24% almost daily. About 31% used cocaine in the last year, 4% on a daily basis. 44% used LSD, 4% daily.

In a 1992 Toronto study, 34% reported having been arrested for their drug use in the past year, 27% had been involved with break and enter offences, 43% had sold drugs, 23% had been involved with robbery, and 22% had experienced medical problems.<sup>13</sup> **A recent study of Montreal street youth found suicide and drug overdose to be so prevalent that the children studied are 12 times more likely to die than their peers.**<sup>14</sup> Montreal is estimated to have at least 4,000 street youth. Of 517 youths initially interviewed by researchers, 10 have died in the past three years. Four hanged themselves, three were killed by drug overdoses, one died of hepatitis A, one was hit by a car, and one of an unknown cause. Eight of those who died had been drug users, and two were infected with HIV. Almost a quarter of the youth interviewed reported selling sex for food, money or shelter. They report injecting themselves hastily for fear of being spotted by the police, and carrying only a limited number of syringes for fear of detection. In another Montreal study, 500 homeless youth, were studied every six months beginning in 1995.<sup>15</sup> In this study the death rate was 11.7 per 100,000 compared with 0.86 per 100,000 for Quebecers the same age. Forty percent were injection drug users when the study began and 10 percent more began injecting each year; 22% had exchanged sex for food, money or shelter.

### **The Inner-City Poor: Vancouver**

**In 1997 a health emergency was declared as a result of the rapid increase of HIV infection in injection drug users in Vancouver East.** Prevalence levels had reached more than 20 percent and incidence rates more than ten percent. In 1998, prevalence rates are estimated at between 25 and 35 percent.<sup>16</sup> These rates place Vancouver in the unenviable position of having the highest levels of HIV infection in injection drug users in the Western world.<sup>17</sup> In addition, Vancouver has the highest levels of overdose deaths in Canada, with more than 300 this year and more than 2,000 since 1991. The high levels of infection and other drug-

related problems have been linked to the poverty and social dislocation of many of the residents of the eastern part of downtown Vancouver.<sup>18</sup>

### **HIV/AIDS and Injection Drug Use<sup>19</sup>**

Drug use puts an individual at risk for infection with Human Immunodeficiency Virus (HIV) and other pathogens such as hepatitis. Injection drug use poses direct risk of infection through sharing of contaminated drug equipment. Non-injection drug use poses indirect risk of infection in that it can increase the likelihood of unsafe sexual and drug-injecting practices. Globally, injection drug use is a primary risk factor for the transmission of HIV. For example, some of the prevalence rates in injection drug users are: Manipur, India, 73% Myanmar, more than 60%; Thailand 40%; Brazil and Argentina, more than 50%; Kazakstan and other parts of Central and Eastern Europe, more than 30%. In many of these countries, injection drug users represent the majority of HIV infections. For example, in Kazakstan, more than 85% of HIV cases are in injection drug users and more than 67% of the rapidly exploding epidemic in China is due to injection drug use. In the United States over 200,000 individuals have developed AIDS as a result of contracting HIV through a shared syringe. States with restrictive syringe purchase and possession laws, such as New Jersey and New York, have HIV incidence rates as high as 50% among their drug injectors and have the largest numbers of women with AIDS and pediatric AIDS cases.

In Canada, injection drug use is second only to homosexual/bisexual activity as a means of transmission in men and second only to heterosexual acquisition in women. It is estimated that approximately 100,000 injection drug users in Canada are at risk of HIV infection through sharing needles and syringes.<sup>20</sup> These individuals are concentrated, for the most part, in the metropolitan areas of Montreal, Toronto and Vancouver, but there is injection drug use in most urban and rural areas of Canada.

Traditionally, heroin has been the main drug administered by injection in Canada; Talwin (a depressant) and Ritalin (a stimulant) have also been popular as injectables at various times in different parts of the country, and are still very popular in Saskatchewan. Over the last several years, cocaine has been used increasingly by injection drug users, either on its own or in combination with heroin. There is also increasing non-medical use of injectable steroids by athletes, dancers and the general male population throughout Canada.

In Canada, as in other countries, the heterosexual transmission of HIV infection is fueled by the spread of infection among injection drug users. HIV infection spreads from injection drug users to their sexual partners. Many injection drug users are in relationships with non-users. There is also a risk that babies will be infected through perinatal transmission of the virus.

Compared to cities such as New York and Milan, where HIV prevalence rates among injection drug users are more than 50%, HIV rates among Canadian injection drug users are low to moderate in most cities. However, by comparison with a number of European and Australian cities, where, in many cases, infection levels are below 5%, rates in some Canadian regions are very high. For example, in Vancouver, prevalence increased from 4% in 1992/3 to 23% in 1996/7 and more than 30% in 1998. In Toronto, a 1997 survey of injection drug users reported a

seropositivity rate of 9.5% compared to a rate of 4.5% in 1991/92. In Montreal, prevalence rates increased to 19.5% in 1997, from 5% prior to 1988. In Ottawa, prevalence rates increased from 10.3% in 1992/93 to 21% in 1997. Recent data from needle exchange attendees in smaller cities in Quebec show that HIV prevalence among IDUs has reached significant levels even outside major urban areas (Quebec City 9% and semi-urban areas of Quebec 5.7%).<sup>21</sup>

**The incidence rates (rate of new infection) of HIV among injection drug users in some Canadian cities are now very high; at more than 10%, the incidence rate in Vancouver is the highest in the Western world. Montreal has an incidence rate of 7%, as does Ottawa. Some regions of Canada report higher incidence rates, especially among Natives.**<sup>22</sup> In 1996/97 about one half of the estimated 3,000-5,000 HIV infections that occurred in Canada were among injection drug users. In BC, injection drug use accounted for 43% of new positive tests in 1996-97 compared with 38% in 1995 and 8.2% prior to 1995. Injection drug use is a more common risk-factor for women, with 19% of adult female AIDS cases attributed to injection drug use versus 3.9% for adult male cases. Aboriginal peoples are overrepresented in inner city injection drug use communities and among clientele using inner-city services such as needle exchange programs and counseling/referral sites.

**Clearly, both prevalence and incidence rates are already very high in a number of Canadian cities. The World Health Organization has cautioned that once levels of infection among injection drug users reach 10%, the epidemic can become explosive for the entire population of that region. In 1997, the Federal government released an Action Plan on HIV/AIDS and injection drug use; to date, there has been little action on this plan. A comprehensive harm reduction approach to AIDS and drug use should be put into place immediately to keep rates of HIV infection from increasing further among injection drug users if we are to have any chance of keeping the level of infection low in the general population.**

### **3. Costs of Substance Use<sup>23</sup>**

#### **Alcohol**

According to the 1993 General Social Survey<sup>24</sup>, **nearly one in 10 adult Canadians (9.2%) report problems with their drinking.** The most common problems affect physical health (5%) and financial position (4.7%). The majority of Canadians (73.4%), report that they have been harmed in some way at some point by the drinking of another person; 41% of all Canadians reported that they had experienced some form of harm in the past 12 months.

There were 6,700 deaths and <sup>25</sup>86,000 hospitalizations associated with alcohol in 1992. Motor vehicle accidents accounted for the largest number of alcohol related deaths while accidental falls and alcohol dependence syndrome accounted for the largest number of alcohol-related hospitalizations. Impaired driving is a major cause of death; among fatally injured drivers, 45% had some alcohol in their blood and 38% were over the legal limit of .08% Blood Alcohol Concentration (BAC). About 20% of current drinkers report that they have driven after consuming two or more drinks in one hour.

### **Tobacco**

An estimated 33,5000 deaths were attributed directly to smoking in 1992. This number is derived from deaths due to chronic bronchitis, asthma, and emphysema and 30% of all deaths due to neoplasm, stroke, hypertension, and heart disease. Smoking related deaths and hospitalizations (combined) are highest in Nova Scotia and lowest in Alberta.

### **Other Licit Drugs**

There are a number of problems related to use of legal drugs. For example, drug interactions occur; as people age, they are no longer able to metabolize drugs in the same way and so are more likely to experience side-effects. Information of harms related to the use of medications on a national scale is extremely limited. The international coding system used by Canadian hospitals categorizes cases according to general drug classes and does not distinguish between legal and illegal drugs. According to the 1994 survey, nearly 16% of those who use medications have experienced some sort of harm to themselves or others at least once in their lifetime. At least one type of harm was reported in the last 12 months by 11.5% of users. The most commonly reported problems in the past 12 months was the impact on physical health (7.5%), followed by outlook on life (5.5%), work/studies (4%), financial position (4%), family/home life (4%), and friendships (2.5%).

### **Illicit Drugs**

There are many health and social problems related to the use of illegal drugs, but a number of these problems have more to do with the legal status of the drugs than with the nature of the drug itself. As with legal drugs, risks are related to dose, frequency of use, route of administration and characteristics of the user. It is difficult to identify the effects of a drug when it is not the singular cause of a problem. A disorder may be said to be "drug-related" because a drug is present in the urine, blood-stream or elsewhere in the body. The actual role of the drug in causing problems is not known. In addition, because the International Classification of Diseases does not distinguish between licit and illicit drugs, statistics on drug-related problems and deaths include an unknown contribution from legal drugs.

Approximately one quarter of the people who reported using illegal drugs, steroids or solvents in the 1994 survey stated that their use had caused some harm in their lifetime (30%) or in the past 12 months (14%). This ranged from 17.5% for harm on physical health to 1.5% for harm caused to their children. In 1991 and 1992, more than half of the people accused of homicide used a substance of some kind (including alcohol) at the time of the incident. About 4% of all homicide victims were on drugs; one in ten had both alcohol and other drugs in their systems.

The number of deaths and potential years of life lost attributable to the use of illicit drugs have been calculated in a 1996 study of the costs of substance misuse in Canada.<sup>26</sup> It is estimated that there were 732 deaths due to use of illicit drugs in 1992 (.4% of total mortality). Suicide accounts for 42% of illicit drug-related deaths; opiate and cocaine poisoning account for 14% and 9% respectively. In 1992, there were 61 AIDS-related deaths in injection drug users (8% of all illicit drug-related deaths); this number is increasing each year as the number of HIV-infected users rises throughout Canada (see section on HIV and injection drug use above). Mortality due to illicit drug use is relatively infrequent compared with alcohol and tobacco-related mortality, but

illicit drug deaths involve younger people. There is a great deal of provincial variation in death rates due to illicit drugs. The greatest number of deaths per capita occur in BC (4.7 per 100,000 population in 1992); **BC remains the highest, with annual overdose rates averaging more than 300 persons.** Alberta (3.1) and Quebec (2.8) also have rates above the national average.

In 1992, there were 7,100 hospitalizations and 58,600 hospitalizations as a result of illicit drug use. Drug psychosis (17%), assaults (17%) and cocaine use (16%) accounted for about 50% of all illicit drug-related hospital admissions. The greatest proportion of hospital days due to illicit drugs is for drug psychosis, cocaine use, and assault. The provincial pattern in potential years of life lost, hospitalizations and hospital days reflect that of mortality rates. Highest rates of hospitalizations are in BC (39 per 100,000) and the lowest in Newfoundland (15 per 100,000).

### **Economic Aspects**

A study of the economic costs of substance use to the Canadian economy was released in 1996 by Eric Single and colleagues.<sup>27</sup> Using international guidelines for cost estimation studies, the study examined the number of deaths and hospitalizations attributable to alcohol, tobacco and illicit drugs in 1992. These morbidity and mortality estimates were the basis for examining the costs of substance use to the health care system and productivity costs. Other costs included costs for the administration of substance-related social welfare payments, law enforcement, prevention, research and other direct costs such as fire damage. (All cost data should be interpreted with caution because of wide variations between studies).

In 1992/3, the average Canadian aged 15 or older spent \$462 on alcoholic beverages; the value of alcohol sales totaled more than \$10.4 billion. Alcohol provided employment for nearly 16,000 Canadians in 1993 and more than \$4.2 billion in government revenue. The reduction of tobacco taxes in 1994 had dramatic economic impact. Government revenue from tobacco products was \$4.65 billion in 1993/94. This is a decrease of \$896.5 million (16.2%) from government revenues from tobacco in the previous year. The domestic market for the pharmaceutical industry, which employs more than 21,000 people in Canada, is valued at \$4.3 billion.

It is estimated that substance use cost more than \$18.4 billion in Canada in 1992 (\$649 per capita), which is 2.7% of the Gross Domestic Product. Alcohol accounts for approximately \$7.5 billion in costs. The largest economic costs of alcohol are \$4.14 billion for lost productivity due to morbidity and premature mortality, \$1.36 billion for law enforcement and \$1.30 billion in direct health care costs. Tobacco accounts for more than \$9.5 billion in costs, and illicit drugs cost the economy \$1.4 billion. The largest cost due to illicit drugs is lost productivity due to morbidity and premature death (\$823 million), and a substantial portion of the costs (\$400 million) are for law enforcement (including criminal-justice system costs). In general, the largest economic costs of substance use are from lost productivity due to morbidity and premature mortality, direct health care costs and law enforcement.

### **Cost of Illicit Drugs to Law Enforcement<sup>28</sup>**

Illicit drug use contributes to crime and law enforcement costs in a number of ways. These include the costs of enforcing law per se; dependent use of “hard” drugs such as heroin, cocaine

or amphetamine is implicated in property crime; and drug use is associated with crimes of violence such as those committed over drug territory.

Criminal offenders have high rates of illicit drug use, with nearly 80% of offenders reporting use of illicit drugs during their lifetime, 50-75% showing traces of drugs (including alcohol) in their urine at time of arrest, and almost 30% under the influence of alcohol or other drugs when they commit a crime. There are a number of possible explanations for the relationship between drugs and crime<sup>29</sup>:

Pharmacological effects of drugs: based on the notion that certain drugs promote violence, this explanation fails to take account of the fact that there is in fact little connection between the pharmacology of illicit drugs and violence.

Crime as income: some dependent users do commit property crimes to support their habits, but most do not; the majority of those who do also engaged in property crime before becoming drug users and continue to do so when they no longer use drugs;

Drug users have a deviant lifestyle: a number of long-term studies have shown that drug use and criminality are related to common factors such as poverty, unemployment and low social values and are determined by underlying personality and social causes.

Crime is a result of the violence of the drug trade: many drug-related crimes result from the “turf wars” between rival suppliers and arguments between buyers and sellers.

**While drugs are a factor related to many crimes, their precise role is unclear; what is clear is that users have to obtain their drugs from a market that is highly priced and violent and where crime is frequent.**

The cost estimation study carried out by Single et al. found that law enforcement costs are a major portion of the economic costs associated with illicit drugs. Law enforcement costs attributed to substance use comprise direct costs for specialized enforcement units plus part of the costs for crimes related to drugs. The fractions for illicit drugs vary according to the degree of legal intervention; for police costs this is the proportion of offences attributable to illicit drugs; for court costs, the fractions are based on the proportion of arrests for drug violations; for penal costs, fractions are based on the proportion of jail sentences for drug-related offences. The fraction for violent crimes attributable to illicit drugs is estimated by dividing the number of deaths in Canada due to homicide and assaults related to illicit drugs by the total number of deaths for these causes; it is estimated that 8% of violent crimes in Canada are related to illicit drugs. A proportion of property crime is also likely to be related to illicit drugs, but since this fraction is not known it is not included in estimates, making them conservative in nature.

Police costs: it is estimated that 2.4% of all crimes are attributable to illicit drugs (violations of federal drug statutes plus 8% of violent crimes plus the cost of the RCMP narcotics division). In 1992, the costs estimates of policing for illicit drugs were \$208.3 million (\$168.4 million for enforcement of drug laws *per se*).

Court costs: these costs include all court staff, judges, building occupancy costs, Legal Aid and crown prosecutors. It is estimated that 5.7% of all crimes resulting in court appearances in 1992 was related to illicit drugs, giving a cost estimate of \$59.2 million (\$46-8 for processing of drug laws *per se*).

Customs and excise: in 1992 it was estimated that Customs and Excise spent \$9 million on drug enforcement.

Corrections costs: these include costs for penal institutions, probation and parole and are estimated at \$123.8 million for 1992 (\$106.2 million for violations of drug laws *per se*).

**Total costs to criminal justice system: the conservative estimate for 1992 is \$400 million (\$330 million for drug-law violations *per se*), which is 29% of the total economic costs for illicit drugs.**

**Other economic costs:** these include health care costs; direct costs associated with the workplace; direct costs for prevention, research and training; fire damage and traffic accidents; and indirect productivity losses due to disease and mortality. The total for this portion of costs was estimated at \$930 million.

**Economic Costs of licit versus illicit drugs:** The total costs of illicit drugs to the economy is only 7.4% of the total estimated cost of substance use in Canada. "It might be argued that undue attention is given by law enforcement to control illicit drugs as these substances only account for a small portion of the economic costs associated with substance abuse in Canada. The findings of the cost estimation study will certainly be used as evidence that current drug policies are not cost effective."<sup>30</sup> For example, there are considerable costs associated with the criminalization of cannabis with little apparent benefit in terms of deterrence. As Single points out, however, these findings might also be used to argue that relatively high costs due to licit drugs show what can happen with a legal source of supply.<sup>31</sup>

#### **4. The Law Regarding Licit and Illicit Drugs in Canada**

##### **Federal Alcohol Regulations**

The federal government has authority over the importing and exporting of alcohol, alcohol-related excise taxes and broadcast advertising. Each province also has a role in regulating the control and sale of alcohol; they also control alcohol marketing and advertising. There are four specific drinking and driving offences in the federal *Criminal Code*: impaired operation of a motor vehicle; impaired operation of a motor vehicle causing death, and impaired operation of a motor vehicle causing bodily harm; operating a motor vehicle with a blood alcohol level in excess of .08%; refusal to provide a breath or blood sample. The provincial highway traffic legislation is important in the apprehension, prosecution and punishment of drinking drivers.

##### **Tobacco Legislation**

Tobacco is covered by federal and provincial legislation. The federal legislation comprises the *Tobacco Sales to Young Persons Act*, *The Tobacco Products Control Act* (which limits tobacco company sponsorship and advertising) and the *Non-smokers Health Act* (which restricts smoking areas). Some provinces have enacted workplace smoking legislation and most prohibit sales of tobacco to young people. Since the mid-1980s, the number of municipalities that have enacted smoking by-laws regarding where smoking can take place has increased rapidly.

##### **Federal Drug Law**

The most important federal statute dealing with illicit drugs is the *Controlled Drugs and Substances Act* (CDSA), which was proclaimed into force in May of 1997. There are six

common offences under it: possession, trafficking, cultivation, importing or exporting and “prescription shopping” (obtaining multiple prescriptions by visiting several doctors). According to the Federal government, CDSA was just a “housekeeping” act. “The CDSA consolidates certain parts of the two previous acts, modernising and enhancing Canada’s drug abuse control policy. Another focus of the CDSA is to fulfill Canada’s international obligations under several international protocols on drugs”.<sup>32</sup> A more detailed analysis of the CDSA and the extent to which it goes beyond merely “keeping house” is given below. The *Food and Drugs Act*, which contained sections on non-medical drug use under the previous drug law, now controls pharmaceuticals, foods, cosmetics and medical devices. In addition to CDSA, other laws pertain to illicit drugs. Amendments to the *Criminal Code* make it illegal to knowingly import, export, manufacture, promote or sell illicit drug paraphernalia or literature. A court has recently struck down these provisions as they relate to drug literature. The judge held that these offences constitute an unjustifiable violation of freedom of speech as guaranteed by section 2 (b) of the *Charter of Rights and Freedoms*.

In Canada, offences are divided into two broad categories; those tried by summary conviction and those tried by indictment. There are also hybrid offences in which the prosecutor may proceed by summary conviction or by indictment. Under the CDSA, possession and prescription shopping are hybrid offences. If the Crown proceeds summarily, the offender is liable to a maximum penalty of six months’ imprisonment and a \$1,000 fine for the first offense, and 12 months imprisonment and \$2,000 fine for subsequent offences. If the Crown chooses indictment, the maximum penalty for possession is seven years imprisonment. All other offences under the Act are tried by indictment, except for certain amounts of marijuana. The maximum penalty for cultivation is seven years imprisonment; trafficking, possession for the purpose of trafficking, importing and exporting all carry a maximum penalty of life imprisonment. The most substantial legal change in the CDSA is in relation to cannabis. No longer a “narcotic”, cannabis is now a Schedule II drug (cocaine and heroin are in Schedule I). The punishments for marijuana possession, distribution and production are slightly different from those for cocaine and heroin. Provided that the amount of cannabis possessed is less than 30 grams and the amount distributed is less than three kilograms, maximum jail terms are reduced to six months and five years respectively (for heroin and cocaine the maximum term for possession remains at seven years and the maximum term for distribution at life imprisonment). The CDSA also covers offences to do with property and proceeds of drug offences (one component of which is “money laundering”).

### **A Missed Opportunity: *The Controlled Drugs and Substances Act*<sup>33</sup>**

The *Controlled Drugs and Substances Act*, was first introduced in February of 1994 by the Liberal government as Bill C-7. The bill very closely resembled Bill C-85, introduced by the Conservative government in June, 1992 and harshly criticised by the Liberals. Bill C-7 was technically a “health” bill, introduced into the House of Commons by the Minister of Health. The bill officially had its roots in the federal health department but its content came primarily from the department of justice and the office of the solicitor general. The bill was drafted by a senior member of the department of justice.

Bill C-7 consolidated much of the existing drug legislation now set out in the *Narcotic Control Act* and the *Food and Drugs Act*. The bill repealed the *Narcotic Control Act* and parts of the *Food and Drugs Act*. It created a number of new drug offences and extended the range of the law to include any drug with a “stimulant, depressant or hallucinogenic effect”. It also added new powers of search and seizure. Numerous depositions to the parliamentary sub-committee in Spring of 1994, including the Canadian Foundation for Drug Policy, The Addiction Research Foundation of Ontario, the Canadian Police Association and the Canadian Bar Association, severely criticised the bill for its *war on drugs* approach and, in particular, for its very harsh stance with regard to cannabis possession. The bill was then revised. These revisions included a lessening of penalties for possession of cannabis for personal use so that simple possession would become a summary offence. Nonetheless, such possession was to remain a **criminal** offence.

After a considerable delay, Bill C-7 went to Third reading in the House of Commons in October of 1995. On October 30th, while the country’s attention was turned to the Quebec referendum and the Bloc was absent from the House, Bill C-7 quietly passed its final reading and moved to the Senate for approval. The Senate Standing Committee on Justice and Constitutional Affairs began hearings on the bill in December of 1995. Depositions included the Law Union of Ontario, the Addiction Research Foundation, and the Canadian Foundation for Drug Policy (**CFDP called for an independent review of the Bill, consistent with promises made in the House of Commons on October 30th, 1995; this review has yet to occur**). On February 2nd, 1996, the government announced the end to the current session of Parliament. Since Bill C-7 had not yet been enacted, it died at this time. During the next session, it was brought back as Bill C-8 and was proclaimed in force in May of 1997.

The impression created by a cursory reading of the CDSA is that enforcement efforts are directed toward large scale traffickers of hard drugs. The truth of the matter, however, is that, just as before, the majority of people affected by the legislation will be people caught for possession of small amounts of cannabis. More than 600,000 people have been given criminal records under old and new legislation for possession of cannabis. Since several new offenses have been created under CDSA related to amphetamines, khat and hallucinogens, the bill will ensure that more Canadians than ever, primarily young ones, would be burdened with a criminal record for simple possession (this is already occurring with respect to khat, especially among the Somali community who were not informed of the criminalization of activities related to a previously legal substance; there is now a black market emerging around khat in Toronto and several other cities).

A number of critics have also pointed out that drugs are not scheduled rationally in the bill: there is no relationship between the harms posed by drugs and the punishment. For example, what is the rationale for scheduling cocaine in Schedule I and amphetamines in Schedule II when the effects and dangers of the two are almost identical? It is clear that to ensure legislation that is just, the government needs to establish a scheduling process with input from experts in pharmacology, law enforcement, epidemiology and other relevant areas.

In the preamble to the Act it is stated that one intent of the legislation is to meet Canada's obligations under international drug treaties. It has been argued, however, that, our international obligations did not require us to enact the new law or anything similar<sup>34</sup> (see below for an overview of Canada's obligations under international drug conventions). It has also been suggested that Canada should see to its own domestic needs first rather than give international drug treaties priority.<sup>35</sup> Ironically, while claiming need for compliance with international treaties, the Act does not consider alternatives to conviction or punishment that are set out in these treaties. There is also room within the UN conventions for the removal of criminal penalties for possession of certain drugs for personal use (as detailed below, a number of countries, including Australia, Italy, Spain and Germany have done this without compromising their position with respect to the treaties).

The CDSA preserves the special enforcement provision that gives police sweeping powers of arrest, search, and seizure in drug cases. The Act will unnecessarily increase the powers of the state, seriously threatening fundamental human rights; in the guise of complying with international drug control conventions, it will violate international human rights conventions and may well violate Canada's own constitutional protections. In its presentation to the C-7 subcommittee, the Quebec Bar Association warned that a challenge under the *Canadian Charter of Rights and Freedoms* was probable. These increased powers, however, will not stop drug use, nor are they even likely to decrease drug use. Rather, these powers and other applications of the criminal law will only make the drug use that continues more dangerous, and lead to more people being killed by adulterated drugs or by drugs of unknown potency. Similarly, the Act does nothing to address the multiple underlying causes of drug use; instead, it assumes that simple repression can solve a problem with such complex roots.

In general, there has been a misunderstanding of the role the new law will play with respect to drug policy. During its passage, sub-committee members emphasized that it was not a policy document but simply a "housekeeping" bill directed exclusively at consolidating existing drug laws and bringing Canadian legislation in line with international drug treaties, repeating the position of the bureaucrats that drafted the legislation. The majority of witnesses to the subcommittee, however, stated that the bill was in and of itself a statement of drug policy, and bad policy at that. "Bill C-7 perpetuates and exacerbates some of the worst excesses of Canadian drug policy and it will only serve to perpetuate the violence associated with the drug trade. It will do nothing to help those who have become dependent on drugs; it will simply turn them -- by the thousands each year -- into criminals, and sometimes force them to commit further crimes and deal with true criminals to maintain their habits. In addition to these direct effects of the Bill, serious harms will also result from indirect effects: because it explicitly exempts tobacco and alcohol, Bill C-7 distracts attention from the much more serious harms associated with licit substances than with illicit ones."<sup>36</sup>

### **The CDSA and Syringe Exchange**

Syringe exchange is often controversial because of legal concerns. In Canada, the legal barriers, such as those posed by current paraphernalia and other drug laws are more perceived than real. For example, clean syringes are actually exempt from paraphernalia charges under current legislation. Although theoretically CDSA should not increase criminal liability since the

paraphernalia legislation remains the same, it in fact further confuses an already confusing situation. The Act states that “a reference to a controlled substance includes a reference to ... any thing that contains or has on it a controlled substance and that is used or intended or designed for use ... in introducing the substance into the human body” (section 2(2)b). This means that syringes containing drugs controlled by the Act themselves become controlled. While a syringe would have to contain a detectable amount of substance in order for it to implicate a user, the Act nonetheless serves to increase concerns around carrying used syringes to exchanges; it is likely that users will be less inclined to want to be caught with dirty syringes as they learn of the new legislation. The discarding of used syringes will add to the concerns expressed by neighbourhood groups about users and the presence of syringe exchanges; concerns that should rightly be directed at the drug laws will, in the confusion, be directed once again to the very mechanisms that could reduce the harms of these laws.

## **5. International Drug Conventions and Canadian Drug Law**

*“An important question to be answered is whether Australian drug laws, so long dominated and directed by influences beyond our shores, and so little attuned to Australia’s own circumstances, should continue to be determined externally.”<sup>37</sup>*

The international Conventions with respect to illicit drugs cover cannabis, cocaine, heroin and many other psychoactive substances. Some of them also pertain to “precursors”, or those substances that are used to make the psychoactive end-product. Three international Conventions on drugs are relevant to the following discussions: the *Single Convention on Narcotic Drugs*, 1961 (*Single Convention*, 1961),<sup>38</sup> the *Convention on Psychotropic Substances* of 1971<sup>39</sup> and the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988 (*Vienna Convention*).<sup>40</sup> As their titles suggest, these conventions deal with matters that are specific to narcotic drugs and psychotropic substances, and the traffic in these.

### **The Implementation of Treaties in Canada**

In Canada, the legislative branch (that is, Parliament and the provincial legislative assemblies) have sole jurisdiction to make rules, which they do by enacting legislation. They may also enact provisions delegating the rule-making power to a regulatory authority. The only limits on this power are those imposed on the legislative branch by the Constitution. Examples of limitations on the power of the legislative branch are the requirement that the division of legislative powers between the federal and provincial governments not be violated, and the *Canadian Charter of Rights and Freedoms*. However, other considerations apart from the Constitution may influence the exercise of legislative power. Implementation of an international treaty is one example. By becoming a party to the three treaties on prohibited drugs and traffic in these, the Government of Canada has undertaken to adapt its own legislation on drugs to ensure that it complies with the provisions of the treaties. All the measures that a State must take domestically to comply with the provisions of an international treaty constitute the “implementation” of the treaty. The most obvious step in implementing a treaty is the adoption or amendment of legislative provisions.

The central aspect of the *Single Convention* is limiting the production and trade in prohibited substances to the quantity needed to meet the medical and scientific needs of the States. The Convention requires that States adopt the necessary legislative and regulatory measures for establishing the prohibitions and controls required, within their own territories. Anything relating to the trade in, and production and possession of the substances is to be governed by legislative or regulatory measures; as we shall see, authorities differ as to the precise meaning of the term “possession” in this Convention.

According to Dupras, **the measures prescribed by the *Single Convention* are the minimum measures that the States must adopt; there is nothing to prevent them from adopting more strict or severe measures of control.** Conversely, there is nothing to bind countries such as Canada to the more stringent measures that they have adopted in their drug policies; indeed, the opposite is true. **The three Conventions recognize the particular features of national legal and judicial systems and specify that the measures that States adopt will respect these systems.** The words used are different in each, but the intention seems to be the same. Article 36 of the *Single Convention*, 1961 states: “subject to its constitutional provisions ...”; article 21 of the *Convention on Psychotropic Substances* states: “having due regard to their constitutional, legal and administrative systems ...”; and article 3 of the Convention against Illicit Traffic states: “subject to its constitutional principles and the basic concepts of its legal system.”<sup>41</sup> In Canada, these particular features may be identified as being all the elements of constitutional law to which each level of government in the Canadian federation (the federal government and the provinces), and each branch of that government (legislative, executive and judicial), is subject.

According to Dupras, implementation that does not comply with those principles and concepts will be void or non-existent at the national level; and failing implementation, there can be no ratification. Since the *Canadian Charter of Rights and Freedoms* was enacted in 1982 and entrenched in the Canadian Constitution, there can be no doubt that its provisions are elements of the “basic concepts of the legal system” of Canada. Parliament and the legislatures may not disregard the Charter, and the numerous judgments of the Supreme Court act as a reminder of this fact. This means that the rights of Canadians have to be protected, including ensurance of:

- Guarantee against unreasonable search and seizure;<sup>42</sup>
- Guarantee against any cruel and unusual treatment or punishment.<sup>43</sup>

## **Cannabis**

For historical reasons, the Conventions treat cannabis, erroneously, as a narcotic. Because, however, it has been dealt with quite differently from other, “harder”, drugs by many countries, cannabis is considered separately here and in later discussions in this paper. Cannabis refers to marijuana and hashish, the oil or resin from the plant; in this paper the terms marijuana and cannabis are used interchangeably. The marijuana plant contains more than 460 known compounds and more than 60 of these are cannabinoids. The only one of these that is both very psychoactive and present in large amounts is known as delta-9-THC (THC). The discovery in the last few years of receptors on the brain that are stimulated by THC suggests that the body makes its own version of THC, a neurotransmitter implicated in regulation of pain and nausea. This has also been an impetus to carry out research on the medicinal properties of THC.<sup>44</sup>

In response to increases in marijuana use in the 1960s and 1970s, governments in the United States, Canada, Great Britain, Australia, and the Netherlands appointed commissions to evaluate the scientific evidence on the harms associated with marijuana use. In 1969, the British Wootten Report noted its agreement with the Indian Hemp Commission of 1894 and the LaGuardia Commission of 1944. It concluded that “the long term consumption of cannabis in moderate doses has no harmful effect”. In 1972, a Dutch commission concluded that “the physiological effects of the use of cannabis are of a relatively harmless nature.” In that same year, the US National Commission on Marihuana and Drug Abuse stated that “The Commission is of the unanimous opinion that marihuana use is not such a grave problem that individuals who smoke marihuana, or possess it for that purpose, should be subject to criminal procedures.” The findings of these commissions have, however, continually been overshadowed by extreme claims of marijuana’s dangers or by suppression of information regarding the real harms and benefits of the drug. **Most significantly, a comprehensive discussion paper on cannabis control policies prepared for Health and Welfare Canada in 1978 was not released until request was made through an Access to Information Request in November of this year.**<sup>45</sup>

During the past thirty years, researchers funded by the US federal government have examined the ways in which marijuana effects the user and society. **This has led to the exposure, and refutation, of a number of myths about marijuana.** These myths include<sup>46</sup>:

1. Marijuana’s harms have been proved scientifically: in fact, the US National Commission on Marihuana and Drug Abuse concluded in 1972 that while marijuana was not entirely safe, its dangers had been grossly overstated. Since then, researchers have conducted thousands of studies of humans, animals and cell cultures. None reveal any findings dramatically different from those described by the US Commission in 1972. In 1995, based on thirty years of scientific research, editors of the British medical journal the Lancet concluded that “the smoking of cannabis, even long term, is not harmful to health.”
2. Marijuana has no medicinal value: marijuana has been shown to be effective in reducing the nausea caused by cancer chemotherapy, stimulating appetite in AIDS patients, and reducing intraocular pressure in people with glaucoma. There is also a great deal of evidence that marijuana reduces muscle spasticity in patients with neurological disorder, is a very powerful pain killer, and is effective as an anti-epileptic in patients unresponsive to other medications. A synthetic THC capsule is available by prescription, but it is not as effective as smoked marijuana for many patients. Pure THC also seems to produce more unpleasant psychoactive side-effects than smoked marijuana. Many people use marijuana as a medicine, and in most countries, including Canada, this means risking arrest (see below under legal situation in Canada).
3. Marijuana is highly addictive: in fact, most people who smoke marijuana do so only occasionally. a small minority of users (less than 1%) smoke marijuana on a daily or near daily basis. An even smaller minority develop psychological dependence on marijuana. Some people who smoke marijuana heavily and frequently stop without difficulty; others seek help. Marijuana does not cause physical dependence, and if there are any withdrawal symptoms at all, these are very mild.
4. Marijuana is a “gateway” drug: in fact, marijuana does not cause people to use hard drugs. What the gateway theory presents as a causal explanation is a statistical association between

common and uncommon drugs, an association that changes over time as different drugs increase and decrease in prevalence. Marijuana is the most popular drug in most western countries today and so people who have used less popular drugs such as heroin or cocaine are, on the basis of probability alone, likely to have tried marijuana. But most marijuana users never use any other illegal drugs, so marijuana is more akin to a closed gate than to a gateway.

5. Marijuana policy in the Netherlands is a failure: for more than twenty years, Dutch citizens over eighteen have been permitted to buy and use cannabis in government-regulated coffee shops. The policy has not resulted in an escalation in cannabis use. Rates of use are significantly lower than those in the United States. The Dutch public overwhelmingly supports this policy of normalization. A recent survey by the Centre for Drug Research at the University of Amsterdam found only two to three percent of Dutch over the age of 12 had used marijuana over a one-month period. In the United States, where it is illegal to grow, purchase or use marijuana, a 1996 government study concluded around five percent of the population used the drug at least once a month (rates for use in the last year are 34% for the US and 29% for the Netherlands). The number of heroin users, the murder rate, crime-related deaths and the incarceration rate are all considerably higher in the US as compared to the Netherlands.

6. Marijuana kills brain cells: in fact, none of the tests used to detect brain damage in humans have found harm from marijuana, even from long-term high-dose use.

7. Marijuana causes amotivational syndrome: in fact, researchers have failed to find evidence of marijuana induced amotivational syndrome. People who are constantly intoxicated, whatever the drug, are unlikely to be productive members of society, but there is nothing about marijuana specifically that causes loss of drive. In laboratory studies, subjects given high doses of marijuana for several days or weeks show no sign of decrease in work motivation. In the workplace, marijuana users tend to earn higher wages than non-users, and college students who use marijuana have the same grade as non-users

8. Marijuana impairs memory and cognition: marijuana produces immediate, temporary changes in thoughts, perceptions and information processing. There is no convincing evidence that heavy long-term use permanently impairs memory or other cognitive functions.

9. Marijuana causes mental illness: in fact, there is no convincing scientific evidence that marijuana causes psychological damage or mental illness in teenagers or adults. Marijuana can induce feelings of panic and paranoia, but these effects are temporary.

10. Marijuana causes crime: in fact, there is no evidence that marijuana causes crime; and marijuana actually decreases, rather than increases, aggression.

11. Marijuana damages the fetus: in fact, studies of newborns, infants and children show no consistent physical, developmental, or cognitive deficits related to prenatal marijuana exposure.

12. Marijuana impairs the immune system: in fact, there is no evidence that marijuana users are more susceptible to infections than non-users. The finding of an association between tobacco smoking and lung infections in AIDS patients warrants further research into possible harms from marijuana smoking in immune-suppressed persons.

13. Marijuana is more damaging to the lungs than tobacco: moderate smoking of marijuana appears to pose minimal damage to the lungs; marijuana users typically smoke much less often than tobacco users and so risk of serious lung damage is lower. There are no reports of lung cancer related solely to marijuana, but the possibility of cancer in heavy users cannot be ruled out. Unlike heavy tobacco smokers, heavy marijuana smokers show no obstruction of the lung's small airways and so do not develop emphysema.

14. Marijuana is a major cause of traffic accidents: in fact there is no compelling evidence that marijuana contributes substantially to traffic accidents and fatalities. In driving studies, marijuana produces little or no car-handling impairment. Unlike alcohol, which increases risky driving practices, marijuana tends to make subjects more cautious. When THC is detected in the blood of fatally injured drivers, alcohol is almost always detected as well. A roadside breathtest for THC has recently been developed.

15. Marijuana is more potent today than in the past: potency data have been kept from the early 1980s to the present, and show that there has been no increase in the average THC content of marijuana. Even if marijuana potency were to increase, it would not necessarily make it more dangerous since users would smoke less to get the same level of psychoactive effect

In November of this year, the British medical journal *Lancet* concluded its editorial on marijuana by stating that “on the medical evidence available, moderate indulgence in cannabis has little effect on health, and the decision to ban or to legalise cannabis should be based on other considerations.”<sup>47</sup>

### **Cannabis and International Treaties**

Two international treaties are relevant to a discussion of cannabis policy: the *Single Convention of Narcotic Drugs* (1961) as amended in 1972, and the 1988 UN *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Vienna Convention). As its full name suggest, the Vienna Convention is primarily concerned with international trafficking, while the *Single Convention* focuses on the domestic policy of signatory nations. The *Single Convention*, to which Canada and many other countries are signatories, is regarded by most analysts as the main potential obstacle to changes in domestic cannabis policy.<sup>48</sup>

Article 36 of the *Single Convention* requires signatory nations to make possession and use of cannabis, “cannabis resin (hashish), and “extracts and tinctures of cannabis” (among other drugs) an offence. Use and commerce in drugs covered under the *Single Convention* are to be restricted to “scientific and medical purposes”. Analysts of the treaty tend to support the recent New Zealand interpretation that: “Although this particular clause seems rather black-and-white, the treaty as a whole provides considerable room for varying interpretations”.<sup>49</sup> A Canadian Department of Justice report of 1979 noted: “**The deliberate vagueness of some critical treaty provisions and the discretion permitted each party allow for a considerable variety of cannabis control regimes.** As one official of the United Nations Division of Narcotic Drugs has recently written: ‘the treaties are much more subtle and flexible than sometimes interpreted.’”<sup>50</sup>

As would be expected of such an influential document, there are a number of different interpretations of the *Single Convention*. For example, Dupras writes:

“To justify the legalization of possession of cannabis, some authors have defended the interpretation that it was the intention of the Parties for the prohibition on possession to be limited to possession for the purposes of trafficking.<sup>51</sup> In the view of those authors, simple possession of cannabis for personal use was never intended to be covered. ... to justify possession of cannabis under the Conventions, these authors assert that article 36 of the *Single Convention*, 1961, which creates the penal offence of possession of cannabis,

covers only possession for the purposes of trafficking. All grounds for the offences to which article 36 refers are directly related to the illicit drug traffic. It also refers to cultivation, production, manufacture, extraction, preparation, offering, offering for sale, distribution, purchase, delivery, brokerage, dispatch, dispatch in transit, transportation, importation and exportation of drugs contrary to the provisions of the Convention.”<sup>52</sup>

“Other authors take the position that possession of cannabis, like that of any other drug or psychotropic substance, must be made an offence by the Parties to the Conventions. In 1972, the Le Dain Commission stated that the expression “possession” in article 36 of the *Single Convention*, 1961 had to include possession for personal use.<sup>53</sup> It also referred to article 36. The Commission stated:

‘It has generally been assumed that “possession” in article 36 includes possession for use as well as possession for the purpose of trafficking. This is a reasonable inference from the terms of article 4, which obliges the parties “to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.” There is also article 33, which provides that “The Parties shall not permit the possession of drugs except under legal authority.” [...] On the face of article 26 it would not be unreasonable to argue that what is contemplated is possession for the purpose of trafficking rather than possession for use, and that the requirements of the article are satisfied if the former kind of possession is made a penal offence. The prevailing view, however, is that the word “possession” in article 36 includes simple possession for use.’<sup>54</sup>

Dupras continues: “The Netherlands Ministers of Health, Welfare and Sports are also of the view that: ‘if the Netherlands decided unilaterally to legalise the market in cannabis and cannabis products ... [it] would be incompatible with article 2, paragraphs 1 and 5, article 4, article 36 and article 49.’<sup>55</sup> In New Zealand, the Drug Policy Forum Trust, which argues for greater liberalization in the use of cannabis, acknowledges that the *Single Convention*, 1961 and the *Convention against Illicit Traffic* require that legislative provisions be enacted prohibiting the possession of cannabis for personal use.<sup>56</sup> The Trust believes article 33 of the *Single Convention*, 1961 is clear and does not seem to be open to interpretation.

It must not be forgotten that paragraph 3(2) of the *Convention against Illicit Traffic* reiterates the Parties’ obligation to make the possession, purchase and cultivation of narcotic drugs for personal consumption, contrary to the *Single Convention*, 1961, a criminal offence. This reminder, which appears in a Convention concluded more than 20 years after the *Single Convention*, 1961, does not seem to leave any doubt as to the Parties’ intention.

Article 33 of the *Single Convention*, 1961 seems plain. It prohibits the possession of drugs. It remains to be determined whether this interpretation of the Convention is justified.”<sup>57</sup>

As Dupras notes, analysts have asked whether the provisions of the *Single Convention* concerning cannabis possession are aimed at small-scale personal use or at large-scale trafficking. One of the main drafters of the 1961 Convention, Adolf Lande, wrote that “the term ‘possession’ used in the penal provisions of the Single Convention means only possession for the purpose of illicit traffic. Consequently, unauthorized possession and purchase of narcotic drugs including cannabis for personal consumption need not be treated as punishable offences or as serious offences.”<sup>58</sup> The official Commentary on the *Single Convention on Narcotic Drugs* 1961, prepared by the Office of the UN Secretary General, states that whether personal use of

drugs requires application of criminal sanctions “is a question that may be answered differently in different countries.” The commentary states that those countries that do interpret Article 36 as requiring a legal approach to personal use “may undoubtedly choose not to provide for imprisonment of persons found in possession, but to impose only minor penalties such as fines or even censure since possession of a small quantity of drugs for personal consumption may be held not to be a “serious” offence under article 36... (p 112). Noll (a senior legal officer of the UN Division of Narcotic Drugs) points out that the “whole international drug control system envisages in its **penal provisions** the **illicit traffic** in drugs; this holds true for the 1972 Protocol.”<sup>59</sup>

The various governmental commissions on cannabis control have reached different opinions regarding whether the *Single Convention* requires a ban on the personal use of cannabis. The LeDain Commission concluded that it did, as did the Williams Royal Commission of Australia (1980), but the 1978 Sackville Commission of South Australia concluded that “the Convention does not require signatories to make either use or possession for personal use punishable offences ... This is because ‘use’ is not specifically covered by Article 36 and the term ‘possession’ in that Article and elsewhere can be read as confined to possession for the purpose of dealing”.<sup>60</sup> The US National Commission on Marihuana and Drug Abuse in 1972 held that “the word ‘possession’ in Article 36 refers not to possession for personal use but to possession as a link in illicit trafficking” and that measures such as “educational programs and similar approaches designed to discourage use could be employed to meet treaty obligations.”

The report of the Australian Institute of Criminology in 1994 concluded that it is only free availability that is ruled out by international treaties, thereby permitting both partial prohibition and a regulated approach.<sup>61</sup> The Victorian Premier’s Drug Advisory Council in 1996 held that partial prohibition was permitted under the treaties, but recommended that the matter be studied further.<sup>62</sup>

Article 28, paragraph 3 of the *Single Convention* states that “The Parties shall adopt such measures as may be necessary to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant.” This clause and Article 22 have been taken to mean that if a country decides that a system other than prohibition is most appropriate for protecting public health and welfare and for deterring illicit trafficking, “**that country is not obliged by virtue of the *Single Convention* to maintain a prohibition policy**”.<sup>63</sup> The authors of the New Zealand report conclude that: “Our reading of this complicated literature, and of the treaties themselves, leads us to conclude that a policy of partial prohibition... would certainly be considered by most authorities as being in compliance with international treaties.... authoritative interpretations of the *Single Convention*... would appear to permit a system of regulation and control.”<sup>64</sup> They suggest that “... **if New Zealand were to notify the United Nations that, after careful study, it has determined that a regulated system of cannabis control were necessary to reduce both public harm and illicit trafficking, it seems unlikely that such an announcement would be condemned** (except, perhaps, by the United States)”.<sup>65</sup> “It seems inappropriate for countries to be forced by international treaty to foster black markets within their borders, especially if doing so serves to disadvantage native populations”.<sup>66</sup>

Clearly, different interpretations of the treaties will continue to be written. It well may be that, as Dupras writes:

“The only way to settle the debate definitively, as to whether possession of cannabis (or another drug) must be made an offence by virtue of one of the three Conventions would be to obtain a decision on the matter from the International Court of Justice. Article 48 of the *Single Convention*, 1961, article 31 of the *Convention on Psychotropic Substances* and article 32 of the *Convention against Illicit Traffic* provide that any dispute relating to the interpretation of these Conventions should be settled by agreement between the Parties and, failing agreement, by the International Court of Justice.

Even if the *Single Convention*, 1961 requires that possession of cannabis be made an offence, it still allows the Parties latitude as to the sanctions or penalties they impose. The sanctions imposed must have a deterrent effect on the offender or any other individual who might be tempted to commit the same offence. The sanction must be determined on the basis of the seriousness of the offence.<sup>(67)</sup> In less serious cases, the sanction may even be replaced by measures for treatment, education, rehabilitation or social reintegration.<sup>68</sup> ... The Conventions recognize, implicitly and explicitly,<sup>69</sup> that imposing sanctions is a matter within the domestic law of the Parties. Each Party may choose the approach that it considers most appropriate to deal with the various situations that may arise.

**The administration of justice within the territory of a Party is a matter within its exclusive jurisdiction.** It need account to no one. No international organization has any right to scrutinize the manner in which the Parties apply the legislative provisions they have enacted pursuant to the Conventions. They do not have to justify their decisions. At most, they could be criticized if their conduct were injurious to other Parties or harmful to the mutual cooperation in which they must engage.

**The tolerance exhibited by the Netherlands and Belgium may be criticized, but no other State or international body may interfere.** The authorities of those two countries seem to have chosen, for their own reasons, not to enforce their legislation prohibiting the possession and use of cannabis.”<sup>70</sup> [emphasis added]

### **The Current Legal Situation in Canada**

At least two judicial decisions in Ontario and British Columbia (*R. vs Clay* and *R. vs Caine*) have concluded that cannabis appears to be a much less dangerous drug for its consumers than either alcohol or tobacco. Deaths from alcohol and tobacco outstrip those from marijuana by a ratio of 10 to 1, even when relative rates of use are taken into account. The most recent figures from Juristat of July 1998 showed that in 1997 there were 65,000 drug charges in Canada; 70% of these related to cannabis use. More than 60% of all drug charges involve possession rather than distribution offences. So the war against drugs in Canada remains primarily one against cannabis. “It is not surprising that there is a reluctance to give up this fight, as hypocritical and as futile as it must appear. Both sides in the war -- the police and the marijuana distributors -- have nothing to gain and everything to lose if cannabis is given legitimacy as recreational drug.”<sup>71</sup>

The most substantial legal change in relation to cannabis law occurred with the introduction of the Controlled Drugs and Substances Act. This for the first time set marijuana apart from other illegal drugs. No longer a “narcotic”, cannabis is now a Schedule II drug (cocaine and heroin are in Schedule I). The punishments for marijuana possession, distribution and production are slightly

different from those for cocaine and heroin. Provided that the amount of cannabis possessed is less than 30 grams and the amount distributed is less than three kilograms, maximum jail terms are reduced to six months and five years respectively (for heroin and cocaine the maximum term for possession remains at seven years and the maximum term for distribution at life imprisonment). These legal changes still support terms that are totally at odds with the norms seen in courts. While no dramatic changes in cannabis policy have occurred through legislation, changes have taken place through policing and the courts.<sup>72</sup> By 1975, fines and discharges had emerged in Canadian courts as the most probable sanctions for marijuana possession. Data are no longer available regarding the rate of imprisonment for cannabis possession; fines and discharges still remain the most common judicial response, both of which still provide a criminal record. **More than 600,00 Canadians now have criminal records for marijuana possession.** The possible adverse consequences of a criminal record include: being at a disadvantage in subsequent criminal proceedings; restricted travel; denial of employment. A number of attempts have been made to reduce the consequences of a drug offense, including pardons and discharges. The discharge provisions of the Criminal Code and the pardoning provisions of the Criminal Records Act in fact make little difference. A discharged offender is deemed not to have been convicted but they would have to admit that they had committed a criminal offence if questioned (such as happens at border crossings).

### **Recent Developments**

In 1997, Christopher Clay, a young owner of a hemp store in Ontario, tested the Canadian law with respect to possessing, cultivating and selling marijuana plants. Clay was found guilty on the charge of possession and given three years probation. **The most significant aspect of the case was that Judge McCart's decision showed that he agreed with almost all of the arguments put forth by the defence lawyers and witnesses. The decision focused on the lack of harms associated with marijuana versus the demonstrated harms of marijuana policies.** Nonetheless, the judge concluded that changing drug policy was the onus of politicians, not the courts. The defence team appealed the decision regarding possession, but the appeal has yet to be heard.

**There have also been a number of significant developments with respect to medical marijuana.** In Canada, it is currently not permissible to prescribe marijuana for therapeutic purposes. Nabilone (Cesamet) and dronabinol (Marinol) are the only two developed products related to the active constituents of cannabis that are currently recognised in Canada. They have a limited medical application in the management of severe nausea and vomiting associated with cancer therapy. They are not approved for the treatment of other medical conditions.<sup>73</sup> In 1997, Terry Parker of Toronto was tried for possession, cultivation and trafficking of marijuana. Parker has used marijuana to treat his epilepsy since he was a teenager. Because Parker admitted to giving marijuana to other for medicinal purposes, Judge Sheppard convicted him of trafficking and gave him one year of probation. **Sheppard acquitted Parker on the other two charges on the grounds that both the old Canadian drug law (*Narcotic Control Act*) and the new drug law (*Controlled Drugs and Substance Act*) are over broad and unconstitutional and violate the *Canadian Charter of Rights and Freedoms*.** In his decision, Judge Sheppard drew heavily on the Chris Clay case stating that "Marijuana causes no physical or psychological harm for the vast majority of users". Sheppard ruled that to deny

Parker marijuana amounts to an infringement of his Charter right to life, liberty and security. He ordered the three plants taken on the second raid to be returned to Parker on the grounds that these were necessary medicine and that Parker, being on disability allowance, could not afford, nor should have to, purchase the marijuana on the street. The Crown has appealed the decision. In the meantime, Parker is free to cultivate and possess marijuana, but other medical marijuana users will have to take their cases to court until a decision is made by a higher court or the Federal Parliament moves to change the law.

In December of 1997, a group of doctors and lawyers made application to Health Canada to allow an Ottawa AIDS patient, Jean Charles Pariseau, to legally use marijuana as medicine. The application was made under the Health Canada special access program. This program allows doctors to request immediate approval of drugs not authorized under the Food and Drug Act if the patient is in an emergency situation. Such applications are common and generally approved as long as there is medical evidence proving the drug helps the patient. It was under the same Health Canada program that drugs such as cocaine, heroin and morphine were first approved for medical use. To date, Pariseau has not received his drug from Health Canada, and has been arrested for growing plants for his own use. Under the Health Canada program, each application for a new drug must include a "manufacturer", and the department claims that it has been unable to find a reliable legal supplier of the drug.<sup>74</sup>

Jim Wakeford is a Toronto resident who is living with AIDS who uses marijuana to quell the nausea provoked by his medications and to stimulate his appetite. Without this medication, both Wakeford and his physician believe that he would have died some time ago. Before his recent trial, Wakeford had written to Health Minister Allan Rock asking for his assistance in finding a way for him to access medical marijuana for personal use. Mr Rock replied that marijuana had not been approved for medical use and that any approval would require prior proof "that the drug is safe and effective for the claimed use". In February of 1998 Wakeford, represented by Alan Young, filed a Civil Suit with the Ontario Court. In his judgment released in September, Judge LaForme stated that it is likely that no process exists to deal with formal requests for exemption. "However, Parliament has provided a specific means for individuals to apply for exemptions and that must be exhausted prior to this court's intervention." The judge commented that if it is established that there is, in fact no process or procedure in place to deal with such applications, "I would have no hesitation in granting perhaps even all the relief Mr Wakeford seeks". **Judge LaForme concluded that the evidence showed that criminalizing Wakeford's marijuana use would infringe his rights under Section 7 of the *Charter of Rights and Freedoms* to liberty and security of the person.** "It is now abundantly clear that our courts recognize, in the strongest terms, that the right to security if the person includes the right to make autonomous decisions with respect to one's bodily integrity." The judge stated that Wakeford's "terminal illness, its dreadful and painful effects on him physically and emotionally, and his desire to treat himself effectively and in a manner that allows him relief and dignity surely qualify as rights protected by Section 7". Jim Wakeford has appealed the decision while also making the formal application to Mr Rock's office under Section 56 of the CDSA, encouraging other's in a similar situation to do likewise. Section 56 provides: "[...] the Minister [of Health] 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 this [Act] or the regulations ... for a medical or scientific purpose or otherwise in the public interest.”

In 1998, Stanley Czolowski of Vancouver, charged by police both for possession and trafficking of three kilos of marijuana, admitted he was guilty but successfully argued that marijuana is the only substance that allows him to combat the pain and nausea that are side-effects of his condition and prescription medications. Czolowski was selling his home-grown pot to the Compassion Club, a Vancouver group that distributes free or low-cost marijuana to people suffering from diseases ranging from glaucoma to cancer, AIDS and epilepsy. Judge Jane Godfrey said she accepted that Czolowski used and trafficked in the restricted drug but that the many problems suffered by Czolowski because of his condition was a powerful argument against banning marijuana from people who use it medicinally. In a judgment that was the first of its kind in Canada, she granted him a discharge. The Compassion Club in Vancouver continues to provide marijuana for medicinal purposes, so far with little police intervention.

Although Canadian organizations have been slow to support medicinal marijuana, many US health and medical organizations have taken favorable positions on medicinal marijuana, including the AMA, AIDS Action Council, the American Academy of Family Physicians, the American Public Health Association, the Lymphoma Foundation of America, the National Association of People With AIDS, the Multiple Sclerosis California Action Network, and several state nurses' associations. All of these groups either (1) favor immediate prescriptive access to marijuana instead of waiting for more research or (2) acknowledge that criminal penalties are not appropriate for medicinal marijuana-using patients. In the United Kingdom, the British Medical Association has stated support for the prescription of marijuana and the College of Pharmacists has made application to begin a large scale clinical trial of marijuana. This November, Britain's House of Lords Science and Technology Committee recommended that cannabis should be reclassified as a Schedule 2 drug, allowing research and prescription by doctors on a named patient basis. The report called for clinical trials of cannabis in the treatment of multiple sclerosis and chronic pain but recommended that doctors should be allowed to prescribe cannabis before its benefits are proved. The recommendations follow an eight month inquiry, which concluded that although there was no conclusive proof of the medical value of cannabis, there was enough anecdotal evidence of its benefits for trials to be started "as a matter of urgency."

Also in November of this year, seven US states voted on access to medical marijuana (California voted in favour of such access in 1996). In six of these access was supported. Voters in Alaska, Arizona, Nevada, Oregon and Washington approved measures to loosen the unreasonably strict rules on the use of cannabis to alleviate illness. By a large margin, Oregonians also rejected a proposal to restore criminal penalties for marijuana possession, which the state had lifted. In the seventh, Washington DC, the vote was not counted due to a Federal ban on use of funds for drug policy reform, but a survey of voters at the polls showed more than 60% in favour of medical marijuana.

### **The Role of Marijuana Policy**

Marijuana policy serves two main functions: to minimize health and safety hazards and to minimize social costs and adverse individual consequences that result from attempts to control

use.<sup>75</sup> The social costs associated with marijuana prohibition include the financial costs of law enforcement, encroachment on individual rights and freedoms, the adverse effects of a criminal record, and the impact of fines and imprisonment on the users. It has been assumed that the benefits of criminal penalties for marijuana possession are its deterrent effect on use. As noted above, there is very little evidence, however, that marijuana laws exert a strong deterrent effect. In fact, Single has noted that substantial increases in marijuana use occurred in both the US and Canada despite the allocation of substantial resources to the enforcement of very coercive measures.<sup>76</sup>

The main reasons typically put forward by those not in favour of changing marijuana laws include the following:

- Marijuana is not a harmless drug.
- The use of hard illicit drugs will increase under a "decriminalized" system because marijuana use leads to experimentation with harder drugs.
- Adoption of a decriminalization approach to use will send the message, especially to young people, that marijuana use is not viewed seriously by our society and carries little risk. This in turn will lead to increased use.
- The legal status of alcohol and tobacco has shown that legality is associated with widespread use in the community and widespread associated problems.
- A decriminalization approach will make dealing of small amounts easier and less subject to prosecution in court. This in turn may result in more organized crime.
- People who are dependent on marijuana will no longer be brought to the attention of the courts and so to treatment.
- There will be an increase in drivers under the influence of marijuana.

The arguments for marijuana law reform have been very similar in all countries where such reforms have been made. **The main reasons put forward for marijuana law reform to decriminalize personal use and cultivation are as follows :**

- Laws requiring court appearances are very expensive in terms of both money and human resources and place extremely heavy demands on the court system. Decriminalization for personal use frees up resources which can be directed towards detecting large-scale drug traffickers and money launderers.
- A criminal conviction for using, or cultivating small amounts of marijuana in private is a consequence which is out of proportion to the seriousness of the offence; it leaves large numbers of people with criminal records who might otherwise have never got a record but who will be affected for life by the stigma.
- By relying on criminal prosecution procedures to deal with small-scale marijuana offences, the law may be contributing to the belief among many young people who have experimented with marijuana that the dangers of other illicit drugs have been overstated. They are then suspect of the veracity of other drug education, and opportunities for true harm reduction with respect to drug use are lost.
- A system which includes criminal prosecution for small-scale marijuana offenders is costly to society in terms of erosion of individual rights and freedoms in the name of drug enforcement.

- The decriminalization of marijuana use will maintain a separation of drug markets so that small-scale users will have no need to come into contact with wholesale drug dealers. In the Netherlands, for example, it was argued that the law reform would separate the small-scale dealing and use of marijuana from large scale trafficking and the associated criminal activity, especially in the heroin market. In South Australia it was argued that the existing laws have allowed a significant black market to operate around the recreational use of marijuana.
- Existing marijuana laws cause more harm to the users than the drugs themselves through erosion of civil liberties, fines and imprisonment.
- The existing laws allow corruption in law enforcement agencies.
- A prohibitionist approach leads to an increase in the use and price of the prohibited substance and creates a market which is devoid of controls, quality, standards and accurate information. Prohibition also has adverse consequences for marijuana research, thereby limiting enquiry into forms of pain relief that are potentially more satisfactory than those provided by the legally available therapeutic substances such as the opioids.

### **Underlying Considerations in Cannabis Policy Reform**

For most Canadian politicians, amending the law regarding cannabis is not an attractive idea since they want to be seen as “tough on crime”. In Canada, the police and the judiciary have created a *de facto* softening of penalties for possession, not the politicians.<sup>77</sup> Like those of the courts, police enforcement practices with respect to marijuana have changed markedly in Canada since the 1970s. Police now primarily (but by no means solely) target growers and distributors. Despite this *de facto* relief, the current law involves considerable enforcement and other criminal justice costs, as well as adverse consequences to individual drug offenders, with little evidence of a substantial deterrent impact on cannabis use.<sup>78</sup> This suggests that the severity of punishment for a cannabis possession charge should be reduced. The available evidence indicates that removal of jail as a sentencing option would lead to considerable cost savings without leading to increases in rates of use. The majority of Canadians -- 69% -- do not support jail sentences for simple possession of cannabis.<sup>79</sup> While diversion of cannabis offenders to treatment or community services should be available, diversion will not resolve the difficulties involved in cannabis enforcement. Diversion would do little to reduce the load on courts and would have no impact on consequences of being given a criminal record.

### **Policy Options<sup>80</sup>**

Fine only: measures could be taken to remove jail as a sentencing option for simple possession, but the criminal record consequences would remain.

Civil offense: another fine only option, which is in place in parts of Australia (where it has saved little money for the judicial system) and in California (where it has resulted in considerable financial savings); in Canada, refers to proposals to exempt the offence of simple possession of cannabis from the criminal law by converting it into a civil offence with a fine under the recently enacted federal *Contraventions Act*. The inability to pay a fine under the *Contraventions Act* does not result in imprisonment and a violation of the CA does not lead to a criminal record. This would take the offence out of the criminal justice system. One problem with this approach is that some provinces have yet to agree with a Memorandum of Understanding with the federal government concerning the *Contraventions Act*. Another drawback is that substituting civil

penalties for criminal ones does nothing to reduce the size and harmfulness of the black market.<sup>81</sup>

Diversion: refers to measures designed to specify and encourage use of diversion mechanisms for simple possession offenders. Bill C-41 (the “Alternative Sentencing” law) presents a number of such options, including “conditional sentences” (under which the criminal sentence is suspended while the offender complies with alternative sentence conditions such as treatment. This does not reduce the workload of the court system, but increases it. All conditional sentences result in a criminal conviction and record. There are serious doubts as to the appropriateness and effectiveness of mandatory treatment, especially for cannabis offenders and casual drug users.

Devolution to provinces: the federal government could legislatively concede jurisdiction over the control of cannabis possession to the provinces and put the onus on them to establish suitable control schemes. This might result in locally more acceptable options but it could also undermine the equity and consistency principles of the law.

De facto decriminalization of possession (prohibition with expediency principle): In 1976 the Netherlands began to allow the use and purchase of marijuana and its derivatives in “coffee shops”. This has not resulted in any negative consequences other than the wrath of the US and France (under the pre-socialist government). Belgium introduced “coffee shops” in several cities this year. One of the chief problems associated with such an approach is “drug tourism”.<sup>82</sup>

Legalization/Regulation: if a cannabis control Board approach were to be adopted, there would be a number of advantages: tax revenues could be used for health care and education; evidence from the Netherlands and elsewhere suggests that legalisation would not increase rates of use of negative health consequences; the state could deliver a more credible message to the young. On the negative side: this is too dramatic a change; the US would object that this violates UN agreements; the US would pressure Canada; while the Canadian public is receptive to decriminalization, it is unlikely to be receptive to legalization.<sup>83</sup>

The key issue concerns selecting the legislative option that provides the best balance between minimising cannabis related harm including the adverse individual consequences from law enforcement, while also reducing related criminal justice costs. In 1995-97, almost one half of all drug offences were for simple possession of cannabis (typically small amounts for personal use). It has been estimated that approximately 2,000 Canadians a year are incarcerated each year for cannabis possession (at a cost of approximately \$150 per day).<sup>84</sup> According to the analysis by the National Working Group on Drug Policy: **Currently, the best option for Canada appears to be the creation of a civil offense for cannabis possession under the Contraventions Act.**<sup>85</sup>

### **Public Opinion on Marijuana Policy**

According to the results of a 1997 Angus Reid Poll<sup>86</sup>, Canadian public opinion on decriminalization of marijuana has shifted quite dramatically over the past decade. While remaining divided about whether or not possession should be a criminal offence, Canadians have moved toward support for decriminalization (51% favours decriminalization, 45% are opposed, and 4% have no opinion). When asked about medicinal use, the vast majority support decriminalization (71% in favour, 27% opposed).

### **Experience with Alternatives to Criminal Prohibition**

**A number of jurisdictions have tried to make cannabis control more rational and cost-effective through depenalization.** In the 1970s, 11 American states reduced penalties for possession of small quantities of marijuana, eliminating jail terms and imposing fines up to \$250. Follow-up evaluations of these measures concluded that they substantially reduced costs to the criminal justice system without leading to significant increases in cannabis use compared to other states which maintained enforcement. Over the past few years, authorities in a number of European countries, including the Netherlands, Germany, Italy and Spain, have decided not to prosecute for possession of cannabis for personal use, focusing law enforcement efforts on large scale traffickers. There is no evidence of significant increases in cannabis use in these countries.

In the early 1990s, two Australian jurisdictions -- South Australia (SA) and the Australian Capital Territory (ACT) -- made the simple possession of cannabis into a civil offence through an expiation (fine) system.<sup>87</sup> The offences are not criminally prosecuted or penalized, there are no criminal consequences and the maximum fine is \$150. Consumption of cannabis in public places is still a criminal offence. Recent studies show no evidence of an increase in cannabis use rates in SA or ACT relative to other states. However, enforcement under the fine scheme appears to focus disproportionately on those of lower socioeconomic status. At the moment, about 45% of those caught fail to pay the fine and still end up before the courts. The Attorney-General's Department has advised that such schemes are consistent with the 1961 and 1988 international conventions.<sup>88</sup>

In each of the cases where marijuana law reform has occurred, the final decision was based on the fact that the costs associated with the existing system were seen to be too high by many segments of society and too many people were seen as being adversely affected by the existing laws. **In all of the cases where *de facto* decriminalization of marijuana has occurred, reduced financial and social costs were achieved without an increase in the risks to the community associated with drug use in general. Other, longer term, benefits have stemmed from the separation of high and low risk drug markets.**

### **International Treaties and Other Drugs**

Canada's drug law does not prohibit all possession or use of illicit drugs. The regulations to the *Controlled Drugs and Substances Act* allow the prescribing of some otherwise illicit substances for treatment or therapeutic purposes. One such example is the prescribing of methadone to drug users. Another is the prescribing of heroin under restrictive conditions for therapeutic purposes. Over the last several years, based on the success of the Mersey model in the United Kingdom, a number of countries have considered the issue of the controlled availability of heroin to drug users within a medical model as a way of dealing with the inadequacies of methadone programs (see section below on Alternatives). In this regard, the seriousness of the heroin problem in British Columbia led the Chief Coroner to conduct a special report on illicit narcotic overdose deaths in the early 1990s.<sup>89</sup> Deaths due to the use of illicit drugs in that province increased from 39 deaths in 1988 to 331 in 1993, and the annual rate has remained close to this rate in subsequent years. Illicit drug use had become the leading cause of death for both males and females in 1993 for the age group 30-44. In the early 90s the majority

of deaths involved heroin either alone or in combination with alcohol and/or other drugs (in the past couple of years a significant number of cocaine related deaths have occurred). The Chief Coroner argued that using the criminal law to combat heroin use had failed and suggested the possibility of providing heroin to seriously addicted people in a para-medical model.<sup>90</sup> (In 1973, The LeDain Commission recommended a controlled trial of prescribing heroin to heavily dependent users.<sup>91</sup>)

Discussions are currently underway regarding heroin trials in three Canadian cities: Montreal, Toronto and Vancouver. The legitimacy of such trials under the international treaties has been established by several countries that have started, or have tried to start, their own trials. Dupras writes: “Although it may be surprising, a program that prescribes heroin for a heroin addict is easier to justify under the three Conventions than is simple possession of cannabis. The reason is straightforward. Prescribing heroin is a medical act, and the program that authorizes it is in fact a treatment whose purpose is rehabilitation. It should not be forgotten that medical or scientific supervision would be an essential requirement (the condition *sine qua non*) for the program in question to be legal.”<sup>92</sup>

The first, and most exhaustive, series of background reports on heroin prescribing was prepared by Australia. In 1991, the Legislative Assembly of the Australian Capital Territory (ACT) authorized the Committee on HIV, Illegal Drugs and Prostitution to submit an interim report on illegal drugs. The Committee concluded that current policy implementation with regard to controlling and/or reducing the use of illegal drugs (prohibition) might not be effective. The committee accepted the international evidence that prohibition policies have not reduced the illegal supply of opiates and have not reduced the number of people taking drugs and considered alternative policy approaches. Members of the Committee visited the Merseyside area in the UK and were impressed with the success of the prescribing approach used there (see Alternatives section for details). It was decided to establish a trial to assess the impact of a policy shift towards the controlled availability of heroin to people already dependent on the drug.

The committee identified several potential benefits of a trial:

- There is a broad consensus of opinion that prohibition as it is currently enforced is not effective, that changes in drug policy are urgently needed.
- There is no agreement on what form these changes should take. The case for increasing the controlled availability of opiates, including heroin, is stronger than the case against. The likely potential benefits of such a change reduced crime, reduced corruption, improvements in health and lifestyle for users, as well as preventing the spread of HIV infection. While there are indications that such benefits would result from a change in controlled availability, these are based on a small number of inconclusive studies.

They also addressed concerns such as the following:

- there may be leakage of government supply to street market; expansion of the program to larger numbers raises concerns about subjects having to be given “take-away” heroin;
- providing heroin to users in a supervised clinical setting may not provide an answer to the relationship between heroin and crime in a realistic setting; many heroin users are involved with crime before they become involved with heroin;

- costs due to supplementing of welfare services will be increased;
- being able to receive heroin legally does not ameliorate the difficulties that users face due to lack of education, diminished vocational skills and deficient social skills.

Obviously, one issue that the feasibility study had to address is: Would such a trial breach Australia's international obligations under the 1961 and 1988 Conventions? The opinion given to the select committee stated: A trial involving the controlled availability of opioids, including heroin, that was conducted for a medical or a scientific purpose would not place Australia in breach of international treaty obligations.<sup>93</sup> With respect to the *Single Convention* of 1961, the report states: "It is arguable that a trial of controlled opioid availability would be consistent with Australia's obligations under the Convention. Article 36(1) of the Convention provides that 'subject to its constitutional limitations', each Party shall adopt measures to ensure that activities such as manufacture, possession, distribution, sale, transport, importation and exportation of drugs 'contrary to the provisions of this Convention ... shall be punishable offences when committed intentionally ...'. The general obligations imposed on Parties to the Convention are set out in Article 4. Article 4 provides that: "The Parties shall take such legislative and administrative measures as may be necessary:

(c) Subject to the provisions of this Convention, *to limit exclusively to medical and scientific purposes* the production, manufacture, export, import, distribution of, trade in, use and possession of drugs' (italics added).

... In addition, Article 2(5) requires that:

(a) A Party shall adopt any special measures of control which in its opinion are necessary having regard to the particularly dangerous properties of a drug so included; and

(b) A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any drug except for amounts which may be necessary for medical and scientific research only, including clinical trials herewith to be conducted under or subject to the direct supervision of the Party.'

[T]he additional controls specified in Article 2(5) are not mandatory but are to be adopted if, in the opinion of the Party, they are necessary. A further argument which could be raised is that the 'special measures of control' referred to in Article 2(5)(b) could include controlled availability of an opioid, a measure which recognises the precautions which must be used in relation to substances like heroin .... **To bring a controlled availability of opioids trial within Australia's international treaty obligations it would be necessary to show that a trial was for a medical or scientific purpose.** While it is arguable that the controlled availability of opioids to drug dependent persons would not place Australia in breach of its international treaty obligations, their supply to users who are not drug dependent is more problematic...<sup>94</sup>

With respect to 1988 Convention, the report stated:

"Turning to the provisions of the 1988 Convention, article 3 obliges Parties to adopt such measures as are necessary to criminalize certain activities. These activities include production, manufacture, distribution, sale, importation, exportation, and possession for personal consumption of narcotic drugs and psychotropic substances '*contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention*' (italics added).

(The 1971 Convention is the Convention on Psychotropic Substances, which is not relevant for the purposes of this discussion.)

As we have seen, it can be argued that the Single Convention merely requires that the use of narcotic drugs is limited to medical and scientific purposes. Any additional restrictions or prohibitions on Schedule IV drugs [which includes heroin] are left to the discretion of the parties. Some commentators have also emphasised that the 1988 Convention clearly distinguishes between trafficking and possession for personal consumption. Thus Article 3(4)(d) provides that 'measures for treatment, education, after care, rehabilitation or social re-integration may be provided either as an alternative to conviction or punishment or in addition to conviction or punishment, regardless of how serious the possession, purchase or cultivation offence might be'<sup>95</sup> - in relation to offences of possession, purchase or cultivation for personal consumption."<sup>96</sup>

The report to the Australian committee concludes:

"If a controlled trial of opioid availability can be regarded as a medical or scientific purpose, then it would not place Australia in breach of international treaty obligations. Indeed, reference could be made to the practice of other participating states -- for example, the United Kingdom -- as a guide to the interpretation of the relevant treaties, according to the Vienna Convention on the Interpretation of International Treaties .... The one policy option which the commentators appear to agree would not be accommodated by the Convention is that of legalization ....

"The qualification on all the above options is that the activities authorised must be for a medical or scientific purpose within the meaning of the general obligations contained in the provisions of Article 4 of the Single Convention. While any Party could adopt such options on the basis that they serve the medical or therapeutic objective of treating drug addiction or abuse, the options could not be adopted if their ultimate purpose was to enable recreational use as distinct from medical or therapeutic use.<sup>97</sup> Nonetheless, the wording of these conventions does not necessarily lead to this conclusion. For example, in the Canadian context, consider the comments of the LeDain Commission into the non-medical use of drugs. In its final report, the Commission stated about the *Single Convention on Narcotic Drugs, 1961*:

[T]he *Single Convention* requires the parties to take such legislative and administrative measures as may be necessary "to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs".

**Article 36, which provides for penal provisions, does not explicitly require that use as such be made a punishable offence. It refers to "possession", and it could be argued that it is possession in the context of distribution. This is a reasonable inference from the fact that all the other acts specified by Article 36 are acts of production or distribution ....** The prevailing view in the international community, however, appears to be that the Convention requires parties to make possession a punishable offence. ... Thus, by their own legislative behaviour, states have tended to give this construction to their obligations under Article 36, although on the basis of technical interpretation a good case could be made for limiting the meaning of possession to possession for the purpose of trafficking."<sup>98</sup> [emphasis added]

Since the publication of the LeDain Report and the forgoing interpretation, Canada has ratified the *1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*. Article 3, paragraph 2 provides that "[s]ubject to its constitutional principles and

the basic concepts of its legal system", each party must adopt measures as may be necessary to establish as a criminal offence the possession, purchase or cultivation of narcotics for personal consumption "contrary to the provisions of the of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention." Thus, qualifications exist on the obligation to create offences relating to personal consumption. The first qualification is that such a measure should be consistent with constitutional principles and the basic concepts of the party's legal system. **The government could defend moving away from a policy of total prohibition on the ground that continued criminalization offends the fundamental principle of restraint in the use of the criminal law.** The former Law Reform Commission of Canada considered this principle to be the foundation for reform of our criminal law.<sup>99</sup> Moreover, the Department of Justice approved this principle as a basis for criminal law reform.<sup>100</sup> The second qualification is that the obligation to create crimes of personal consumption of drugs only applies to those occasions when such possession is, in effect, contrary to the provisions of the 1961 Single Convention. **In short, these conventions, as written, allow for specific exceptions to prohibition.** Nor does national legislation create an insurmountable barrier to reform. As noted above in the section on medical marijuana, the *Controlled Drugs and Substances Act* provides for exemptions of **any** persons and controlled substances under Section 56 "if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose **or is otherwise in the public interest.**" [emphasis added]

### **Modifying or Denouncing the Conventions**

These 1961 and 1988 conventions also allow parties to seek to amend them or to withdraw from them by denunciation.<sup>101</sup> Such action would not breach these conventions. As the LeDain Commission pointed out, "[d]enunciation ... would not, of course, be in violation of international obligations since it is a right expressly provided for in the [1961] Convention."<sup>102</sup> In this regard Dupras notes that as "long as the drug Conventions are worded as they currently are, the Parties will have to maintain legislative provisions prohibiting the possession of cannabis for personal use. The Parties could choose to change this situation by adopting amendments to the Conventions to that effect.. Each of the three Conventions has provisions whereby they can be amended."<sup>103</sup>

The issue of whether to amend or denounce these conventions is a complex one. For example, some critics of the policy of total prohibition of drug use argue that the wiser course of action would probably be to amend the 1961 Single Convention to create an alternative international framework that focuses on harm reduction, while denouncing the heavily prohibitionist 1988 Trafficking Convention.<sup>104</sup> **Canada may thus choose to amend or to denounce these conventions, but it is a choice mandated by other considerations, not by the terms of the conventions themselves.**

### **Recent Developments on International Drug Treaties**

On June 8-10, 1998, thirty heads of state and 150 delegates from around the world gathered for a special UN session to discuss strategies for combating the supply and demand of illicit drugs. The summit marked the tenth anniversary of the 1988 UN *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*. The conference was led by Pino Arlacchi, head of the UN International Drug Control Program (UNDCP). UN delegates adopted and

agreed to finance Arlacchi's US\$5 billion, 10-year strategy to eradicate opium poppy and coca plants worldwide. Delegates also promised to curb money laundering, examine the growth of synthetic drug manufacturing and use; increase judicial cooperation including extradition; and tighten controls over precursors chemicals used to make illicit drugs. The illicit drug trade is estimated to be a \$400 billion industry representing 8% of total international trade.

The drug summit was originally suggested by Mexico in 1995 to address drug-related problems. **Originally, the drug summit was scheduled to critically examine current strategies and address alternatives, but that examination was removed from the agenda.** Organizations advocating alternative drug policies, such as the International Harm Reduction Association, were not allowed formally to participate in the summit although they were allowed to ask questions of the various panels. The drug summit prompted a debate between so-called drug-consuming and drug-producing countries, and the value of demand reduction versus supply reduction as anti-drug strategies. President of Mexico Ernesto Zedillo rejected American criticism of Mexico's anti-drug effort: "It is our men and women who first die combating drug trafficking... Our communities are the first to suffer from violence, and our institutions are the first undermined by corruption."

Worldwide protest of the UN drug summit was carried out in several major cities across the globe, and included an open letter to UN Secretary General Kofi Annan that appeared in a two-page advertisement in the New York Times on June 8th. Over 500 leaders (including former UN General Secretary Javier Perez de Cuellar and former Secretary of State George Shultz) from around the world signed a letter urging that the UN's existing drug policy be reexamined and the debate be opened. Numerous newspapers published articles and editorials on the event; most significantly, the vast majority of these (including editorials in the New York Times, the Globe and Mail and the Ottawa Citizen) were in support of the views expressed in the letter to Kofi Annan and opposed to the UN's approach. "The UN kept off the program virtually all the citizens' groups and experts who wanted to speak. There is no discussion of some interesting new ideas such as harm reduction... that cut the damage drugs do. Like previous UN drug conferences, this one seems designed primarily to recycle unrealistic pledges and celebrate dubious programs."<sup>105</sup>

## 6. Drug Use and Human Rights

"In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing the recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society." (Universal Declaration of Human Rights, Article 29, 2)<sup>106</sup>

**The almost no discussion, written or otherwise, on drug use and human rights.**<sup>107</sup> The only explicit reference to drug use in international human rights conventions and treaties is in the European Convention on Human Rights. The first, and only, mention of human rights in global treaties is in the Vienna Convention of 1988, which states that all measures to eradicate cultivation of and demand for illicit substances must "respect fundamental human rights" and

ensure “protection of the environment”.<sup>108</sup> **Most international treaties and conventions, like national drug laws, have not been examined with respect to their compliance with human rights agreements, either national or international.**<sup>109</sup> The omission is glaring since “Drug use can trigger a wide variety of human rights infringements, especially when the rights of drug users are considered unworthy of respect. This occurs primarily because of prejudice and stigmatization... .”<sup>110</sup>

The problems caused by drug use cannot be separated from the physical, social and policy environment in which they occur. Policies that are intended to reduce drug related harms are most effective in supportive environments. This has resulted in increased attention being paid to public health and international human rights law in the attempt to create such an environment. In this context, it is widely agreed that human rights law should apply to drug policies as to all other public policies. Drug legislation can be compatible with human rights objectives if it follows the same objectives:

- the achievement of the highest standard of health, defined as the complete physical, mental and social well-being;
- the prevention of the spread of disease related to drug use;
- and the protection of public safety, such as accidents.<sup>111</sup>

The need for immediate attention to these matters is reinforced by the fact that most countries have already implemented control policies that have a negative effect on the human rights of drug users. For example<sup>112</sup>:

- detection of drug users which includes breaches of privacy; absent or diminished data protection and protection against self-incrimination; mandatory medical examination or drug testing; the compatibility of registers of drug users with human rights protection;
- integrity of persons, which includes absent or diminished due process; arbitrary searches, seizures, arrest or detention; and mandatory treatment;
- criminal justice procedures which includes interference with the presumption of innocence and rules of evidence; diminished protection against self-incrimination; and the use of special rules and practices relating to offenses committed while intoxicated;
- detention which includes arbitrary arrest, detention, or imprisonment; absent or reduced access to medical and social assistance when in detention; absent or diminished protection against cruel, inhuman, and degrading treatment; and arbitrary or excessive sentencing policies and practices;
- health care which includes absent or reduced availability to care and treatment; and absent or reduced availability of and access to preventive measures, such as clean needles, methadone maintenance and education;
- employment which includes arbitrary or discriminatory drug testing policies; absent or reduced work or promotion opportunities; unjustifiable dismissal; and absent or reduced accommodation of disabled or handicapped persons who use drugs;
- housing which includes absent or reduced housing opportunities; unjustifiable eviction; and insecure tenure;
- education which includes absent or reduced opportunities for education;
- mobility which includes arbitrary or discriminatory exclusion from immigration and travel and unjustifiable searches or enquiries;

- insurance which includes absent or reduced eligibility for life, disability or health insurance.

Wrongful discrimination is another, more pervasive infringement of human rights affecting drug users; this is to a great extent directly related to the widespread stigmatization of drug users. “When laws and policies pertaining to drug use are not scrutinized sufficiently to assess their compliance with human rights standards, it is only possible to emphasize the urgent need for such analysis and to suggest issues in need of further study.”<sup>113</sup>

The fact that possession of certain drugs is illegal in most societies raises many privacy issues, which are frequently left unexamined.<sup>114</sup> Drug use, societies responses to it, and legal and policy approaches to it have negative effects on the human rights of drug users. These includes the infringements of the rights of drug users, vulnerability to human rights abuses, and decreased ability to exercise these rights due to the effects of drug use. These harms can often be avoided or reduced by reforming the negative legal and policy approaches to drug use that are part of society’s discrimination against drug users. Reducing such harms would involve<sup>115</sup>:

- accepting drug use as a private activity and limiting governmental control only to risky situation, such as those involving public safety;
- preventing or reducing stereotyping, stigmatization, scapegoating and discrimination linked with drug use;
- recognising that drug use can impair health and thereby interfere with opportunities to exercise human rights and that protection of drug users in these situations is necessary;
- shifting legal and policy approaches to an emphasis on harm and demand reduction;
- ensuring that the human rights of drug users are not curtailed during incarceration;
- evaluating domestic and international legal and policy responses to drug use with regard to their compliance with human rights agreements.

These issues make it clear that drug use is not really a health or criminal justice issue at all, but a political one. The problems revolve around lack of political will and the solutions lie in mobilisation of that will. **The “drug problem” must be recast in such a manner that politicians understand that drug use, health and well being are as much about protecting human rights as they are about prevention of disease or compliance with international drug treaties.**

## 7. Drugs and Crime

“Redirecting drug policy to better serve the aims of crime control would require the abandonment of dearly held beliefs and long-established practices. But the potential gains would be large.”<sup>116</sup>

The link between drug use and crime is complex and highly politicized. Although the nature of the causes and the direction of causality are not known, it is true to say that heavy substance use is associated with a criminal lifestyle which includes such characteristics as aimlessness, self-absorption and an inability to relate to other people.<sup>117</sup> The very nature of the criminal lifestyle and the risk-taking inherent in it suggests that alcohol and other drugs would be an important factor as both an accompaniment or facilitator of the crime and as a way of coping with the

consequences of the lifestyle. Drugs, drug policies and crime are related in a number of ways: intoxication can reduce the barriers to law-breaking created by conscience and by the fear of consequences; intoxication can result in carelessness or aggressiveness on the part of potential victims; money spent on drugs and reduced earnings can make it more likely that someone will commit a crime; illicit activities can result in violence; illegal activities can make it more likely that someone will carry a firearm; the short-term economic opportunities of black markets can divert youth from education to crime and criminal records, a cycle that is very hard to break; resources for enforcing laws around crimes against person and property are diverted to deal with drugs.<sup>118</sup>

Since the most common form of intoxication is that associated with alcohol, and since alcohol can increase levels of aggression, alcohol is associated with many more crimes-of-intoxication than all other drugs combined. Crimes related to the need for money and with drug distribution are primarily associated with illicit drugs. The extent to which these crimes would be reduced if the drug laws were changed would depend on consumption levels, the pharmacology of the drug and its relationship with alcohol.

### **Alcohol and other Drug-Related Crime**

**Alcohol use is cited more frequently than any other substance in wife-assault.** In Statistic's Canada's national Violence Against Women Survey<sup>119</sup> at least 29% of women victimized by a partner cited alcohol as a precipitating factor while only 1% mentioned other drugs. The Survey shows that wife assault is generally more harmful when drinking is involved. Over one-half (56%) of violent men who were drinking at the time of the incident physically injured their spouses, and of these 47% inflicted injuries requiring medical attention. By comparison, one-third of violent men who were not drinking physically injured their spouses, and of these, 37% inflicted injuries requiring medical attention. **Among those accused of murder in 1991/92, alcohol use was cited in 66% of cases,** followed by alcohol and other drugs in combination (27%) and other drugs alone (7%). Federal inmates also report being under the influence of alcohol more frequently than other drugs while committing crimes (in a 1992 survey, 44% had consumed only alcohol, 29% had consumed only other drugs, and 27% had consumed both).

### **Illicit Drug-Related Crime**

Drug crime is activity that involves illicit substances as defined by law, such as possession and supply. It also involves violence in the drug trade and crime that supports drug habits or facilitation of crime and victimization. The relationship between drug use and crime is based on data analysed by Juristat. The interpretation of drug-related crime statistics is difficult. Reported drug crime is a reflection not only of drug use but also of police enforcement activity and reporting procedures. In 1997, all drug incidents involved offences under the new Controlled Drugs and Substances Act (CDSA). **Cannabis offences accounted for 7 in 10 of the 66,521 drug-related incidents reported in 1997. "Historically, the majority of drug incidents involve "possession" (62% in 1997) and most possession incidents involve cannabis".**<sup>120</sup> After increasing three years in a row, the rate of drug-related incidents remained virtually unchanged in 1997. After growing steadily since 1991 with an average annual increase of 6%, the rate of cannabis offences also remained virtually unchanged in 1997, and this stability

affects the overall rate of drug crimes. Continuing the downward trend since 1992, the rate of cocaine offences dropped in 1997 (-1.6%). After a large increase in 1996 (+8%), the rate of offences involving other drugs such as heroin and amphetamines increased by only 1% in 1997. While arrests for possession declined in the late 80s, this trend has been markedly reversed in recent years.<sup>121</sup>

The highest recorded rates of drug-related offences is in the Yukon Territory (763 per 100,000 population) followed by the Northwest Territories (595 per 100,000). Of the 10 provinces, BC has the highest rate (445) and the lowest is PEI (105). In 1991 and 1992, 51 people were killed in connection with drug disputes, 3% of the murders in that time. In 1992, 31% of those accused of personal robbery and 40% of those accused of commercial robbery were on a substance during the incident.<sup>122</sup>

In 1992/3 there were 782 admissions to federal adult correctional institutions for drug-related offences, an increase of 6.8% from the previous year. Drug-related admissions represented 14% of all admission to federal correctional institutions.<sup>123</sup> At the provincial level, approximately 15% of admissions to correctional facilities are drug related.<sup>124</sup>

### **Drug-related Violence**

As noted, drug disputes, especially over dealing territories, give rise to violence and sometimes death. Without the level of gun possession seen in the United States, Canadian drug-related homicides have remained low compared to its Southern neighbour. Over the last decade, however, there has been an increase in violence and murder related to drugs. This has been especially evident in Vancouver and in Montreal. In Quebec, for reasons that are obscure, many of the drug-territory incidents and deaths have involved use of bombs by biker gangs. More than 50 people have died in the past four years in the criminal-gang war, fought between the Hell's Angels and the Rock Machine for control of the lucrative illegal-drug trade in Quebec.

The rise in violence also results in increases to police spending and the size of drug-related forces. **As Canada follows the US example of allowing drug moneys from seizures and so forth to filter down, drug enforcement could become a self-supporting industry if it continues to rely on repressive approaches.**<sup>125</sup> It is pertinent to note the comments made by a Dutch police official in the 1970s regarding the problems of relying primarily on a repressive approach to drug taking: "The narcotic department of the police force will develop into a big, well-trained and excellently armed unit, which will have to be improved and increased permanently, to keep up with the never-ending escalation."<sup>126</sup> The Dutch, instead, chose to adopt a harm reduction approach and to focus their efforts on traffickers; and approach that has proven very successful at reducing drug use, drug-related crime, and violence.

## **8. Correctional Institutions**

"We owe it to the prisoners, and we owe it to the community, to protect prisoners from infection in prison. Unless we do so, courts or a commission of enquiry may one day have to explore why not enough was done to prevent HIV infection in

prisons, although everyone was aware of the risks and knew the measures that could be taken to reduce them".<sup>127</sup>

### **Drug Use and Correctional Service**

A study conducted by Correctional Services Canada (CSC) in 1989/90 found that more than 10% of 371 prisoners admitted using drugs every day in the 6 months prior to incarceration and 17% had regular drinking binges. Sixty four percent (64%) of offenders said that they had consumed alcohol or other drugs on the day of their crime.<sup>128</sup> Figures from France, Holland, Switzerland, Italy and Spain indicate that, during the three months prior to entry, 20-30% of prisoners had injected drugs at least once a week.<sup>129</sup> This fact alone explains why prisoners are at risk for being HIV positive on entry to prisons. The increasing numbers of drug users imprisoned over the last twenty years means that prisons are the single largest response to the drug problem in many countries. **More resources are used in moving drug users through the criminal justice system than on any other form of management, medical or social.**

As a consequence of drug prohibition in the United States the prison population has increased to one and three quarters of a million inmates in the last twenty years. In 1997, more than three million were maintained in correctional control under probation or parole. While the majority of drug users are white, the majority of people arrested for drug use are black. While African-Americans represent only 12% of the US population, they account for nearly 40% of the nations prisoners. More than thirty percent of all African-American men between the ages of 20 and 30 are either in prison, on probation, or under parole - more than are in American colleges. About half of these incarcerations are drug-related offences and another 20-30% involve drug users. In the United States, imprisonment has been the primary response to the drug problem. (Deinstitutionalization of psychiatric patients in the United States has caused additional problems for the criminal justice system: today there are ten times as many mentally disturbed and/or substance abusing persons in prisons and jails than there are in mental hospitals).<sup>130</sup>

Despite a decline in the crime rate over the past five years, the number of inmates in US correctional facilities rose again in 1997. The total number of Americans incarcerated was more than 1,725,000 in 1998, meaning that the national incarceration rate was 645 per 100,000 persons, more than double the 1985 rate of 313 per 100,000. The continued divergence between the shrinking crime rate and the rising rate of incarceration raises a number of questions, including whether the United States is relying too heavily on prison sentences to combat drugs and whether the prison boom has become self-perpetuating. **Since the early 1970s, drug offences have accounted for more than a third of the growth in the incarcerated population, and since 1980 the incarceration rate for drug arrests has increased 1,000 percent.** In fact, the incarceration rate for drug offenders alone today is about 145 per 100,000, which is higher than the average incarceration rate for all offences from the 1920s to the early 1970s, 110 per 100,000. Twenty five percent of the new inmates entering prison in New York state are "drug-only" offenders, with no record of other types of crimes.<sup>131</sup>

Canada has the dubious honour of having the highest number of drug arrests per capita of any nation other than the United States; with respect to drug legislation and enforcement it has been described as having "a bite worse than its bark".<sup>132</sup> There are currently about 1200 inmates

serving time for drug-related offences in Canadian federal prisons (these house offenders sentenced to two or more years of confinement). By far the majority of drug offences are seen in the provincial system, which handles sentences of less than two years; there are several thousand inmates serving time for drug-related offences in provincial institutions. Lest we feel smug in comparing ourselves with the United States, we should remember that there are more drug users in Canadian jails and prisons than there are in treatment programs. The overall result of this increased enforcement activity has been an overloading of courts and jail cells. **At a cost of \$50,000 per inmate per year it is clear that resources could be better spent.**

### **Drugs in Prison**

The Parliamentary Ad Hoc Committee on AIDS heard evidence that up to 50% of inmates may use drugs.<sup>133</sup> In a 1995 survey, 40% of 4285 federal inmates self-reported having used drugs since arriving in their current situation.<sup>134</sup> That there is extensive drug use and drug dealing in prisons should come as no surprise for several reasons:

1. Worldwide, the main response to drug use and drug dealing is criminalization and imprisonment.
2. The only countries that do not have significant drug problems in their prisons have the death penalty for both drug possession and trafficking.
3. Drug use and abuse are ways of dealing with boredom, anxiety and despair; just how many prisons are there that are able to promote stimulation, relaxation and hope in their inmates by natural means?
4. Drug use as a means of altering consciousness is a universal phenomenon that has been documented since the beginnings of recorded history. To imagine that there would not be drug use in prisons would be to ignore the facts about human nature as well as about the effects of drugs.
5. Drug dealing provides high incomes, requires no equipment or training, and drugs can be easily passed on without detection. In a climate of Prohibition, drug costs are high and guards and other staff can be offered high levels of pay for their assistance. **The result is an economy that is almost perfect for the prison environment**, especially since many of the participants have been involved in dealing before entering the institution.

In Canada, many of the inmates of correctional facilities as well as those on parole use drugs as a part of their lifestyle. There are no strong deterrents to substance abuse in prison because cases take too long to go through and withholding privileges has little effect compared to the high positive reward value of drugs. In prison, offenders may be involved in an active drug trade that defies all barriers and sets up conflicts involving debts and coercions. Inmates can make a great deal of money selling drugs and the price of drugs can increase from 200-500% over street value. The drug trade is a major source of violence in federal prisons.

**Inmates who enter the institution with no history of drug use often become drug users in prison.** Injection-drug use is also prevalent in prisons, and the scarcity of needles often leads to needle sharing. Inmates report that injection-drug use and needle sharing are frequent and that sometimes 20 people will use one needle without cleaning it. Staff of CSC report that “drugs are part of prison culture and reality”, that “drug use is widespread in institutions”, and that there are “many needles in the prisons”.<sup>135</sup> The extent of injection drug use in prison is

difficult to determine for obvious reasons, but what is clear is that when drugs are injected, clean needles and syringes are not available. A study of HIV transmission among injection-drug users in Toronto found that “over 80% had been in jail overnight or longer since beginning to inject drugs, with 25% of those sharing injecting equipment while in custody”.<sup>136</sup> In another study, 11% of federal inmates self-reported having injected since coming to their current institution; of these, only 57% thought that the equipment that they used was clean.<sup>137</sup> In one institution in western Canada, 71% of inmates reported that they had used injection drugs. Of these, 12% reported drug use only in prison; 20% only on the street; and 68% reported doing both. A total of 89% admitted having shared a needle at least once.<sup>138</sup>

Drugs enter prisons on a regular basis; one official estimate is that only 5% of all drugs entering institutions are apprehended by security.<sup>139</sup> The CSC recently recommended that the Criminal Code be amended so that the introduction of contraband into a penitentiary is a criminal offence: this has not yet occurred and it is not clear how such a law would be enforced or whether it would really reduce harm or simply change the nature of the harm, perhaps even exacerbating it.

### **HIV/AIDS and Hepatitis Seroprevalence**

There is now evidence of the rapid spread of hepatitis B and C in prisons; these pathogens tend to be found in persons with HIV and are passed through blood or semen, or both. Between January and August, 1995, 223 new cases of active hepatitis C and 22 new cases of hepatitis B were reported in federal prisons; these data suggest that there is potential for the rapid spread of HIV in prisons. Three studies in Canadian prisons found seroprevalence rates of between 28% and 40%. Hepatitis C is usually spread by either blood transfusion or sharing of contaminated drug paraphernalia. Among inmates of correctional institutions, hepatitis-positivity is a probable marker of injection drug use. **Taken together, these data strongly suggest that we should expect to see a marked rise in HIV prevalence in our correctional institutions over the next several years.**

Seroprevalence studies undertaken in federal and provincial prisons have shown rates of HIV infections between 1% and 7.7%; these studies were conducted several years ago so it is clear that current rates are markedly higher than this.<sup>140</sup> In federal prisons, the number of inmates known to be HIV-positive has increased at an alarming rate: in January, 1991, 27 inmates were known to be HIV-positive, while in March 1996, 159 inmates (more than 1% of the total inmate population of 14,100) were known to be HIV-positive. Rates of HIV among injection drug users in correctional institutions reflect the levels of infection in the drug injecting community outside the institution. For example, among inmates who inject drugs in Provincial prisons in Quebec, 8% of men and 13% of women are HIV positive. Studies of Federal jails in BC and Ontario found that about 1% of inmates tested were infected with HIV, about ten times the rate in the general public. The highest rates of infection were among prisoners with a history of injection drug use (2.1% for BC; 3.8% for Ontario). In some institutions, especially in Quebec, close to 5% of inmates are HIV-positive. Overall, estimates of HIV prevalence among prisoners vary from 1 to 4% in men and 1 to 10% in women; in both groups infection is strongly associated with a history of injection drug use.<sup>141</sup>

Hepatitis C seroprevalence rates are even higher: studies have revealed rates of 28-40%. Transmission of hepatitis C has been documented in at least one prison.<sup>142</sup> Studies undertaken in prisons in the USA, Australia, Scotland and other countries have provided evidence that outbreaks of HIV infection can occur in prison unless HIV prevention seriously.<sup>143</sup> While there have thus far been no documented cases of HIV transmission in Canadian prison, groups of inmates sharing syringes with HIV-positive members have been identified in a number of institutions.<sup>144</sup>

### **Responding to Drug-Related Harm in Prisons**

Issues raised by HIV/AIDS and drug use in prisons have been extensively studied on Canada. The most comprehensive analysis of the issues was undertaken by the Expert Committee on AIDS in Prisons (ECAP) in 1992-93. ECAP interviewed prison authorities, staff and inmates; reviewed Canadian and international policies and reports; and sent questionnaires to prison staff and prisoners. The Committees' Final Report was released in March of 1994.<sup>145</sup> The report takes a strong public health approach to HIV/AIDS in prisons, and a harm-reduction approach to drug use. It contains 88 recommendations, including recommendations to make full-strength household bleach available to inmates and to provide injection drug users access to methadone. The report concludes that sterile injection equipment will have to be made available in prisons. The report emphasises that adoption of a harm-reduction approach to drug use in prisons does not mean condoning drug use but rather means discouraging unsafe injecting behavior. **It concludes by saying that it will be essential to reduce the number of drug users who are incarcerated. Canada has one of the highest incarceration rates per capita in the world. This rate is particularly high for drug-related offences and second only to the USA.** Many of the problems created by HIV and drug use in prisons could be reduced if alternatives to imprisonment, particularly in the context of drug-related crimes, were developed and made available.

### **The Prison System's Response**

The CSC accepted many of the ECAP recommendations: in 1996 it decided to make bleach available in all federal prisons. CSC stated, however, that it would not provide methadone maintenance programs; and would not pilot-test needle-exchange programs in prisons. Instead of accepting these recommendations, only a few months after the release of ECAP's report, the CSC announced a "strategy to combat drugs in federal penitentiaries" that is in many ways inconsistent with ECAP's recommendations. Among other measures, the use of random urine testing for drug use has been increased "substantially" in federal institutions; searches of visitors are undertaken more frequently; and visitors attempting to bring drugs into institutions not only face criminal charges, but may be barred from further visits. These measures have been criticised on the grounds that they are extremely costly, intrusive and, ultimately, may be ineffective and even counterproductive. A commitment has been made to offer inmates better access to drug treatment programs.

As a result of the CSC's failure to implement ECAP's recommendations with regard to drug use, individual's and organizations consulted during phase one of a project on legal and ethical issues raised by HIV/AIDS (undertaken by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society), urged the two organizations to continue working on issues raised by

HIV/AIDS and drug use in prisons. In particular, they suggested that the joint project examine whether governments and the prison systems have a legal obligation to provide prisoners with the means that would allow them to protect themselves against contracting HIV and address the issue of the potential liability for not providing condoms, bleach and sterile needles and the resulting transmission of HIV in prisons. In 1996, the project published an extensive report in which it urges Canadian federal and provincial prison systems to:

- adopt a more pragmatic approach to drug use, acknowledging that the idea of a drug-free prison is more realistic than the idea of a drug-free society and that, because of HIV/AIDS, they cannot afford to continue focusing on the reduction of drug use as the primary objective of drug policy;
- acknowledge that making bleach, sterile needles, and methadone programs available to inmates does not mean condoning drug uses, but is a necessary and pragmatic public health measure; and
- educate the Canadian public and decision-makers about the importance of implementing harm-reduction measures in prison.<sup>146</sup>

**The report points out that , in 1995-96, the CSC spent \$1,200,000 for its urinalysis program; \$1,000,000 for other components of its drug strategy, but only \$175,000 for its entire AIDS Program.**<sup>147</sup> Urinalysis programs are hardly a good use of scarce resources: such programs cost more than appropriate public health responses to drug use, namely evaluated drug reduction and rehabilitation programs in all prisons.<sup>148</sup> Further, they are intrusive, requiring prisoners to urinate on command and in full sight of staff. They are also likely to have negative impact on efforts to reduce the harms from drug use. In theory, drug testing should reduce the amount of drug use in prisons because people should be dissuaded from using drugs through fear of disciplinary action. The long-term effects on level of drug use remain to be seen. In the short term, however, the majority of inmates report “no impact” on level of drug use.<sup>149</sup> Even if urinalysis programs do result in a decrease in drug use, this should not be overvalued. Reduction of level of drug use is an important goal, but reduction of the spread of HIV and other harms is more important. In particular, there is a fear that, because of urine testing, inmates’ drug use, rather than diminish, may shift from relatively harmless drugs that are detectable in urine for up to one month, to potentially more harmful drugs that have much shorter windows of detection. As a result, injection drug use may increase and, with it, the risk of HIV transmission and other harms.<sup>150</sup> Canadian prisoners confirm that this is happening, switching from marijuana to cocaine and heroin.<sup>151</sup> So serious did this problem become after random drug testing was introduced into British prisons that urine testing for marijuana was discontinued earlier this year.

The report also reviews Canadian and international law and argues that prison systems are failing to meet their legal and moral responsibility, because they are clearly not doing all they could to protect the health of inmates: measures that have been successfully undertaken outside prison with government funding and support, such as making sterile injection equipment and methadone maintenance available to injection-drug users, are not being undertaken in the vast majority of prisons, although some prisons, such as those in Switzerland, have shown that they can be introduced successfully, and receive support from prisoners, staff, prison administrators, politicians and the public.<sup>152</sup>

## **Legal Action**

As early as 1989, a Canadian court held that detention centres in Toronto were failing to come to grips with the detention of people with HIV/AIDS by not providing adequate treatment and by not educating staff. **That and similar cases since have shown that Canadian courts are willing to closely scrutinise the action or inaction of prison authorities in the area of HIV/AIDS.** Recent evidence of this is a 1996 case in which an HIV-positive woman undertook legal action against a provincial prison system for failing to provide her with methadone. The woman had been refused continuation of her methadone maintenance program once she entered prison. She petitioned the court for relief in the nature of habeus corpus, arguing that, under the circumstances she found herself in, her detention was illegal. In response to the petition the woman was prescribed methadone in prison.<sup>153</sup> Provincial prison policy has since been amended to allow for methadone treatment of prisoners. In another 1996 case, a Quebec man with a serious heroin problem was sentenced to a term of imprisonment with the specific aim that he be allowed to undergo methadone treatment.<sup>154</sup>

Because of such precedents, where courts have shown a willingness to hold that not providing those already infected with adequate care constitutes a violation of their constitutional rights, there is hope in Canada that courts may be willing to hold that denying incarcerated people the opportunity to prevent infection in the first place is also unconstitutional. It is increasingly being argued that the law (constitutional law, the law of negligence and criminal law) could be used to force prison systems to introduce long-overdue harm-reduction measures, or to hold them liable for not providing them and for the resulting transmission of HIV in prisons.

**The World Health Organization recommendations on the control of AIDS in prisons state that health care within prisons should be equivalent to health care in the community. For those of us who have started to feel that we have begun to make headway in introducing harm reduction as an acceptable policy in our countries, the situation in prisons should make us realize how much is still to be done. Reducing drug-related harm in society means reducing such harm in prisons too, and in that regard we have so far clearly failed.**

The impression is often given that prisons are a separate world. In fact, of course, the opposite is true: prisons experience the problems experienced outside as well as their own unique problems, and there is a constant flow of people between prisons and the general population. In attempting to put a thorough-going harm-reduction program in place we need to recognize that harm comes not just from drug misuse but also from the measures employed to control drug use. What we need most of all at this point in time is an open and frank debate about how we can reduce drug-related harm in all of its forms, and this includes restructuring the criminal justice system, rethinking drug strategy and reassessing our social policies. We need to expand community-based programs to combat excessive imprisonment: this means we must develop new approaches to drug issues and social policy which involve many agencies working together to reduce drug-related harm to the individual, the community and society as a whole. It is clear that in order to be truly effective, **any attempt to reduce drug-related harm in prisons needs to be part of a thorough-going harm-reduction approach to drugs in society as a**

**whole.** This approach must include evaluation of the effects of drug use, trafficking and prohibition itself.

## **9. Harm Reduction**<sup>155</sup>

*“First, do no harm”* (Hippocratic Oath)

Harm-reduction is a relatively new social policy with respect to drugs which has gained popularity in recent years, especially in Australia, Britain, Germany and the Netherlands, as a response to the spread of Acquired Immune Deficiency Syndrome (AIDS) among injection drug users. Although harm reduction can be used as a framework for all drugs, including alcohol, it has primarily been applied to injection drug use because of the pressing nature of the harm associated with this activity.

Harm-reduction has as its first priority a decrease in the negative consequences of drug use. This approach can be contrasted with abstentionism, the dominant policy in North America, which emphasizes a decrease in the prevalence of drug use. According to a harm-reduction approach, a strategy which is aimed exclusively at decreasing the prevalence of drug use may only increase various drug-related harms, and so the two approaches have different emphases. Harm reduction tries to reduce problems associated with drug use and recognizes that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term. This is not to say that harm reduction and abstinence are mutually exclusive but only that abstinence is not the only acceptable or important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence; it is consequently an approach which is characterized by pragmatism.

The spread of HIV has been a catalyst for the rise in popularity of harm reduction but in North America in particular harm reduction attracted attention because of effects of drug prohibition other than the spread of AIDS alone. The violent crime, gang warfare, prison over-crowding and police corruption associated with prohibition have reached a level such that policy makers, practitioners and members of the public alike are seeking alternatives to prohibitionist drug policy. The harm reduction approach attempts to identify, measure and minimize the adverse consequences of drug use at a number of levels: individual, community and societal.

The roots of harm reduction as we now know it are in the United Kingdom, the Netherlands and North America. In the 1980s, three important factors led to the establishment of the Mersey model of harm reduction in the UK: the ability of physicians to prescribe drugs, including heroin; the early establishment of syringe exchanges; and the cooperation of the local police. All of the available evidence on HIV infection among IDUs in Merseyside suggests that the Mersey HIV prevention strategy for IDUs is very effective, with extremely low levels of HIV in drug users and a decrease in drug-related acquisitive crime in many parts of the region, while the national rate is increasing.

In the early 1980s Amsterdam recognized that drug use is a complex, recurring behaviour and that reduction of harm means providing medical and social care in order to avoid some of the more harmful consequences of injection drug use. Needle exchange began in 1984 and since then many Dutch cities have taken a pragmatic and non-moralistic attitude toward drugs that has resulted in a multifaceted system which offers a variety of harm reduction programs. Police in the Netherlands focus attention and resources on drug traffickers, not users.

Methadone maintenance programs for opiate users began in Canada in the late 1950s and in the United States in the early 1960s. The spread of AIDS in opiate users has led to expansion and liberalising of methadone programs in a number of countries with good results, but many other countries, including Canada and the United States, are slow to provide an adequate response to the AIDS crisis.

A number of countries or regions have adopted harm reduction as both policy and practice. For example, the British Advisory Council on the Misuse of Drugs has stated: "we have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services which aim to minimize HIV risk behaviour by all available means should take precedence in developmental plans"<sup>156</sup> The World Health Organization has expressed a similar opinion, stating that policies aimed at reduction of drug use must not be allowed to compromise measures against the spread of AIDS.<sup>157</sup>

### **Features of Harm Reduction**

The main characteristics or principles of harm reduction are::

**Pragmatism:** Harm reduction accepts that some use of mind-altering substances is inevitable and that some level of drug use is normal in a society.

**Humanistic Values:** The drug user's decision to use drugs is accepted as fact, as his or her choice; no "moralistic" judgment is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected.

**Focus on Harms:** The extent of a person's drug use is of secondary importance to the harms resulting from use.

**Hierarchy of Goals:** Most harm-reduction programs have a hierarchy of goals, with the immediate focus on addressing the most pressing needs.

### **Definition**

Harm reduction can be viewed as both a goal and a strategy. In both cases, the person's use of drugs is accepted as fact. This does not mean that harm reduction approaches preclude abstinence but only that there is acceptance of the fact that there are many possible approaches or strategies that can be taken to address drug-related problems, harm reduction and abstinence being two of these. A harm reduction approach to a person's drug use in the short term does not rule out abstinence in the longer term, and vice versa. The National Working on Drug Policy suggested the following definition of harm reduction strategies: "**A policy or program directed towards decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use**".<sup>158</sup>

Harm reduction programs and policies include:

- syringe exchange and availability;
- methadone programs;
- prescribing of drugs other than methadone, including stimulants;
- explicit, honest education and outreach programs;
- law enforcement policies and practices;
- "tolerance areas", such as safe injecting sites, supervised by medical personnel, and safe dealing areas, monitored by police;
- alcohol programs such as moderate drinking programs, standard drink labels and server intervention programs;
- nicotine policies and programs such as policies controlling smoking in public places to delivery of nicotine through gum, patches, inhalers and smokeless cigarettes.
- marijuana policies such as *de facto* decriminalization of small amounts of cannabis.

The popularity of harm reduction on an international scale is evidenced by the increasing support for the International Conference on the Reduction of Drug Related Harm, now in its ninth year, and by the recent formation of the International Harm Reduction Association (IHRA). Despite the increase in popularity amongst workers in the field, many health and addictions agencies in North America and elsewhere remain ambivalent about harm reduction as it pertains to alcohol and other drugs. Harm reduction raises some difficult questions, but it is evident that it is better to debate these openly rather than to ignore them as has been done all too often in the past. Comprehensive harm-reduction programs that are culturally sensitive are necessary: harm reduction must be multifaceted, not just a singular intervention. The data regarding such drug-related consequences as AIDS make it clear that we need a long-term plan for harm reduction. Risk reduction is a social process, it is not something that public health officials can impose; an effective programs must provide multiple means for behaviour change and needs to be conducted on a long-term basis.

Harm reduction, in the final analysis, is concerned with ensuring the quality and integrity of human life, in all its wonderful, awful complexity. Harm reduction does not portray issues as polarities, but sees them as they really are, somewhere in between; it is an approach that takes into account the continuum of drug use and the diversity of drugs as well as of human needs. As such, there are no clear cut answers or quick solutions. Harm reduction, then, is based on pragmatism, tolerance and diversity: in short, it is both a product and a measure of our humanity. Harm reduction is as much about human rights as it is about the right to be human.

## **10. Alternatives to the Canadian System**

“The lessons from Europe and Australia are compelling. Drug control policies should focus on reducing drug-related crime, disease and death, not the number of casual drug users.”<sup>159</sup>

### **United States**

The United States enforces one of the most extreme forms of total drug prohibition in the world. Although there is *de facto* decriminalization of marijuana possession in some states and increasing support for medical marijuana (see above), for the most part policies in the United States are uniformly of a strictly prohibitionist nature. There are few needle exchanges, since some states still have laws against selling of needles without prescription or outlawing needle exchange. There is widespread drug testing, both in the workplace and in schools. Very harsh penalties for all drug offences apply, with sentencing according to strict mandatory minimum guidelines. The result has been: continuing very high levels of drug use (some of the highest of any country in the world), despite some decreases in sections of the population; escalation of costs; extremely high prevalence of HIV and other pathogens, especially among drug users (some of the highest rates in the Western world); and rapid prison expansion. Despite a fivefold increase in Federal expenditures for supply reduction efforts since 1996, cocaine is cheaper today than a decade ago and heroin purity exceeds 60% compared to 30% in 1990.<sup>160</sup>

In October, Amnesty International released a strongly worded report on the human rights record of the United States. Amnesty accuses the US of double standards and creating a climate "in which human rights violations thrive". The report, attacks the US for what it calls "a persistent and widespread pattern of human rights violations". US federal and state authorities, police, immigration and prison officers are all criticised in the report which documents generalised gratuitous violence, sexual abuse and cruelty. Many of the violations identified by Amnesty are related to enforcement of drug laws; more than 50% of incarcerations in the United States are drug-related. Conditions in American prisons come in for particular criticism in the Amnesty report. The number of people in US jails has tripled since 1980 to more than 1.7 million, and chains and leg-irons are commonly used as restraints despite being prohibited by international law. They also point out that up to one third of all young black men are in jail or on parole or probation. "We felt it was ironic that the most powerful country in the world uses international human rights laws to criticize others but does not apply the same standards at home."<sup>161</sup>

Despite America's overseas efforts, worldwide opium and cocaine production has doubled in the last ten years. The number of countries producing drugs has also doubled. Pressure to end production in one country only serves to increase production elsewhere. Since a single 35-square kilometre plot is enough to grow all the opium consumed in the US, the likelihood that the US will stop production is very small indeed. Borders are not easily sealed when it is estimated that a single DC3 flight can carry a year's supply of heroin to the US and twelve trailers a year's supply of cocaine.<sup>162</sup>

In 1980, the federal budget for drug control was approximately US\$1 billion, and state and local budgets were 2-3 times that. **By 1997, the federal drug control budget had reached \$16 billion, two-thirds of it for law enforcement agencies; state and local funding had also increased to at least that level.** "These are the results of a drug policy overreliant on criminal justice 'solutions', ideologically wedded to abstinence-only treatment, and insulated from cost-benefit analysis".<sup>163</sup>

## United Kingdom

Physicians in the United Kingdom are permitted by law to prescribe any drug except opium for their patients. This practice dates back to a committee put together by Sir Humphrey Rolleston during the 1920s. The Rolleston Committee was a group of leading physicians experienced in the treatment of dependent drug users. One of the most significant conclusions of the Committee was the following: "When...every effort possible in the circumstances has been made, and made unsuccessfully, to bring the patient to a condition in which he is independent of the drug, it may...become justifiable in certain cases to order regularly the minimum dose which has been found necessary, either in order to avoid serious withdrawal symptoms, or to keep the patient in a condition in which he can lead a useful life".<sup>164</sup>

Although there have been some important changes to the British System in response to the changing nature of the user population and tightening of controls over physicians, in many ways the recommendations of the Rolleston Report are still being followed. This is particularly true in the Mersey Region, where services follow the philosophy that even if you can't "cure" dependence, you can still care for drug users, providing injectable opiates and other drugs to registered users. The local police play a vital role in ensuring the success of this approach by not placing drug services under observation and by referring drug users who had been arrested to these services. The majority of clients receive oral methadone, but some receive injectable methadone, others injectable heroin, and a small number receive amphetamines, cocaine or other drugs. These drugs are dispensed through local pharmacists. In some parts of the UK, users can also be prescribed smokable drugs in the form of reefers (drug users who are able to give up injecting often find that they are not able to switch immediately to oral prescriptions which don't provide the "rush" that an injected drug does; smokable drugs provide this rush).<sup>165</sup>

**The government's statutory Advisory Council on the Misuse of Drugs (ACMD) stated in 1988 that AIDS is a greater threat to public health than drug misuse, and recommended that drug services modify their policies to make contact with and change the behaviour of the maximum number of drug users even when they are still actively using drugs.**<sup>166</sup> The ACMD advised that drug services should proceed according to the hierarchy of objectives for behaviour change, starting with the cessation of sharing of injection equipment followed by a switch to non-injecting drug use, a reduction in drug use and, ultimately, cessation of drug use.

The Mersey region has the second highest rate of notified addicts of any Regional Health Authority in the UK. The level of HIV infection amongst drug injectors in the Mersey Region is very low, less than 1%. There have been significant decreases in crime related to property, robbery of pharmacies and break and enters. Since no experimental trials or controlled studies have been conducted in this region, the data are considered to be too unreliable for the purposes of setting policy in other countries. The Mersey Model has been followed successfully in most parts of the United Kingdom, with a national average of only 1% HIV infection in injection drug users.<sup>167</sup> The police policy of "cautioning" for small amounts for personal use has now been extended to all drugs and is practiced throughout the country.

## **Switzerland**

In the past, drug problems in Switzerland have been left to the cities. One park in Zurich, a “safe area” for open drug use, became a major civic problem as the number of users grew, many of them from outside the city and country, and drug-related harms increased. The park--now known as Needle Park--was closed down when the unsanitary conditions, overdoses and complaints became too great a problem for the city to deal with. In order to avoid the mistakes of Needle Park, the Swiss government agreed in 1992 to take over some responsibility from the cities.

In January, 1994, the Swiss government began a multi-year, multi-city scientific trial to provide drugs to long-term dependent users to assess the effects on their health, social integration and behaviour. The program began with 700 dependent users in eight cities. The program was later expanded to include 1,146 patients in seven cities at 18 treatment centres for a small daily fee (US\$13). The program:

- provided participants with medical access to injectable, oral and in some cases smokable heroin, morphine, methadone and, under some conditions, cocaine. Most users preferred heroin to morphine. Two programs allowed clients to take a few heroin reeferers home each night;
- offered lodging, employment assistance, treatment for disease and psychological problems, clean syringes and counseling;
- allowed health officials in participating cities the option of providing cocaine to dependent users with the aim of determining extent to which the problem of cocaine psychosis will occur in a population otherwise taken care of. Opinion was divided over taking a maintenance approach to hard-core cocaine users;
- set no strict limits on dosages, but provides guidelines for what constitutes typical doses.
- maintained eight inmates in one prison on heroin, so far with good results.

Retention rates were high for both the six- and 18-month research periods. Patients showed improvement in physical health, mental health, and social situations as well as a reduction in new HIV infections. The final report was released July 10th, 1997 by the Swiss Federal Office of Public Health. The heroin maintenance experiment was declared a success: crime dropped by 60%, unemployment by 50%, and significant public funds were saved due to a reduction in the costs of criminal procedures, imprisonment and disease treatment. As a result, the Swiss Government is extending the heroin trial.

One innovative harm reduction approach being practiced in Switzerland, the Netherlands and Germany involves toleration by authorities of facilities known as "injection rooms", "health rooms", "contact centres" or similar terms. These are facilities where drug users can get together, and obtain clean injection equipment, condoms, advice, medical attention and so forth. The majority of these places allow users to remain anonymous. Some include space where drug users, including injectors, can take drugs in a comparatively safe environment. This is regarded as better than the open injection of illicit drugs in public places of consumption of drugs in "shooting galleries" that are usually unhygienic and controlled by drug dealers. In Switzerland, the first drug rooms were established by private organizations in Bern and Basel in the late 1980s. By the end of 1993 there were 8 such facilities, most operated by city officials. Several other cities in the German-speaking parts of Switzerland opened drug rooms in 1994. An evaluation of

three of these facilities after their first year of operation showed that they had been effective in reducing the transmission of HIV and the risk of drug overdose.<sup>168</sup>

A decrease in the incidence and prevalence of HIV and hepatitis B and C infection has occurred among drug users in Geneva on methadone maintenance during the past 8 years, suggesting that drug users have changed HIV risk-taking behavior in response to prevention campaigns.<sup>169</sup> The prevalence of HIV infection among subjects who entered treatment before 1988 was 38% compared with 4.5% among those who entered treatment after 1993. Similarly, the prevalence of HBV and HCV declined from 80.5% to 20.1%, and 91.6% to 29.8%, respectively, during the same time period. In addition to the national HIV information campaigns that began after 1986, several other HIV prevention measures were instituted in Geneva. In 1987, syringes became available in pharmacies and, in 1991 a nation wide syringe exchange and availability program that includes dispensing machines was initiated. This program now includes syringe exchange in all prisons and heroin distribution in one prison. Methadone treatment programs also became increasingly available during this period. **These comprehensive approaches have made Switzerland an outstanding example of the cost-effectiveness of pragmatic approaches to drugs.**

### **The Netherlands**

The main objective of drug policy in the Netherlands is to reduce the risks that drug abuse poses for the users themselves, their immediate environment and society as a whole. The Dutch tradition is one of taking a pragmatic approach to seeking solutions for concrete problems. While legislation is considered useful, great value is attached to organized social control.

**Although the risks to society are taken into account, the government of the Netherlands has tried to ensure that drug users are not caused more harm by prosecution and imprisonment than by the use of drugs.** The Dutch Code of Criminal Procedure contains the expediency principle which empowers the Public Prosecutions Department to refrain from instituting criminal proceedings if there are public interests to be considered "on grounds deriving from the general good".<sup>170</sup> Guidelines have been established for detecting and prosecuting offences under the *Opium Act*. No special action is taken by police to detect possession of drugs for personal use, or selling or possessing up to 30 grams of cannabis products. The amended *Opium Act* and prosecution policy in the Netherlands have thus created a *de facto* decriminalization of the use of marijuana and other cannabis products. These changes have resulted in reduced penalties for small scale cultivation and use of marijuana and increased penalties for wholesale dealers and international traffickers.<sup>171</sup>

One commentator explains how Holland meets its international obligations as follows: "The Single Convention and the obligations of the Illicit Trafficking Convention of 1988 do demand criminalization of possession, trafficking, dealing, cultivating and producing soft drugs as well as of hard drugs. This obligation is met in Dutch legislation in the *Opium Act*. But there are no clauses in the relevant UN drug conventions that concern the actual *enforcement* of the legislation. The Single Convention acknowledges explicitly that enforcement of statutes may be limited on the basis of principles that are a fundamental part of a nation's sovereignty. This clause provides the latitude the Dutch have been using in their drug policy: by interpreting the

legal principle of expediency as a fundamental sovereign principle, the Dutch have been able to develop a policy of (partial) non-enforcement of violations of the *Opium Act*.<sup>172</sup>

The International Narcotics Control Board has criticized this *de facto* decriminalization of drug use by the Netherlands as contravening UN policy. In response, Dutch critics of prohibition argue that prohibition is based on too literal an interpretation of the punitive measures set out in these treaties. Indeed, they argue that these treaties allow states to regulate cannabis production if it is decided that that is the most appropriate way to protect public health and welfare.<sup>173</sup>

More specifically:

“The logical interpretation [of Articles 22 and 28 of the Single Convention on Narcotics Drugs, 1961] is that it is up to each individual nation to decide for itself which measures are most appropriate for protecting public health and welfare and for deterring illicit trafficking. If a country becomes convinced that prohibiting the cultivation of, say, the cannabis plant, is not the most appropriate means, that country is not obligated by virtue of the *Single Convention* to enforce prohibition, provided that it establishes a government agency that regulates and controls cultivation. In that case, this country does not act in contravention of Article 3 of the treaty concerning the illicit traffic in narcotic and psychotropic substances (Vienna, 20 December 1988).”<sup>174</sup>

In a number of Dutch cities there is undisturbed sale of marijuana in coffee shops, where the use of alcohol and hard drugs is not allowed. The authorities monitor the coffee shops and youth centres where marijuana trade occurs to ensure that there is no sale of large quantities, no sale of other drugs, no advertisements, no encouragement to use and no sale to minors. The aim of this policy is to separate the markets for hard and soft drugs, so that the people who use the latter do not become marginalised. Use of marijuana has also been normalized to a certain extent in that there is recreational use by some and acceptance of use in public places. These changes to the Dutch drug laws have not been followed by an increase in the use of cannabis products. In fact, by keeping cannabis dealing away from the hard drug market and by honestly addressing the myths associated with its use, it appears to have become less attractive to young people.<sup>175</sup>

The Netherlands is one of the birth-places of harm reduction; agencies began methadone prescribing programs in the 1970s, expanding and liberalizing these in the 1980s in order to deal with hepatitis, HIV, drug-related crime and other harms (“low threshold programs”). Research has shown that the rigidity of programs is positively related to rates of crime, other drug use, and exposure to infection. Low-threshold programs do not aim at treating the addiction; instead, they aim primarily at contacting heroin users and regulating or stabilizing their use by preventing withdrawal symptoms.<sup>176</sup> One example of innovation has been the “methadone by bus” project in Amsterdam. Mobile methadone clinics cruise the city, stopping at different locations daily. The liquid methadone is consumed on the spot and clean needles and condoms are available.<sup>177</sup> The Amsterdam Municipal Health Service also has a small number of persons on injectable methadone or morphine.<sup>178</sup> One of the main reasons that methadone programs have proven effective in getting people into treatment in Amsterdam is that the methadone bus program requires no urine samples and no mandatory contact with counselors. The number of people entering drug-free treatment and resocialization programs in Amsterdam has more than doubled

since the introduction of the methadone buses and the needle exchange schemes, which began in the early 80s. As with the UK, the Dutch harm reduction programs have become a model for other countries because of their pragmatism, humaneness, and success. A three-month trial to supply heroin users with pharmaceutical heroin began in Amsterdam and Rotterdam in July of this year. The experiment involves 25 dependent users in both cities, and if successful, it will be expanded to include 750 users nationwide.

In addition to drug rooms and "coffee shops", Rotterdam has also informally adopted a tolerance-area policy known as the "apartment dealer" arrangement. Following this policy, police and prosecutors refrain from arresting and prosecuting dealers living in apartments proving they do not cause problems for their neighbours. This approach is part of a "safe neighbourhood" plan in which residents and police work together to keep areas clean, safe and free of "nuisance".

### **Germany**

Germany has ratified the Single Convention on Narcotic drugs and the 1971 Convention on Psychotropic Substances and the 1988 Convention on drug trafficking. Case law, however, has modified this legislation. With regard to cannabis use, the Federal Constitutional Court, in a 1994 judgement, required that the statutory possibility of refraining from prosecution where the person has cannabis in insignificant quantities be applied as a rule to occasional personal consumption where there is no danger to third parties.<sup>179</sup>

At the local level, the large German cities follow a policy of harm reduction. This is evident from the fact that several European cities, including Frankfurt, Amsterdam, Hamburg and Zurich, have signed the Frankfurt Resolution. This document concludes that the attempt to eliminate the consumption of drugs in society has failed, that criminal prosecution should focus on combatting illegal drug traffic, and that harm reduction policies should be pursued to permit drug users to live a life of dignity.<sup>180</sup> Thus, in Hamburg, local authorities have adopted a policy of *de facto* decriminalization of possession of small amounts of cannabis (up to 30 grams), cocaine (up to 5 grams) and heroin (up to 1 gram).<sup>181</sup>

Until 1987 methadone maintenance for all practical purposes was outlawed in Germany. A pilot methadone project was then launched, involving five separate cities (since expanded to eight). An assessment of these projects after five years revealed, among other things, a dramatic drop in heroin use (over 90% of patients totally discontinued illicit narcotic consumption) and improvement in the general health of the patients.<sup>182</sup> Reported results of methadone treatment in the cities indicated a reduction in drug use and in criminal activity such as prostitution, a decrease in fatalities, and improvement in health.<sup>183</sup> Methadone treatment has expanded greatly, to over 5,000 clients. Almost 2,000 physicians in Germany have received approval to prescribe methadone.<sup>184</sup>

**Frankfurt offers a fine example of a comprehensive harm reduction approach to the problems of a large city.** It has created a readily accessible (low-threshold) network of services for drug users ranging from day-or night rest areas, to needle exchange programs, to the establishment of "safe injection rooms" or "health rooms" where heroin users can inject

themselves in a clean, stress-free environment.<sup>185</sup> The police worked with a group that met on weekly basis (the Monday Group), made up of city officials and administrators, doctors and police officials. The police have maintained their policy of apprehending dealers but initiated a new policy of tolerating an open scene within a clearly defined area of one of the parks. The policy has led to a significant reduction in the number of homeless drug users, drug-related crimes, and drug-related deaths in the city. While not all of the problems have been solved, there has been a decrease in crime and violence and overdose deaths have been reduced by 80%.<sup>186</sup> Public health and social service workers find that it is easier to provide services when drug scenes are readily accessible and relatively static. Several German cities are preparing to start a trial of heroin prescription to users. These trials have the support of the majority of the countries police chiefs.<sup>187</sup>

### **Australia**

Until the mid-1980s, Australian drug policies and programs closely resembled those of its fellow Commonwealth member, Canada. Unlike Canada, however, the Australian response to the AIDS threat was rapid and pragmatic. National and state advisory committees on AIDS and drug use were set up early and were, for the most part, able to get a great deal achieved. As a result, Australia has a low level of HIV infection in drug users, and there is very little spread of infection in this group. Measures introduced to combat the spread of AIDS in Australia included syringe exchange schemes and the marked expansion of methadone programs. The criteria for admission to these programs were also made less stringent, and many more spaces were allowed for maintenance of clients with little motivation to change drug-using behaviour. These changes to drug programs have been supported by a change in national and state policy towards drug abuse such that the highest priority has been given to the containment of HIV and other drug-related harms. Under the change of government over the past four years there was a move back toward tougher enforcement of prohibition, as reflected in the Federal government's decision not to proceed with a heroin trial.

The Legislative Assembly of the Australian Capital Territory (ACT) appointed a select committee on HIV, Illegal Drugs and Prostitution in September of 1989. In 1991, the Assembly authorized the Committee to submit an interim report on illegal drugs. The committee came to the conclusion that current policy implementation with regard to controlling and/or reducing the use of illegal drugs (prohibition) might not be effective.<sup>188</sup> The committee accepted the international evidence that prohibition policies have not reduced the illegal supply of opioids and have not reduced the number of people taking drugs; Prohibition policies, particularly in countries like the United States, also actively work against health policies seeking to control the spread of AIDS. In Australia, all major parliamentary and judicial reports on illegal drugs since 1971 have emphasized the for more research into this area, making the way for a departure from a strict abstinence philosophy. The committee considered alternative policy approaches. Members of the committee visited the Merseyside area and were impressed with the success of the prescribing approach used there. So began a process which resulted in the design of a heroin prescribing trial is widely supported by politicians, health-care workers and the community.

The committee identified several potential benefits of a trial:

- There is a broad consensus of opinion that prohibition as it is currently enforced is not effective, that changes in drug policy are urgently needed.
- There is no agreement on what form these changes should take. The case for increasing the controlled availability of opiates, including heroin, is stronger than the case against. The likely potential benefits of such a changes reduced crime, reduced corruption, improvements in health and lifestyle for users, as well as preventing the spread of HIV infection.
- While there are indications that such benefits would result from a change in controlled availability, these are based on a small number of inconclusive studies. They also addressed concerns such as the following:
  - there may be leakage of government supply to street market; expansion of the program to larger numbers raises concerns about subjects having to be given “take-away” heroin;
  - providing heroin to users in a supervised clinical setting may not provide an answer to the relationship between heroin and crime in a realistic setting; many heroin users are involved with crime before they become involved with heroin;
  - costs due to supplementing of welfare services will be increased;
  - being able to receive heroin legally does not ameliorate the difficulties that users face due to lack of education, diminished vocational skills and deficient social skills.

The Committee concluded that the risks can be minimized and are outweighed by potential benefits. The cost is estimated at approximately Aus\$10,000 per person per year. The ministerial Council on Drug Strategy approved the project on July 31st, 1997. Before the trial can commence, approval must be obtained from the United Nations’ International Narcotics Control Board. Though approved by the Australian government, heroin trials were criticized by US State Department officials and considerable pressure was also brought to bear on the new prime minister by a local media tycoon.<sup>189</sup> In August 1997, the Australian federal cabinet decided not to pass the necessary legislation to allow heroin to be imported for trial or allow financial support for it. Michael Moore (an independent member of ACT parliament) said of the decision, “It was made in ignorance and it was built on fear...”<sup>190</sup>

In the early 1990s, two Australian jurisdictions -- South Australia and the Australian Capital Territory (ACT) -- made the simple possession of cannabis into a civil offence through an expiation (fine) system. The offences are not criminally prosecuted or penalized, there are no criminal consequences and the maximum fine is \$150. Consumption of cannabis in public places is still a criminal offence. Recent studies show no evidence of an increase in cannabis use rates in SA or ACT relative to other states.<sup>191</sup> However, enforcement under the fine scheme appears to focus disproportionately on those of lower socioeconomic status. At the moment, about 45% of those caught fail to pay the fine and still end up before the courts, so the scheme in its current form has not saved the justice system a significant amount of money. Revisions to the scheme are in progress, and Australia is considering a national program of cannabis policy reform.<sup>192</sup>

**With its rapid and pragmatic response to HIV and its willingness to consider alternatives to prohibition, Australia provides an example of a federation willing to focus on the reduction of drug-related harm at the national and regional level.** A significant component of this willingness for drug policy reform has been the Australian Drug

Law Reform Foundation, comprised of parliamentarians, professionals and members of the community who are concerned about the damage done by drugs and drug policies.<sup>193</sup>

## 11. Conclusions and Recommendations

*“It is time to re-frame the problem. For decades there had been a futile debate about whether self-destructive drug use is a “criminal problem” or a “medical problem”. I hope that it can now be clear that it is neither -- it is a political problem.”<sup>194</sup>*

Problems related to drugs, licit and illicit, are already high in some regions of Canada, and are increasing rapidly in others. Rather than being the result of drug use *per se*, however, harms related to illicit drugs are in most cases the result of ineffective and inappropriate drug policy. The recently proclaimed *Controlled Drugs and Substances Act* (CDSA) was a missed opportunity for debate and drug policy reform. This could have been a time to reevaluate Canada’s drug laws and draft new ones based on public health and harm reduction; the latter is especially pertinent given that Canada’s Drug Strategy, in place when the new law was passed, explicitly stated that its aim was to reduce drug-related harms. **During hearings in the House of Commons on the proposed new drug law, the Liberal government stated that it would call for a full independent review of drug policy within one year of the bill becoming law. The CDSA was proclaimed in force in May of 1997 and still there is no sign of a much-needed review of drug policy in Canada.**

Canada’s drug legislation is irrational and often confusing. CDSA promises only to exacerbate the problems of old legislation and to add to the confusion rather than clarify. The government will continue to depend on the inconsistencies that come from allowing discretion to police, crowns and judges to modify the legislation. The result will be a continuation of the misdirection of resources, the criminalization of drug users and the unnecessary infection, and death, of numerous Canadians. CDSA ignores the evidence regarding<sup>195</sup>:

- the ineffectiveness of criminal deterrence against users;
- the need for public-health based alternatives;
- the high social, individual and financial cost of policies based on criminalization; and
- the importance of looking to the experience of countries other than the United States in formulating our drug policies.
- it will continue to force Canadian governments to waste hundreds of millions of dollars annually to fight a war with weapons that cannot win the “war”; at the same time, it will drain much-needed funds from other programs;
- it will show Canada as a regressive and repressive society when many other countries are beginning to turn away from the excessive use of the criminal law to deal with drugs;
- it will show that we have learned nothing from the failed experience of total prohibition of alcohol during the 1920s or from the utter failure of the United States to resolve its drug problems through ever increasing application of the criminal law.

*The Economist* has often criticized the continuing reliance on prohibition in Western countries. “Prohibition, and its inevitable failure, make a bad business more criminal, more profitable and

more dangerous to its customers than it need be. Lifting the ban, and replacing it with detailed regulation, might certainly expose more people to risky experiments with drugs.... But prohibition's failure is more dangerous yet, both for individual drug-takers and for societies corrupted, subverted and terrorised by the drug gangs. The trade is banned by national laws and international conventions. Repeal them, replace them by control, taxation and discouragement. Until that is done, the slaughter in the United States, and the destruction in Colombia, will continue. Europe's turn is next."<sup>196</sup>

Drug and other social policy around the world has most certainly been a catalyst for the spread of AIDS and other drug-related harms.<sup>197</sup> Current Canadian drug laws will contribute to the deaths of thousands of people in the coming years through the spread of drug-related HIV and other infections, through overdoses and through violence. CDSA will only serve to perpetuate and exacerbate these harms, for the following reasons:

- the criminal law generates a very profitable black market in drugs and this profitability creates a strong incentive to traffic in drugs. Criminal sanctions have little effect on this behaviour.
- users have to pay black market prices for their drugs. In order to support what can become a very expensive habit, many dependent users must steal or traffic.
- the profitability of the drug trade leads to corruption and violence amongst the various parties involved. Innocent bystanders get caught in this violence. Society as a whole is adversely affected by the ongoing violence and corruption.
- the criminal law increases the probability that drug users and their sexual partners and children will become infected with HIV and others pathogens. This is because current laws encourage users to inject drugs. Laws prohibiting drugs such as heroin and cocaine have encouraged people to use them in more cost-efficient ways, often by injecting. This happens for several reasons; the high price of illegal drugs means that users cannot afford to waste them and they inject rather than taking drugs through less efficient means, such as smoking; because the drugs are illegal, users keep as little of the drug with them as possible, to avoid detection or to minimize punishment if caught, which means they must compensate by using more efficient means of ingestion. Drug laws such as CDSA also prohibit substitutes that could be taken orally and more safely.
- the high price of illicit drugs has forced some people into sex-for-money or sex-for-drugs to support their habits, thereby increasing the risk of spreading HIV and other infection.
- current laws promote public attitudes that are anti-drug user as well as anti-drug. This has created a culture of marginalized people by making them into criminals for using drugs; the stigma associated with being labeled a criminal alienates them from conventional society and traditional support networks. Because of the marginalization and distrust of authority, it is difficult to reach users with educational messages concerning harm reduction, safe injection practices or drug treatment.
- alcohol and other drug policies have made it more likely that drug-dependent women who are pregnant or who have children will not seek help for fear of having their children taken from them. When women with children do seek help, few services provide child care or other means of allowing the woman to obtain treatment and still fulfill her role as caregiver. The alcohol and other drug information given to women is frequently inaccurate and hysterical, being based on prohibitionist and puritanical dogma rather than on scientific fact.

Female drug users who are HIV positive, and, if pregnant, their children, are especially at risk if the woman feels that she cannot approach helping services.

- drug laws have resulted in strong opposition to syringe exchange programs in some communities since they are seen as condoning drug use. CDSA so confuses the situation with respect to the legality of syringes that it is likely to increase problems with respect to syringe exchange in Canada.
- users of illicit drugs are exposed to adulterated drugs of unknown levels of purity. In 1998, more than 300 people died in BC from high-grade heroin and cocaine overdoses; there have been more than 2000 such deaths in BC since 1991, most of them preventable by such measures as drug regulation and safe-injection sites.
- users who are concerned about arrest for possession of drugs will avoid carrying their own drugs and needles. Without safe-injecting sites, they may attend "shooting galleries" instead, where it is more likely that they will share needles.
- when users do get arrested, they rarely receive adequate treatment. Many are put into correctional facilities (at a cost of \$50,000 per year), where many of them continue to use drugs and few receive appropriate treatment.
- our social policies stigmatize and marginalize sex-trade workers and make it more likely that they will have to work in unhealthy and unsafe conditions. The nature of this lifestyle encourages drug use. Current policies make it likely that drug using sex-trade workers will have frequent contact with law enforcement authorities and may end up in prison.
- prisons have become overcrowded with people charged with drug offenses, making it more likely that AIDS and hepatitis will spread in prisons and that there will not be adequate space for those charged with real crimes, such as violent offenders. A number of prisoners report using drugs and injecting for the first time in their lives when they are in prison.

Much of the cost of illicit drugs in Canada is attributable to policing and the criminal justice system. Yet studies have repeatedly shown that prevention and treatment are far more cost-effective than are approaches which depend on the criminal law. Methadone and other forms of treatment can cut down on the amount spent on illegal drugs, and so can reduce crimes committed to obtain drugs.<sup>198</sup> Treatment can also reduce other criminal behaviour through reducing alcohol and drug use.<sup>199</sup> The result is a saving not only in terms of economic loss due to theft but also in terms of legal and prison costs. Drug treatment is a more cost-effective method than confinement for reducing drug use and crime: about two-thirds of the benefit for one-tenth of the annual cost.<sup>200</sup> Such reduction in criminal behaviour, however, occurs only as long as the user stays in treatment and only as long as treatment is effective. Effectiveness of treatment and whether the user stays in treatment or not depend on the type of treatment they receive. Flexible treatment programs, where multiple options exist for each person, appear to be the most effective in keeping users away from illegal drugs and the most successful at retaining clients.

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A recent study by bipartisan public health researchers in the United States found that medical treatment for drug dependence works as well as treatment for diabetes and other chronic diseases, dramatically reduces crime and is much cheaper than jail.<sup>202</sup> The report concluded that: **every dollar invested in drug treatment can save \$7 in societal and medical costs.**

These findings confirm those of previous studies of comparative approaches to drug dependence.

In Canada, the majority of drug users cannot get treatment when required. When people are able to access treatment, most of this is abstinence based, which is thought to be appropriate for only a fraction of those who need treatment or support services. Lack of relevant services and treatment is particularly marked with respect to cocaine and crack-cocaine. There is a pressing need to study and adopt new approaches to stimulants. Some effective approaches being used in other countries include prescribing the drug of dependence or alternatives, including coca leaf and tinctures, which allow stabilisation and rehabilitation of the user.<sup>203</sup>

Solutions to complex problems are never simple or unidimensional. Solutions are even harder to find when the problem is wrongly construed to begin with. What has been called the “drug problem” is in fact but one manifestation of fundamental problems in modern society. Bruce Alexander writes: “The reason why the old interventions are not accomplishing much and the “new” ideas are unpromising is obvious to many people. Self-destructive drug users are responding in a tragic, but understandable way to lives that were hopelessly and cruelly dislocated before their “drug problem” began. It is a fact of history and psychology that prolonged dislocation of individuals...or of groups...predictably begets desperate, obsessive attempts to find some kind of integration and identity... In the absence of achievable, healthy possibilities, this usually takes the form of lifestyles built around vice, violence and excess, frequently including and ultimately self-defeating use of drugs. Thus, the problem on Vancouver’s streets is not really a “drug problem” -- drug use is only a part of a much larger pattern of response to prolonged dislocation.”<sup>204</sup> Not surprisingly, studies of the harms attendant upon drug use in different countries have found that the minimising of harms is as much about social policies as it is about drug laws.<sup>205</sup> Drug policy reform without broader social policy reform will achieve a great deal, but not nearly enough, by way of reduction of drug-related harms.

Surely it is no coincidence that drug-related harms are greatest in those segments of Canadian society affected most by increases in poverty and decreases in social services. Canada tumbles on the international ratings of development once poverty enters the equation. A recent United Nations meeting on poverty was told that Canada has failed to comply with its obligations under the International Covenant on Economic, Social and Cultural Rights. These and other human rights violations affect levels of drug misuse and drug users directly and indirectly. Failure to address these fundamental issues leaves Canadians vulnerable to more abuses and yet more problems, in an unending cycle. This renders Canadian governments open to increasing levels of criticism from human rights activists and, potentially, to numerous legal challenges; this is especially true with respect to the situation in correctional facilities.

Rather than considering other options and looking to Europe for alternatives, we look to the United States for solutions. Yet the United States represents the most glaring failures of social policy in general and prohibitionist drug policy in particular: Washington DC has one of the highest murder rates in the world and US prisons are overflowing with drug offenders. Despite massive expenditures, particularly over the past several years, drugs remain widely available, purity has increased and many drug prices have remained constant or fallen.

Why, then, does prohibition persist and alternatives remain such an anathema to law enforcement and many politicians? Gil Puder, an outspoken member of the Vancouver police force puts it bluntly: “The reality is that policing’s make-work project called drug prohibition has been so successful that society can no longer afford to pay for the crime wave we’ve created...”<sup>206</sup> Regarding the relationship between prohibition, weapons, and the industry of law enforcement, Puder writes that the “violence of prohibition is simply good for business.”<sup>207</sup> He concludes that: “There are simply too many people who have formed their value system around an idea, an idea that has back fired to magnify social misery and run roughshod over our justice system. Critical thinkers might ask why prohibition advocates are content to blame others for the disaster left in the drug war’s wake. There’s a simple reason for this, going far deeper than the overt examples of personal gain and empire building. The defining characteristic of the drug war is that it enable people to form a self-concept, based not on the quality of their character, but through disparaging the morality of others.”<sup>208</sup>

Canada needs an honest dialogue about the harms (and benefits) of all drugs. We must start to talk openly and honestly about drugs and about alternatives to prohibition, even if it is easier and politically “safer” to accept the status quo. Some might argue that the international drug conventions stand in the way of reform, but such arguments ignore the wide range of options left open by the treaties especially with regard to national laws and practices. The arguments of reformers on all sides of the fence return to the interpretation of the term “possession” in the *Single Convention*. No doubt analysts will continue to grapple with this question, but in the meantime we must not forget that drug users continue to be criminalised, marginalised, become ill and die. The terms “suffering” and “death” leave little room for interpretation. Academic debates on semantics should surely not be allowed to stand in the way of implementing policies and programs that will reduce suffering and which are consistent with Canada’s own Constitution and legal system.

Many would agree that the global war on drugs is now causing more harm than does drug use itself. Persisting in our current policies will only result in more drug use, more empowerment of drug markets and criminals, and more disease and suffering. Surely it is time for an open debate on national and global drug control policies in which we seek to find solutions that will reduce the harms of drug policy as well as of drug use itself. Such a debate would allow us to address the underlying factors that give rise to drug-related problems to begin with and so allow us to move on from simple “Band-Aid” solutions. Canadian drug laws must be re-examined and alternative means of reducing the harms associated with drugs in society must be honestly and openly considered. Drugs should be treated as a health, social, and political issue rather than a criminal one. We need the creation of an independent committee which can identify and develop alternative policies and programs on how to deal with drugs in an enlightened, humane and effective manner.

## **Recommendations**

It is recommended that:

1. There be an enquiry into drug policy in Canada and its relationship to domestic and international law, including human rights standards. This enquiry would examine drug policies and programs in other countries.
2. The Canadian AIDS Strategy be coordinated with a new, fully funded, Drug Strategy.
3. Federal and provincial governments and their agencies treat drug use as a health and social issue, not a law enforcement problem.
4. Funding for law enforcement, education and treatment should be equal.
5. Governments provide well funded, research based, effective, drug education for the community and schools to be developed and delivered by education and health professionals.
6. Support services for drug users and those at risk of drug misuse be increased substantially.
7. Treatment services (harm-reduction and abstinence based) for drug users be increased substantially to meet demand and special attention be paid to the needs of vulnerable groups including pregnant women and women with children, Natives, street youth and HIV-infected individuals.
13. A wide range of treatment options, including the medical prescription of heroin and stimulants, be tested and evaluated.
14. Needle exchange programs be increased to meet demand and safe injecting facilities be established.
15. Criminal sanctions for the personal use of illicit drugs be removed.
16. Regulation and taxation of commercial production and sale of cannabis be considered.
17. Non-custodial sentencing options such as drug treatment, counseling or community service orders for those apprehended for minor drug related offences be adopted.
18. Measures be taken immediately to reduce drug-related harms in prisons including cessation of drug testing (especially for marijuana), implementation of syringe exchange and improved access to treatment, including methadone.
19. Canada adopt a thorough-going harm reduction approach to drugs for the benefit and well-being of all members of the community.

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